Bath & North East Somerset Council

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Date: 20th November 2014
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To: All Members of the Wellbeing Policy Development and Scrutiny Panel

Councillor Vic Pritchard
Councillor Katie Hall
Councillor Sharon Ball
Councillor Sarah Bevan
Councillor Anthony Clarke
Councillor Bryan Organ
Councillor Kate Simmons
Councillor Neil Butters
Councillor Eleanor Jackson

Chief Executive and other appropriate officers
Press and Public

Dear Member

Wellbeing Policy Development and Scrutiny Panel: Friday, 28th November, 2014

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Friday, 28th November, 2014** at **10.00 am** in the **Kaposvar Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
for Chief Executive

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

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

1. **Inspection of Papers:** Any person wishing to inspect minutes, reports, or a list of the background papers relating to any item on this Agenda should contact Jack Latkovic who is available by telephoning Bath 01225 394452 or by calling at the Guildhall Bath (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 – Reception: Civic Centre - Keynsham, Guildhall - Bath, The Hollies - Midsomer Norton. Bath Central, and Midsomer Norton public libraries.

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

4. **Recording at Meetings**:-

   The Openness of Local Government Bodies Regulations 2014 now allows filming and recording by anyone attending a meeting. This is not within the Council's control.

   Some of our meetings are webcast. At the start of the meeting, the Chair will confirm if all or part of the meeting is to be filmed. If you would prefer not to be filmed for the webcast, please make yourself known to the camera operators.

   To comply with the Data Protection Act 1998, we require the consent of parents or guardians before filming children or young people. For more information, please speak to the camera operator

   The Council will broadcast the images and sound live via the internet www.bathnes.gov.uk/webcast An archived recording of the proceedings will also be available for viewing after the meeting. The Council may also use the images/sound recordings on its social media site or share with other organisations, such as broadcasters.

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

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

7. **Emergency Evacuation Procedure**

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

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

Wellbeing Policy Development and Scrutiny Panel - Friday, 28th November, 2014

at 10.00 am in the Kaposvar Room - Guildhall, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

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

3. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

4. DECLARATIONS OF INTEREST

   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 or a member of his staff 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 (Pages 7 - 20)

8. CABINET MEMBER UPDATE (10 MINUTES)

The Cabinet Member will update the panel on any relevant issues. Panel members may ask questions

9. CLINICAL COMMISSIONING GROUP UPDATE (10 MINUTES)

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

10. HEALTHWATCH UPDATE (10 MINUTES) (Pages 21 - 64)

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

11. ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES ACQUISITION - BRIEFING PAPER (20 MINUTES) (Pages 65 - 74)

The Panel are asked to consider an update from Kirsty Matthews (RNHRD) and Sarah Truelove (RUH).

12. CARE ACT 2014 - UPDATE AND OPTIONS FOR CHARGING FOR SERVICES (30 MINUTES) (Pages 75 - 86)

The Panel is asked to:

1.1 Note the general update on the Care Act; and

1.2 Express a view on the options for charging for services summarised in paragraphs 4.7 to 4.16 and detailed in Appendix 1.

13. MEDIUM TERM SERVICE & RESOURCE PLAN UPDATE (45 MINUTES) (Pages 87 - 102)

The Panel is asked to:

(1) Comment on the update to the 3 year medium term plan update for Adult Social Care, focusing on matters affecting 2015/16, and note that this will be the third year of the plan.

(2) Identify any issues requiring further consideration and highlighting as part of the budget process for 2015/16.

(3) Identify any issues arising from the draft plan it wishes to refer to the relevant portfolio holder for further consideration.

COFFEE BREAK (10 MINUTES)

14. TEENAGE PREGNANCY UPDATE (20 MINUTES) (Pages 103 - 114)

The Panel are asked to consider an update from Paul Sheehan.

15. ALCOHOL STRATEGY REFRESH (20 MINUTES) (Pages 115 - 150)

The current B&NES Alcohol Harm Reduction Strategy (2012) was adopted by B&NES Council in April 2012. A commitment to refresh the Strategy in light of national and local developments was agreed with Wellbeing Policy, Development and Scrutiny Panel in May 2012. A Joint Scrutiny Inquiry Day in October 2013 and its subsequent recommendations have informed the Strategy refresh, alongside national and local developments since 2012.

The Panel are asked to agree with officers ecommendations in the report.

16. PANEL WORKPLAN (Pages 151 - 154)

This report presents the latest workplan for the Panel (Appendix 1).

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

BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Friday, 19th September, 2014

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

32 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

33 EMERGENCY EVACUATION PROCEDURE

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

34 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

There were none.

35 DECLARATIONS OF INTEREST

Councillor Vic Pritchard declared an “other” interest as a representative of the Council on Sirona Care & Health Community Interest Company.

Councillor Eleanor Jackson declared an “other” interest as a representative of the Council on Sirona Care & Health Community Interest Company.

Councillor Katie Hall declared an “other” interest as a representative of the Council on Sirona Care & Health Community Interest Company.

Councillor Tony Clarke declared an “other” interest in agenda item ‘Royal National Hospital for Rheumatic Diseases NHS FT – Organisational update’ as a representative of the Council on the RNHRD Board.

36 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

The Chairman informed the Panel that NHS England has just launched a 12 week public engagement on the draft service specifications for congenital heart disease.

The Chairman said that one of the options for the Panel to contribute towards Congenital Heart Disease review is via Joint Scrutiny Committee; or the Panel could wait until the potential local impact is known from engagement exercise.

The following was **RESOLVED**:

If the Panel would contribute towards the Joint Scrutiny Committee, then the following members would represent B&NES at the Joint Scrutiny Committee – Councillors Pritchard, Hall and Jackson.

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

There were none.

38 MINUTES

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

39 CABINET MEMBER UPDATE

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

Councillor Allen added to an update that the Better Care Fund had been submitted this morning and that funding allocated to the Council for the Care Act implementation would not be enough. Local Members of the Parliament had been on the case of getting adequate funding for the Council.

The Chairman commented that 33 people identified as rough sleepers was a considerable number of people and asked what had been done to compensate in terms of measures for helping reducing the number of rough sleepers.

Councillor Allen responded that some measures had been put in place by previous administration. The Council also continued to work with partners in terms of delivery of homelessness services. The Council had adopted Homelessness Strategy as one of the key documents to tackle this issue.

Councillor Allen also said that the numbers of rough sleepers had been more accurate than before due to more accurate way in which the count had been conducted.

Councillor Jackson asked about sofa surfers and asked if ‘bedroom tax’ had an impact on amount of homelessness.

Councillor Allen responded he would provide more information on this matter at the next meeting. Sofa surfing had been seen as invisible homelessness and could be an issue.

Councillor Hall asked what would be predicted shortfall as a result of Care Act implementation.

Jane Shayler (Deputy Director: Adult Care, Health and Housing Strategy and Commissioning) responded that modelling of the likely additional financial burdens of

the Care Act is currently predicting a shortfall in the region of £1m when taking into account the relatively small amount specifically identified by the Government in the Better Care Fund. A briefing on the implications is being used to raise awareness, including for all Councillors, of the issues for Bath and North East Somerset and, also to inform future years financial planning.

Councillor Bevan asked if the next count of rough sleepers, which was scheduled for November, could give false estimate on how many people were sleeping rough as they might be somewhere where is warmer.

Councillor Allen explains that this count would be more accurate for a count for winter provision for rough sleepers.

The Chairman commented that the Panel would need to get a further feedback from Councillor Allen on rough sleepers at the next Panel meeting.

The Panel agreed with this suggestion.

40 CLINICAL COMMISSIONING GROUP UPDATE

The Chairman invited Dr Ian Orpen (CCG) to give an update (attached to these minutes) to the Panel.

Councillor Hall pointed out that new continence service was due to start on the 1st October and asked for an assurance that the service would assess, diagnose and treat people with continence problems and provide ongoing support to people with long term incontinence so that they can lead as fulfilling, and independent lives as possible. And also that the service would provide post-operative support to patients who have had continence surgery, including patients who require support with intermittent self-catheterisation.

Councillor Bevan commented that people should be explained about Antibiotic Guardians and what would happen when they signed the pledge.

Councillor Clarke welcomed an update on the treatment of military veterans.

Councillor Jackson commented that the first CCG's Annual General Meeting on the 11th September in the Pump Room in Bath was good though the room was not big enough to accommodate even more public.

Councillor Butters welcomed the Antibiotic Guardians pledge and suggested that leaflets with information on the pledge could be left at GP surgeries for info.

The Chairman thanked Dr Orpen for an update.

41 HEALTHWATCH UPDATE

The Chairman invited Ann Harding (Healtwatch) to introduce the report.

The Chairman expressed his concern that the Care Quality Commission (CQC) did not respond to serious concerns raised by a member of staff, who works in a supported living site for people with learning disabilities, about welfare of people at that site (pg 17, second paragraph).

The Chairman said that he would write to the CQC, on behalf of the Panel, expressing his concerns as above.

42 ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FT - ORGANISATIONAL UPDATE (30 MINUTES)

The Chairman invited Kirsty Matthews (Chief Executive of the Royal National Hospital for Rheumatic Diseases) and James Scott (Chief Executive of the RUH Bath) to give a presentation.

The following points had been highlighted in the presentation:

- RNHRD financial context (the RNHRD is one of the smallest Foundation Trusts in the country)
- Why is the RNHRD in this position?
- What does this mean for the RNHRD?
- RUH - Overarching principles for acquisition
- The benefits of the proposed acquisition
- Working together to deliver acquisition
- Acquisition programme governance
- Understanding the RNHRD's services
- Next steps

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

The Chairman expressed his concerns on the CQC report where one elevated risk, which related to staff turnover rate being higher than expected when compared to national date, had remained rated red. The Chairman felt that this was not justified considering current financial position of the RNHRD.

The Chairman informed the Panel that he would write to the CQC expressing his concerns as above.

James Scott informed the Panel that, although the RUH's intent has been to go ahead with acquisition, there were still four points to be considered:

- The RUH would have to be licensed as an NHS Foundation Trust to go ahead with the acquisition of the RNHRD;
- The RUH had been negotiating with the Department of Health on help around clearing the debt position picked up from the RNHRD;
- The Councils of Governors, and the Boards, from both hospitals would have to agree with the acquisition; and
- May 2015 Elections.

James Scott added that a lot of planning and preparation had happened.

Kirsty Matthews added that the staff and media had been informed on what had been happening so far, and that the RNHRD had been delivering day to day operations despite financial troubles they had.

Councillor Clarke commented that if all goes well in terms of the acquisition then there would be potentially very little change in provision of clinical services. However, if there would be significant changes of services then the RNHRD should consult with this Panel on change of services.

It was **RESOLVED** to note the report and presentation and to request a further update from Kirsty Matthews and James Scott for November 2014 meeting.

43 UPDATE ON - NHS 111 SERVICE (20 MINUTES)

The Chairman invited Cathryn Phillips (CCG Commissioning Project Officer) to introduce the report.

The Panel welcomed the report. Members of the Panel felt that NHS 111 service had improved significantly since challenging start in February 2013 and, after the development of a rectification plan, full service commencement in October 2013.

The Panel acknowledged that the NHS 111 service had continued to experience challenges around recruitment and retention of call handlers and Clinical Advisers which contributed to:

- Delays in call handling
- Higher than necessary ambulance dispatch rate
- Delays in warm transfer (i.e. directly from the original call handler to a clinical advisor) and call back.

Cathryn Phillips explained that Commissioners and Care UK had recognised the importance of having experienced and skilled staff to be able to address many of these issues. Staffing levels needed to be more accurately matched to call volume forecasting to ensure that the Key Performance Measures set within the contract had been met at all times.

Members of the Panel appreciated that, at the beginning of this year, Care UK made a decision to change staff shift patterns to better match with demand.

The Panel asked if lessons had been learned since challenging start in February 2013.

Cathryn Philips and Care UK representatives acknowledged that the start of the NHS 111 Service had not been as successful as expected, however, the CCG had been receiving daily progress reports against the targets and Appendix 2 of the report shows performance for the period April – August 2014. The graphs demonstrated many of the difficulties the service has experienced over the last five months, although evident improvements in August. These would continue to be monitored for sustained and continued improvement in performance.

The Chairman asked about handling of 14 complaints (out of 62,515 calls).

Cathryn Phillips responded that Care UK had been investigating complaints and incidents and reported the same through the monthly quality reports and discussion at the clinical governance group.

The Panel said that the service was now in much better shape than it was a year, or 18 months, ago and congratulated the CCG and Care UK on the current performance of the NHS 111 Service.

It was **RESOLVED** to note the report and receive another update on the NHS 111 Services in 6 months' time.

44 UPDATE ON - NON EMERGENCY PATIENT TRANSPORT SERVICE (30 MINUTES)

The Chairman invited Dominic Morgan (CCG) and representatives from Arriva Transport Solutions Ltd to introduce the report.

The Chairman welcomed the report by saying that he appreciated how CCG, and also Arriva, had recognised that there were still some problems to overcome, and there was still some work to be done.

Dominic Morgan agreed with the Chairman and added that some issues around the process, resources, contracts, etc. should be resolved in the next few months.

Councillor Jackson presented concerns from one of the dialysis patients, especially concerns in terms of booking a pick up time.

Dominic Morgan and Arriva representatives took on board comments from Councillor Jackson and assured that they would investigate what had happened and come back with a response to Councillor Jackson outside the meeting.

Dominic Morgan added that Arriva had invested a lot of their resources into dialysis group of patients, especially in pick up time.

The Chairman, on behalf of the Panel, congratulated Arriva and the CCG on this report, and on present results. The Chairman asked for another 6-monthly update.

It was **RESOLVED** to note the report and to receive another update in 6 months' time.

45 THE NEW PUBLIC HEALTH SYSTEM (30 MINUTES)

The Chairman invited Bruce Laurence (Director of Public Health) and Ulrike Harrower (Public Health England) to give a presentation.

The following points had been highlighted in the presentation:

- The main areas of public health work
- The players in the system

- The roles
- How it fits together and some examples

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

The Chairman commented that changes in provision of health services should be communicated to the public to gain their confidence in the new system.

Bruce Laurence responded that communication with the public has been a key in terms of transparency. The Public Health team had been actively working with the Communications and Marketing team in terms of informing the public on what had been happening.

Councillor Hall asked what the Council could do to promote health and wellbeing agenda to wider population.

Bruce Laurence responded that the Council had approved Fit For Life strategy. The other aspect would be in creating an environment which would be easier for people to improve their health, with as realistic as possible approach in mind.

Ulrike Harrower added how helpful it would be in taking everyone on the board.

Members of the Panel asked about Ebola threat and how prepared we were.

Bruce Laurence responded that Ebola had been transmitted by contact and it had not been perceived as direct health threat in this country.

The Chairman suggested that Public Health, or Health and Wellbeing, approval should be included in every report.

It was **RESOLVED** to note the report and presentation and for Democratic Services Officer to pass on Panel's wishes, to senior Council officers, to promote Public Health in all Council decisions.

46 LOCAL SAFEGUARDING ADULTS BOARD ANNUAL REPORT FOR 2013-14 (20 MINUTES)

The Chairman invited Lesley Hutchinson (Assistant Director, Safeguarding and Personalisation) to introduce the report.

The Panel congratulated Lesley Hutchinson and her team for an excellent report. The Panel also praised joint working between Lesley's team and Licensing.

It was **RESOLVED** to note the Local Safeguarding Adults Board Annual Report for 2013-14.

47 PANEL WORKPLAN

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

- Royal National Hospital for Rheumatic Diseases NHS FT update – November 2014
- NHS 111 update – March 2015
- Non-Emergency Patient Transport Services – March 2015
- Community Transport – date to be confirmed
- Loneliness and Isolation – date to be confirmed
- Mental Health update – date to be confirmed
- Care Act implications – November 2014

The meeting ended at 1.45 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

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

Wellbeing Policy Development & Scrutiny Panel – September 2014

Winterbourne View Update – Improving Lives Reviews

As an action from the Winterbourne View Concordat of Action, which is overseen by a national Joint Improvement Programme, the Improving Lives team was commissioned to undertake reviews of the ex-patients of Winterbourne View plus a number of other cases of concern. A total of 44 reviews were undertaken by the Improving Lives Team. These reviews were completed during the spring/summer of 2014, and included two people funded by Bath and North East Somerset.

The three primary themes of the review were to look at:

1) Are people safe now?
2) What do people think of their current support?
3) What are the plans for the future?

Members of the Improving Lives Team visited Bath and North East Somerset and met with the individuals concerned, their advocate and members of staff. A report was then compiled detailing their findings and conclusions.

I am pleased to feedback that the two reviews completed for people supported by Bath and North East Somerset were excellent, with recognition of the very positive support that both people receive from their support staff, the life that each person is now building in their own community and the optimism for a successful future. To quote the Improving Lives lead – *"all professionals involved in the individuals care need to be praised for supporting this person to lead such an independent life".*

Update on Rough Sleepers

(from the Cabinet Member for Wellbeing and the Cabinet Member for Homes & Planning)

In November 2013, a snapshot estimate conducted across various services and access points in Bath & North East Somerset found 33 people known to be sleeping rough. This was a increase on the previous year findings of 22 which was conducted in accordance with different guidance and is not, therefore, directly comparable. Since then a number of actions have been put in place and anecdotally we understand that the number of rough sleepers has decreased. However, a formal snapshot estimate is planned for late November which will confirm the numbers.

A report on homelessness, including rough sleeping, is being presented to the Housing & Major Projects Policy & Development Panel. Initially scheduled for the November meeting, this has now been rescheduled for the 20th January meeting. This is to allow the results of the Rough Sleeper Estimate to be included in the H&MP update report.

Members of the Wellbeing Panel are invited to view the report when published, or attend the meeting.

CCG Briefing
Well-Being Policy Development & Scrutiny Panel Meeting
19th September 2014

Armed Forces Commissioning

At a previous meeting, members of the panel asked for an update on the treatment of military veterans.

Under long-standing arrangements, war pensioners in England, Scotland and Wales have been given priority NHS treatment for the conditions for which they receive a war pension, subject to clinical need. This provision has now been extended to all veterans where a person has a health problem as result of their military service.

How the process works

When referring a patient who they know to be a Veteran for secondary (more specialist) care, GPs have now been asked to consider if, in their clinical opinion, the condition may be related to the patient's military service. Where this is the case, and with the patient's agreement, it should be made clear in the referral.

Where secondary care clinicians agree that a veteran's condition is likely to be Service-related, they have been asked to prioritise veterans over other patients with the same level of clinical need. Veterans will not be given priority over other patients with more urgent clinical needs. It is for the clinician in charge to determine whether a condition is related to Service and to allocate priority.

Five Year Strategy on Armed Forces Commissioning

The Armed Forces Health Commissioning is led by NHS England and the Bath, Gloucestershire, Swindon and Wiltshire (B,G,S&W) Area Team. They have recently produced the final draft of a five year strategy. A copy of this strategy has been shared with the CCG and is available on request.

Armed Forces health commissioners have entered into formal contracting arrangements with a total of 48 secondary care providers across England for 2014/15

New CCG GP Appointed

The CCG is delighted to announce the appointment of Dr Daisy Curling to the vacant Sessional GP Board Member position. The appointment process included an interview which confirmed Dr Curling had the appropriate skills and experience. Her appointment was then confirmed by a GP vote, as required by the CCG Constitution, with 100% support.

Operational Resilience and Capacity Planning Update
The newly created System Resilience Group (SRG), as mandated by NHS England has expanded the previous role, remit and responsibilities of the Urgent Care Working Group (UCWG). SRGs now work across whole care communities and are responsible for Planned and Unplanned Care and delivery of associated national targets.

All SRGs have been directed through the new national Operational Resilience &Capacity Planning (ORCP) process to create robust evidence-based capacity plans following an Independent Analytical Review (IAR) to ensure the whole care system can deliver uninterrupted and high standards of care throughout 2014/15. To support this work, additional non recurrent monies have been allocated to SRGs and this equates to £1.135M for BaNES.

BaNES have worked with all providers to agree and fund additional resilience and capacity for 2014/15 and to provide assurance to the national resilience team. All systems have been experiencing high levels of demand so far within 2014 and BaNES is no exception to this trend.

BaNES SRG has agreed to support provider requests which appropriately reduce demand and conveyance to the RUH; increase access and capacity to meet the current and predicted high winter demand for services; and support the flow of patients through the local care system.

BaNES is re-enforcing our strategic and operational management of the local care community through the continued use of our Operational Performance Management Framework (OPMF), successfully introduced during 2013/14. We currently seeking assurance for our planned approach via NHSE and will be making the ORCP arrangements available for the public.

Your Health, Your Voice - Further Meeting
The CCG's patient and public engagement group met on the 4th September in Radstock. 'Your health, Your Voice' has just under 50 members with a mix of core members and individuals who want to be kept informed about the work of the CCG. The agenda included an introduction to commissioning, presentations and discussion regarding mental health inpatient beds and the primary care challenge fund. Those who attended found the meeting useful and informative.

CCG's 1st AGM held
The CCG held its first Annual General Meeting on the 11th September in the Pump Room in Bath. Tracey Cox, Acting Accountable Officer and Sarah James, Chief Financial Officer presented the Annual Report and Accounts and there were a number of presentations to give a flavour of the work of the CCG during its first year of operation. These included a presentation about the Dementia Workers Service from Ruth Grabham, Medical Director and Laura Marsh, Senior Commissioning Manager; a presentation about Antibiotic Prescribing by Elizabeth Beech, Prescribing Advisor; and a presentation about the new Urgent Care Centre by

Elizabeth Hersch, GP Board Member, Catherine Phillips, Senior Commissioning Manager and Heather Maughan, Bath and North East Somerset Doctors Urgent Care.

New continence service due to start on 1 October

The Community Continence Service will be provided from Sirona Care and Health CIC in partnership with the RUH from 1st October 2014. The service will assess, diagnose and treat people with continence problems and provide ongoing support to people with long term incontinence so that they can lead as fulfilling, and independent lives as possible. It will also provide post-operative support to patients who have had continence surgery, including patients who require support with intermittent self-catheterisation.

Antibiotic Guardians

Antibiotic resistance is one of the biggest threats facing us today
Without effective antibiotics many routine treatments will become increasingly dangerous. Setting broken bones, basic operations, even chemotherapy all rely on access to antibiotics that work. To slow resistance we need to cut the use of unnecessary antibiotics. **November 18th** is European Antibiotic Awareness Day. As part of that we're asking everyone in B&NES to become Antibiotic Guardians
Please take 2 minutes to make your pledge by visiting the website: **http://antibioticguardian.com/**.
For further information please contact Elizabeth Beech- Prescribing Advisor NHS Bath and North East Somerset CCG via BSCCG.information@nhs.net.

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Bath & North East Somerset Council		
MEETING/ DECISION MAKER	**Policy Development & Scrutiny Panel** **Committee**	
MEETING/ DECISION DATE:	**28th November 2014**	
TITLE:	**Healthwatch Bath and North East Somerset update**	
WARD:	All	
AN OPEN PUBLIC ITEM LIKELY TO BE TAKEN IN EXEMPT SESSION		
List of attachments to this report: Please list all the appendices here, clearly indicating any which are exempt and the reasons for exemption		

1 THE ISSUE

1.1 Update report from Healthwatch Bath and North East Somerset

2 RECOMMENDATION

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

5 THE REPORT

Report to the Wellbeing Policy Development and Scrutiny Panel 28th November 2014

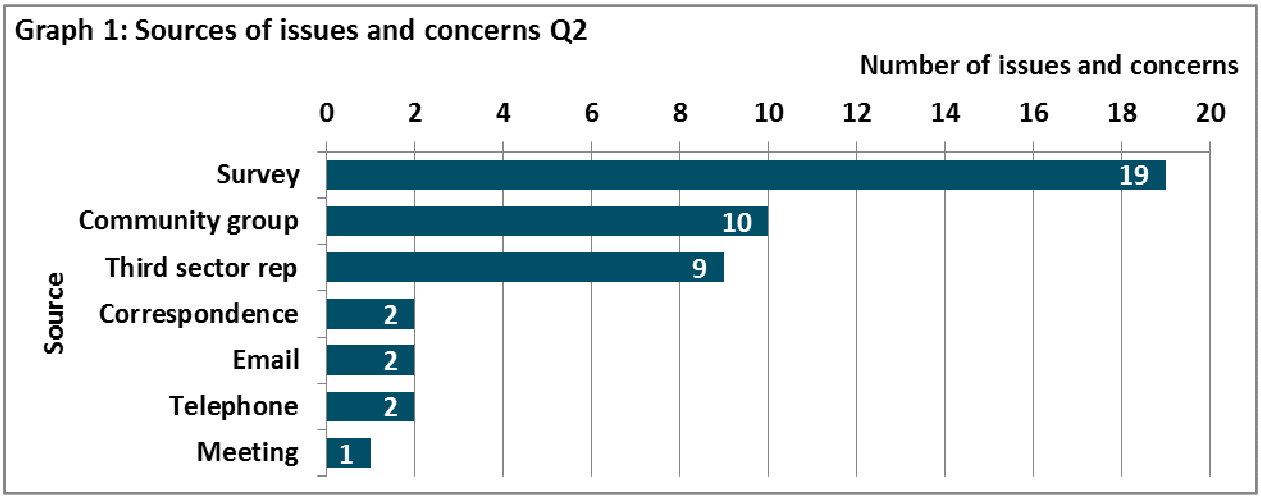
Healthwatch Bath and North East Somerset: Issues and Concerns
Year 2 Quarter 2: July – October 2014

Healthwatch Bath and North East Somerset has heard 45 issues and concerns from health and social care service users, carers, family members, and service providers since July 2014.
This report considers the types of comments and the services they relate to, and the themes emerging from the issues and concerns heard between July and October 2014 (Q2).

1. Sources of Comments

Healthwatch Bath and North East Somerset uses several channels through which it hears issues and concerns about health and social care services from the public (see Graph 1).
In Q2, the most commonly used method of capturing service users' feedback was responses to a survey, which was carried out as part of a special inquiry into hospital discharge.

Graph 1: Sources of issues and concerns Q2

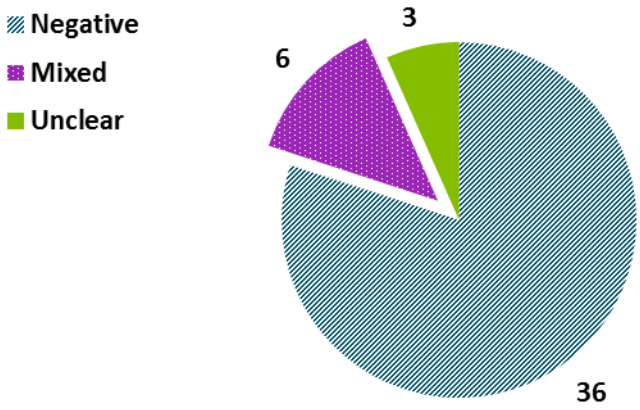


2. Sentiments of comments

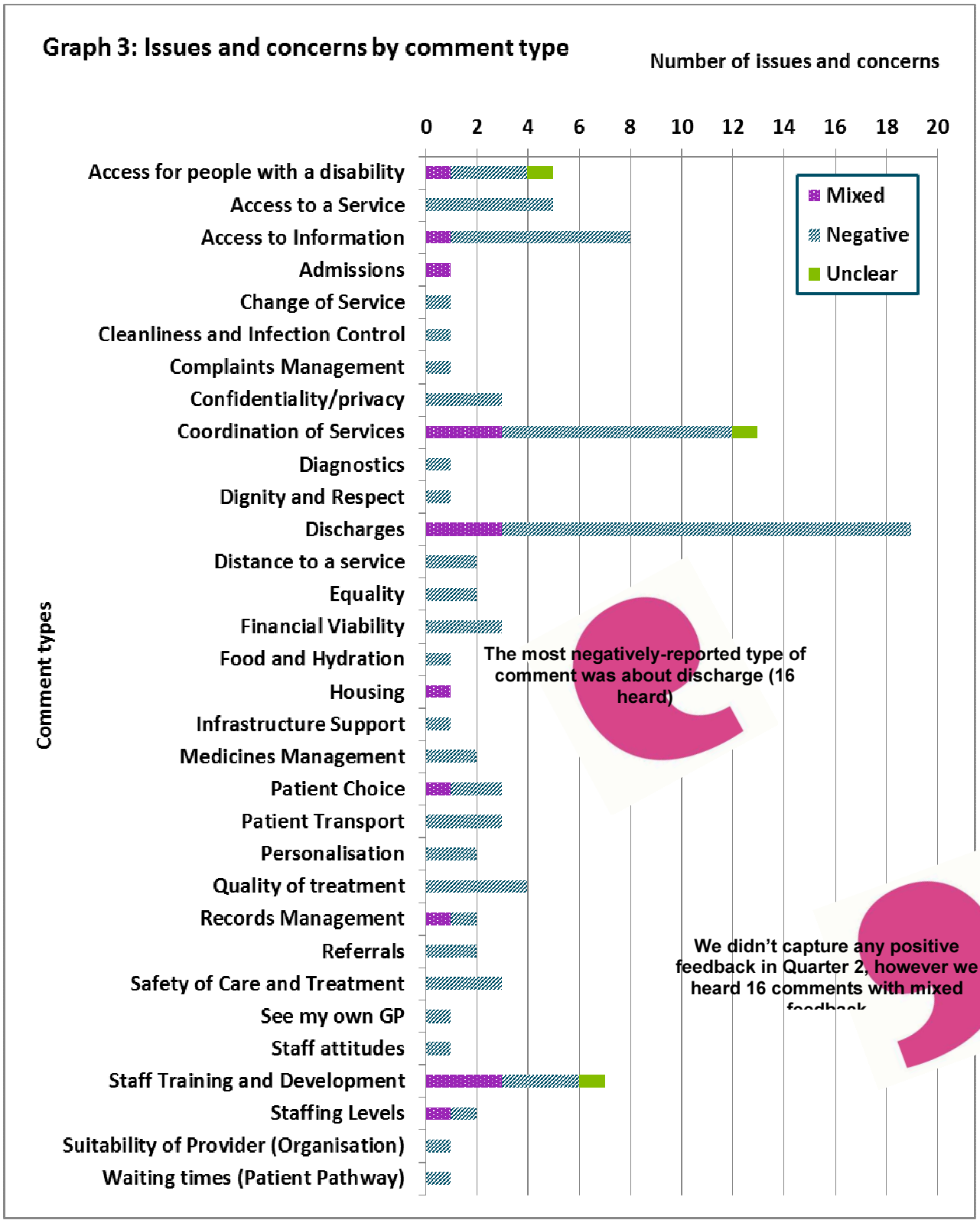
The sentiments of the service feedback heard by Healthwatch Bath and North East Somerset are shown in Graph 2:

3. Comment types

Graph 2: Sentiments of issues and concerns



Graph 3 shows the issues and concerns heard by Healthwatch Bath and North East Somerset, according to the type of comment. Some stories could be categorised by more than 1 type of comment.
The most often-heard types of issue and concern in Q2 related to discharges (19 in total, 3 mixed, 16 negative).

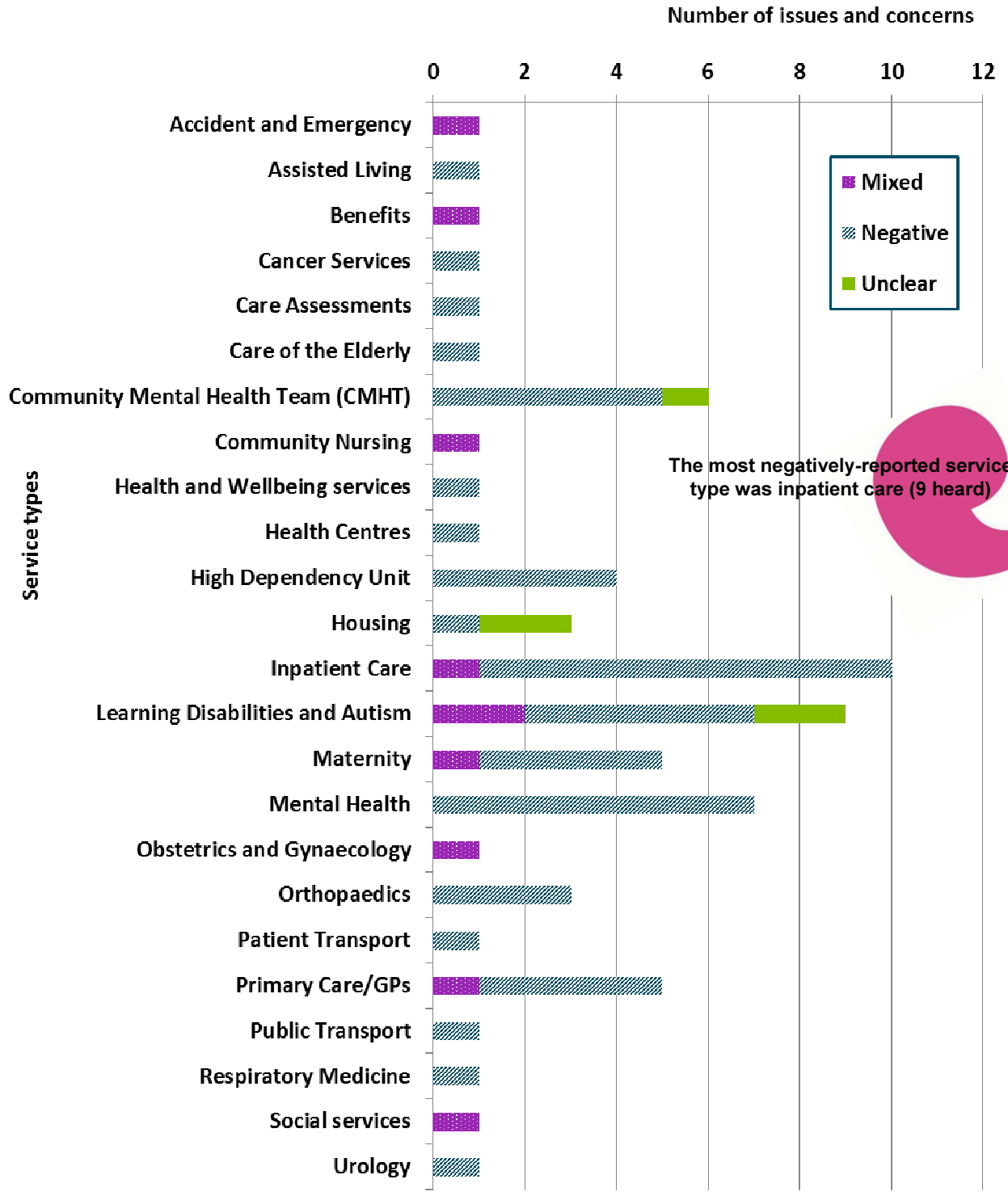


4. Service types

Graph 4 shows the issues and concerns heard by Healthwatch Bath and North East Somerset, according to the service they refer to. Some stories could be categorised by more than 1 type of service.

The most commonly referred-to service in Q2 was inpatient care (10 in total, 1 mixed, 9 negative).

Graph 4: Issues and concerns by service type



5. Themes

From analysis of the issues and concerns heard in Q2 of Year 2 of Healthwatch Bath and North East Somerset, the following themes have been identified:
(*these themes are likely to have emerged as a result of direct, targeted engagement with specific service user groups, as part of Healthwatch Bath and North East Somerset's community development remit with priority groups in the area, and involvement in Healthwatch England's first Special Inquiry into hospital discharge)

- **A perceived need for training in the needs of people who have autism***

  Commentators report that health and social care professionals need to demonstrate increased awareness of the needs of people with autism, in order to ensure that services are meeting their needs. An example of this is that proformas used within services should be designed and used that a) enable people to identify themselves as having autism where necessary/appropriate, and b) meet the communication needs of people with autism.

- **A perceived need for improved communication between services and carers of people with mental ill health***

  Commentators report a variety of issues they have experienced as carers of people with mental ill health. These include difficulties in navigating mental health services, for example being able to access services, being able to continue to access these services, and knowing how to address any issues or concerns they may have with those services.

  In Year 1 Quarter 4, carers' issues was also identified as a theme. This was more broad feedback but highlighted similar issues reported by carers:

  'Several commentators have reported a lack of easily accessible information on care options and carers' issues. They have identified a lack of signposting to this information, and reported difficulties in having to navigate the system to find out about, and gain clarity on, their options.' **(from Healthwatch Bath and North East Somerset Year 1 Quarter 4 Issues and Concerns report).**

- **Discharge from secondary care***

  A clear theme has emerged around the efficacy and efficiency of current discharge processes. An emerging 'sub-theme' is identifiable specifically in the context of maternity services. Commentators have reported a lack of information about after care following discharge, particularly following caesarean section procedures.

  As mentioned above, the issues and concerns heard in Quarter 2 were collated as part of the Healthwatch England inquiry into hospital discharge. A report on the findings of this inquiry in the region covering Bath and North East Somerset, Somerset, South Gloucestershire and Bristol is available on the Healthwatch Bath and North East Somerset website: http://tinyurl.com/lo7mdx3. This sets out the main results of the inquiry, which are based on issues and concerns heard in Bath and North East Somerset and by Local Healthwatch in the other 3 areas, which were triangulated and found to substantiate each other, resulting in the following key findings:

- Approximately 90% of respondents received little or no Voluntary and Community Sector (VCS) support post-discharge. Many felt that an effective referral into the VCS would have improved their experience.
- The discharge process should be quicker and more streamlined, with more effective planning.
- The majority of respondents were happy with the quality of care they received but felt that they and their families/carers should have been more involved in their discharge process.

- Complex discharge e.g. where a patient is moving into a care home, should be better managed to avoid gaps in medication provision etc.

Intelligence gathered from other organisations in Bath and North East Somerset corroborates with these findings. For example, the Sirona Health and Care Complaints and Concerns report (May 2014), identifies premature discharge from Sirona services as a theme emerging from their complaints data.

6. Next steps

Healthwatch Bath and North East Somerset will take this information to their partners, stakeholders, and to their Advisory Group, who will advise on any further work to be undertaken to investigate these themes further. Individual issues that have been 'acute' or ongoing at the time they were fed back to Healthwatch Bath and North East Somerset, have been considered by the Project Coordinator or Development Officer, and remedial action taken where necessary/possible/appropriate.
For 5 of the issues and concerns heard, we have been able to capture the specific 'next steps' taken by or advised to the commentator:

- **Table 1: Issues and concerns - next steps**

Next step	No. of cases	Outcome
Signposted to advocacy	3	Unknown
Signposted to VCS organisation	1	Unknown
Forwarded to Bath and North East Somerset Council Safeguarding Team (Adults)	1	Email 28/8/14 from BathNES Council: Concerns being managed through the safeguarding process

Where issues and concerns heard in Quarter 2 specify a service, Healthwatch Bath and North East Somerset will contact the service provider and request a response on that issue or concern. Responses will be reported on in Quarter 3.

7. What we heard, who we told, what they did

Where issues in Quarter 1 specified a service, Healthwatch Bath and North East Somerset contacted the service provider and requested a response on that issue. Of the 23 issues and concerns reported in Q1, the relevant service was identifiable from 7 comments. We wrote to the service commissioner and the responses gathered are detailed in Table 2 (page 6).

8. What we heard in Quarter 2

The issues and concerns heard in Q2 are presented in Appendix 1. They have been sorted by service type, as feedback has stipulated that this would be the most useful format for commissioners and service providers to access and use meaningfully in service planning and improvements.

- **Table 2: What we heard, who we told, what they did**

Issue/Concern	Organisation - Provider	Response
Commentator recounted an issue that she witnessed recently at RUH Audiology - a patient was upset because she thought that was due to have an appointment at Audiology, however it appeared that she was registered with Sirona. It took a long time for the hospital staff to sort it out; at one stage there were 4 members of staff trying to help, which was very annoying for other people that needed to book in.	Royal United Hospital Bath NHS Trust (RUH)	We would wish to apologise to the patient and the other people waiting to book into the Audiology clinic for this delay and any embarrassment caused to those present at the time. From the account quoted from the report, it does seem that several staff did at least try to help the patient with their appointment booking; the issue is that it was not carried out as efficiently as it might have been and this feedback will be relayed to the appropriate staff working in the Audiology team to ensure that they learn from the comment and make changes to practice in future. There are changes currently being made to improve the RUH Audiology service to patients.
Commentator raised a concern about their GP's handling of a serious complaint. A meeting was arranged to discuss the matter, but the GP didn't seem to know the circumstances, he wasn't aware that any concerns that had been raised (despite the commentator having written a letter) and didn't really listen. A second, more formal meeting was arranged including a rep from SEAP, the GP, a senior nurse and the Practice Manager. Again the commentator felt that the Practice representatives didn't listen, weren't prepared (they seemed unaware of the commentator's letter written, or the circumstances surrounding her husband's case), they didn't answer the commentator's concerns, repeated themselves, and argued with her. The commentator wrote a similar letter to RUH, who immediately apologised and have taken steps to improve. They wanted to listen and learn from the commentator's experiences and she felt very	Royal United Hospital Bath NHS Trust (RUH)	Thank you for this positive feedback on the RUH response to the complainant. It is very helpful to know when a situation goes well, as well as when things require improvement and this feedback will be relayed to the relevant staff. There is currently a project taking place to improve the experience of people using the RUH complaints process, which includes patients and ex-complainants in the work that is progressing. We will use this positive feedback, as well as any other feedback that we receive on the complaints process, in order to continuously improve the service to patients and the public.

reassured that every effort would be made to make sure her experience wouldn't happen to other people. They showed her how they would use her experience to influence future care.		
South Bristol Hospital have set up a system whereby community transport drivers can pass on their vehicle/ registration details, enabling them to park 'legally' in non-emergency ambulance bays when dropping off patients. This allows them to accompany patients into the building, particularly useful when transporting frail patients.	University Hospitals Bristol NHS Foundation Trust (UHB)	This initiative is in response to feedback from patients and carers living in more rural areas to enable them to access services at the hospital more easily.
Commentator had a routine mammogram and was told to arrive at the BRI for 2pm. Upon arrival she discovered it was a first come first served system so lots of people had turned up at 1pm to be at the front of the queue. Due to her position in the queue she wouldn't have been seen until 4.30pm, which meant she would be late to collect her children from school in BaNES. As a result she had to leave and was probably recorded as a no-show.	University Hospitals Bristol NHS Foundation Trust (UHB)	UHB are pursuing a response to this feedback.
The commentator's husband woke in the night bleeding. They called 999 and an ambulance arrived. Patient was taken to RUH A&E, treated quickly, offered clear advice and discharged. GP promptly referred him to a specialist and an appointment was made for the following week at Southmead, available at a variety of times. The appointment was kept and an operation was booked - a very positive experience so far. The couple made their way to Southmead for the operation	North Bristol NHS Trust (NBT)	A meeting is planned with NBT to discuss this response.

(5am start to get there for 7.30am) only to be told that the operation had been moved to the afternoon. The hospital were unable to say when in the afternoon it would take place, and in the meantime the husband was nil by mouth. The couple were offered the option of going home to return later but they live too far away. The couple spoke to other patients there who had also had their appointments changed. Commentator queries why appointment times are so thoughtless for those that live a long way away, and why hospitals have block appointments.		
Commentator was under a Frenchay Hospital consultant for MS and has received a great service.	North Bristol NHS Trust (NBT)	A meeting is planned with NBT to discuss this response.
Commentator was under a Frenchay Hospital consultant for MS and has received a great service. Trying to find an effective painkiller has been very difficult, but for the last year she has found a method which has worked (1gm suppository of paracetamol). Harptree Surgery have said this approach is too expensive and won't let her have anymore. They suggested an alternative, which she has tried and found ineffective. The GP surgery have also tried to change her statin medication to a cheaper alternative, but again she has found this ineffective and has fought her case to remain on the same one.	NHS England – Bath and North East Somerset, Gloucestershire, Swindon and Wiltshire Local Area Team	If patients are not happy with a change in their brand of medication, they should talk to their GP who can advise on their condition, treatment options and medication issues. The other professional that people can gain advice from is the community pharmacist who will understand how the different medications are made up and work. This NHS Choices article (http://tinyurl.com/njbrrzt) explains the national strategy to use non- branded medication when possible as this is an effective and efficient way for the NHS to better use its resources. Generally the active ingredients are the same across different medication brands, however, in rare cases the medication may not be as effective and in these circumstances it is a good idea for patients to discuss this with their GP or local pharmacist.

Appendix 1

Accident and Emergency

- Commentator described concerns about admissions to RUH Bath, particularly people with dementia. Concerns around safety, falls prevention and staff awareness/ understanding of the condition, particularly if admitted via A&E. Discharge liaison nurses are excellent.

Assisted Living

- Commentator contacted Healthwatch with concerns about a supported living facility in Bath for adults with learning difficulties.

Cancer Services

- Commentator has experiences of sitting waiting for patient transport for hours. Commentator has been picked up late in the evening so that they arrived late, tired and more confused at a strange destination. Commentator is concerned that, as an elderly person, they were the last patient to be dropped off - at 9.00pm which they feel doesn't take their needs into account. Commentator's family would have collected them if they had known of the poor patient transport service. No communication with them was undertaken.

Care Assessments

- Commentator received feedback from the group: the Community Care Assessment form is completely inappropriate for autism.

Community Mental Health Team (CMHT)

- Commentator would like time alone with the Care team to discuss her concerns/ issues regarding her son's mental health condition, before the Care team meeting. She feels there are things she often wants/needs to discuss in private, without having to embarrass or undermine her son in the meeting.
- The group stressed that they want to work with Community Mental Health teams to make their jobs easier, they feel they do excellent work and want to support this through collaboration.
- The commentator expressed frustration at the 'politics of access' for example mentalisation services are available in South Glos under AWP but not B&NES due to budgets. Concerns about lack of access to 'universal services for all'.

Health and Wellbeing services

- Commentator tells of a woman who lives in Whitchurch, who is a carer for her husband who has dementia. She is unable to access social care & health services because the appropriate services are in Bristol. B&NES offers only inadequate alternatives in Bath & Radstock which she cannot attend without transport - she doesn't drive & taxis are too expensive. She is severely stretched & sleep deprived, so is in no position to make a formal complaint, though intelligent, well informed & articulate.

Commentator has previously come across similar situations with people living on the Bristol/South Gloucestershire boundary.

High Dependency Unit

- Commentator would like to see more involvement of family in discharge process especially when they are providing post discharge care. Family found it hard to find the correct people to discuss patient discharge with. Staff seemed unwilling to facilitate meeting up or speaking on the phone to the family (who would be providing care post discharge).
- When discharged out of a patients' own GP area, commentator feels hospital should make sure satisfactory cover and follow-ups are in place. Poor assessment of where patient being discharged to i.e. is it suitable? will everyone be able to cope?
- Commentator experienced a lack of communication between staff about when discharge likely. Ultimately very last minute due to late communication with family.
- Commentator experienced problems with medication supplied on discharge (not labelled correctly).

Hospital Service

- Commentator received feedback from the group: Consultant at hospital didn't understand son's eating issues, i.e. as he doesn't like to have regular meals this affects his diabetes management.

Inpatient Care

- Commentator would like to see quicker discharge times. Commentator feels that the wait for medications was too long and unnecessarily delayed discharge.
- Commentator experienced unnecessary delays in effecting discharge. One patient in commentator's ward waited all day to be discharged!
- Commentator experienced lack of communication between staff regarding expected discharge dates. The hospital got their hopes up that they are going, then changed the story which caused distress.
- Commentator felt that there was insufficient consultation with family as to what the patient is capable of and not just taking patient's assurances at face value e.g. can she manage to climb stairs? Patient said yes, but her family would have responded that no, she can't manage this independently. Commentator was also concerned that they experienced insufficient occupational health assessments.
- Commentator experienced delayed discharge due to wait for medicine, but otherwise discharge went smoothly

Learning Disabilities and Autism

- Commentator received feedback from the group: It's not helpful to be signposted to services where the staff have not had autism training.
- Commentator received feedback from the group: autism social workers need to work closer with the clients and not just signpost to other services.

- Commentator received feedback from the group: Housing – must be consideration that some need their own space and can't share even if under 35.
- Commentator received feedback from the group: Need understanding that some with ASC just need sheltered accommodation which is very quiet, clean and safe.
- Commentator received feedback from the group: Housing forms are discriminatory and don't have a box in which to prompt disclosure of autism.

Maternity

- Commentator experienced two discharge processes following a C-section birth. On the initial discharge, commentator was given sanitary towels to put over bleeding caesarean cut. These are not sterile, could not be kept in place, and commentator feels sure contributed to the infection detected subsequently. Discharge from maternity ward after C-sections should make it very clear which dressings are needed, providing enough for the first few days, and make it very clear how to obtain more.
- Commentator was readmitted after potentially unsafe discharge following C-section with a painful haematoma. The care was fine in RUH but she had huge problems getting the right care afterwards. It was not clear who had responsibility for wound management. Commentator had 13 weeks of trouble before the wound closed. The midwives could not continue their care; district nurse came out but had wrong dressings.
- Commentator went to day assessment unit for help with wound following C-section, and was given a prescription for dressings to be dispensed by RUH pharmacy. That pharmacy then told them that RUH had not dispensed dressings for several years. Commentator then had to get a GP to convert the prescription to a GP one, so that a normal pharmacy could dispense it. Even then, the dressings were far too small for the size of the wound! In some pain, and with her new born in tow, commentator ended up with practice nurse who finally sorted them out, dealt with the 4 infections, prescribed antibiotics, and managed to set out a programme for wound cleansing and redressing twice weekly, she also gave correct sterile dressings. This was a stressful experience and the commentator is sure this delayed their recovery.
- Commentator feels that Hospital should ensure patients know basics of wound management e.g. commentator was not aware if she could shower and there was a distinct lack of information and support provided.
- Commentator feels that the hospital should make sure patients know who has clinical responsibility for care post-discharge. The baby comes under the midwife and health visitor but the commentator's wound was not managed by either.

Mental health

- Commentator expressed frustrations around confidentiality - he cares for his wife who has a mental health condition, however is not kept informed about the medication she is taking, why it's been prescribed, what the effects may be and how they might impact on other medications being taken. This is key information for him when trying to care for her, but he's not allowed to know.

- Commentator expressed huge concern and frustration about not being able find out where her son is and if he is receiving treatment. He ran away due to his fears for his own safety and others. The commentator is trying to track him down but is not able to find out information due to confidentiality. Her son is over 18.
- The commentator explained that services are often decreased without negotiation, for example his son has been discharged from the Care team due to perceived 'improvement' without the carer being consulted. Commentator feels these decisions are made based on clinical evidence alone, without taking a holistic view of a person's mental and physical wellbeing.
- The commentator is concerned about fragmentation of services. They explained that carers have to be experts and be prepared to push for answers and action. This is exhausting on top of a stressful caring role.
- Commentator felt that complex diagnoses, such as personality disorders, are avoided to prevent financial commitment to management.
- The group explained that it is key to get a named person or contact within every service to get any action. PALS is not a productive/ constructive approach to problem-solving.
- A family-centred approach is really important but doesn't seem to happen most of the time. Family counselling was suggested as a positive option.

Obstetrics and Gynaecology

- Commentator reports that discharge was ok but the staff were not able to give her a discharge note as no doctor was available at the time to do it. She is still waiting for it to arrive. She will be contacting the hospital about this.

Orthopaedics

- Commentator recounted an issue that has been on-going since 2009 when he had an accident and shattered his femur, which required surgery to rebuild. Since then his walking ability has deteriorated and in June 2012 he had a second operation during which the surgeon hit his bone with a chisel and hammer. Attended clinic 2 weeks later for a scan and was told that his hip bone was cracked (possibly from the impact of the surgical procedures carried out). In November 2012 the commentator had a hip ball replaced and contracted a serious infection. In December 2013 this operation was done again, and again the commentator contracted an infection. He had to take antibiotics and stopped in late spring/ early summer. He is still not able to walk very well.

Outpatients

- Commentator used hospital transport which took four and a half hours to arrive, to take them 5 miles home. Very frustrating indeed. Wouldn't ever want to use this service again.
- Commentator feels that hospitals should ensure that meds are ready on time when due to leave, to avoid delayed discharge process.

Patient Transport

- Commentator reported that people have been asking Well Aware if there are any transport schemes linking Bath and Bristol so they can attend appointments at the BRI or Southmead. Arriva have not been able to help them (because they don't travel to Bristol). The Dial-a-Rides only cover their own local area and the small community schemes don't serve Bristol, so unfortunately Well Aware haven't been able to help them. We have told them that they can use the HUB service if they can get to Temple Meads, but that really isn't much help.

Primary Care/GPs

- The commentator explained that from 2005 - 2013 he went to ADP Oldfield Park Dental Practice, where he saw several dentists. He described several incidents where he was in extreme pain after treatment, needing to arrange emergency appointments as a result. He has had fillings fall out, several teeth become temperature sensitive, deterioration in gum health and regular abscesses. In 2013 he joined a new surgery (Green Park Dental Practice) but was told that due to the extensive damage caused by ADP they would not treat him in case legal action arose. The new dentist advised contacting the Citizens Advice Bureau, who then signposted the commentator to the General Dental Council and a solicitor. The new dentist arranged for the commentator to see a Dental Surgeon at Bristol Dental Hospital but the surgeon said the damage was too extensive for his students to work on. The new dentist then signposted the commentator to NHS Riverside Drop In centre where X-rays confirmed that his teeth had been damaged through incompetence. The NHS advised seeking compensation and private care to get the problems resolved. Commentator can't afford this process.
- Commentator visited the dental practice for an emergency appointment. The dentist said she needed root canal treatment, but failed to do this successfully as he was unable to locate her root canals, and said she should 'visit another dentist who was more qualified'. The commentator was sent away with a patched up tooth. The temporary seal on the tooth was poorly done and she had 4 weeks of painful recurrent tooth infections, requiring several visits to the Riverside walk-in centre for antibiotics (costs were incurred). The commentator missed valuable days at university prior to her exams. In an X-ray taken by another dentist, she was shocked that the tooth had been drilled down the middle and almost clean in two. She eventually returned home from university to her family dentist, who agreed that her tooth should be extracted. The commentator has had to spend £4000 on dental implants through private treatment - the NHS won't fund this as it is considered cosmetic. The dentist in question admitted that he was newly qualified and lacked experience in root canal treatment - the commentator wonders why he didn't consult his supervisor instead of causing more damage.
- Commentator received feedback from Group members: No consistency in seeing the same GP. This situation improved for one group member when they sent a letter to the GP with information on their son's sensory issues.
- Commentator received feedback from Group members: GPs need training on benefits & how the sensory issues, dyspraxia, OCD etc. of a person with autism affect

their ability to work or cooperate if on Job Seeker's Allowance and so may need access to Employment & Support Allowance.

Urology

- Commentator's father-in-law is in his nineties and suffers from many ailments but is still mentally alert. He has been admitted to RUH many times in the last few years. Mostly they are for UTI which result in him becoming detached from reality. Some are for breathing problems and some for spasms resulting from a past hiatus hernia. He is also grossly overweight which means he needs hospital ambulances to get him in and out of hospital. On more than one occasion he has been discharged when it was clear to the commentator that he still wasn't well, but these concerns were ignored and within days he had been taken back in almost as an emergency. The discharge process from the RUH is poorly handled as father-in-law cannot be returned home until all his care packages have been restarted and his pharmacy informed to supply new dossete pill boxes. Commentator has to repeatedly nag the hospital staff to do this properly as every time it seems to be different staff involved, who do not seem to know what has to be done. All in all the RUH discharge process could do with some considerable improvement.

Healthwatch England has undertaken a National Inquiry in to unsafe discharge and Healthwatch Bath and North East Somerset with other Healthwatch have worked through July and August to contribute to the national inquiry. Eventually there will be a national report from Healthwatch England, but below is the local Healthwatch contribution for information.

Healthwatch Discharge Report: July and August 2014

Contents

Introduction

The Healthwatch Special Inquiry into hospital discharge took place during July and August 2014. The theme of this work was identified nationally by Healthwatch England, and implemented locally by Healthwatch in Bristol, BANES, South Glos and Somerset.

This document will refer to the four local Healthwatch contracts above as 'Healthwatch', and to the national organisation as 'Healthwatch England'.

This work will be conducted in four phases:

- Phase 1 – evidence gathering and focus groups
- Phase 2 – surveying and analysing themes
- Phase 3 – reporting to local Trusts and making recommendations
- Phase 4 – ongoing monitoring of whether, and if so how effectively, recommendations are implemented at a local level

Engagement

In keeping with our local and equitable approach, Healthwatch provided patient and public groups and individuals with many and varied ways to share their feedback about discharge experiences:

We utilized our *Network of Networks* to appeal for feedback via our volunteer Champions and Representatives.

We contacted partner organisations within the Voluntary and Community Sector (VCS), e.g. the Deaf Health Partnership, who referred members to us.

Hospital Trusts and other providers, for example Bristol Community Health, worked with us to signpost patients to have their say.

We continued to ensure that patients were given the opportunity to make confidential freepost submissions to us – for example, via a stand in the Urgent Care Centre at South Bristol Community Hospital. We also reviewed any recent feedback we had already heard, and included this in the report.

We provided an online questionnaire, as well as printed hard-copies of for those who do not or cannot use the internet.

Healthwatch also organised a series of in-depth focus groups with the following groups and communities:

- People who are carers
- People who have had a brain injury
- The Chinese and Vietnamese community
- People who have had a stroke, and/or who are living with the long-term effects of stroke, and their families and carers
- People who have a history of mental ill-health or who are currently living with mental ill-health
- People who have Multiple Sclerosis

A wide range of groups were approached and invited to take part in this work. Groups were approached according to whether they aligned with the Healthwatch priorities as outlined in the workplans. The above groups took the decision to engage with this particular investigation.

Consultation Approach

Healthwatch employed a range of qualitative methodologies using a variety of questioning techniques in order to optimise the accessibility and reach of this enquiry.

Questionnaires

The questionnaires contained a number of structured questions which were used to identify details of the respondents' experience and which allowed us to structure our analysis according to location of discharge and several other factors as dictated by Healthwatch England.

In addition, respondents were given an opportunity to complete an unstructured and free-text section. These statements were analysed qualitatively and informed the findings within this report. Using questionnaires enabled the Special Inquiry to reach a larger cohort than would have been reached using only face to face methods, as a questionnaire approach is less limited by time and resource limitations.

Focus Group Approach

Focus groups were conducted with a semi-structured approach. Participants were encouraged to lead discussion, and Healthwatch facilitators only prompted when discussions began to lose focus.

Prompts from facilitators involved questions about discharge as recommended by Healthwatch England, including questions about safety of discharge; provision of medication; involvement of carers and family members; and links with primary care and the voluntary and community sector.

This face to face approach enabled the Special Inquiry to explore subjects related to discharge in more detail. This mixed-methods design facilitated the collection of good quality, complementary data from which recommendations have been made.

Summary of Findings

Although specific groups of patients have differences in their discharge experiences, there are common themes that affect everyone who spoke to us.

The vast majority of those surveyed felt that their discharge would have been improved with effective referral into the Voluntary and Community Sector (VCS) following treatment in a secondary care setting. This was especially true of those living with long-term conditions, and those discharged following mental health treatment or support.

Many of those surveyed felt that the discharge process should be quicker, and that more effective planning of the various elements involved in their discharge would streamline the process. We spoke to many patients who had experienced excellent discharge; however, a more significant proportion shared experiences which included delays of many hours – in some cases an entire day - waiting for medicines to be dispensed or for transport to be arranged.

The majority of those who spoke to us praised the quality of care they received and the attitude of staff. However, this feedback was often qualified with unhappiness over rushed conversations with medical staff and a general perception of a lack of patient and family involvement in decision-making. This trend was especially true among patients for whom English is a second language and was a concern that was often shared by carers and those for whom they are caring.

Less-common but more serious concerns were raised regarding potential gaps in discharge and medication provision in some instances. This was true in cases involving a patient moving into a care home or being discharged back to an area in which they did not previously live, for example. Healthwatch will work with local Trusts and stakeholders to identify whether any such gaps exist and if so how to close them.

1. Survey Feedback

The findings of the questionnaire into discharge have been listed below.

The findings below were prompted by the following question:

‘What do you think could be improved for people when being discharged from a hospital, health unit or care home?’

Efficiency of Discharge and Planning for Post-Discharge Care (110 Comments)

The procedural element of discharge needs to improve and discharge needs to happen faster.

Discharge should be planned more carefully, and earlier in the care pathway, to ensure that when necessary the patient can be discharged with relatively little delay.

Procedural accuracy for complex discharge (weekend or holiday discharge, discharge into a care home, discharge to another part of the country or discharge for those with continuing complex needs) should improve, including a proper and robust system to ensure the safe provision of notes to the patient and to their GP.

The following elements of discharge need to be planned out and organized ahead of time to expedite the process:

1. Transport, where needed should be booked in advance and ready at the point of discharge
2. Medication should be ready upon discharge. No patient should be waiting several hours for pharmacy services in order to be discharged
3. Staff should provide a thorough and honest assessment of the ongoing needs of the patient post-discharge, which should include input from carers and family members where appropriate
4. Discharge must include provision of information on how to access support post-discharge, including charitable or voluntary sector support
5. The links between secondary care, and primary and social care need to be examined to ensure smooth transition post-discharge.

Communication and Discussion (45 Comments)

A significant proportion of patients feel that clinical staff do not listen meaningfully to their views, and that decisions are sometimes rushed in order to move them out of hospital and back into the community.

Patients want to feel that families and carers are being consulted and kept informed.

Where a patient does not fully understand something, they want to be given time, space and support to understand it better.

Patients who have specific requirements or needs want compassionate and sensible recognition of their needs (this includes people with sensory impairments, older people, people with learning difficulties and others). If a translator is required, then the Trust should identify this quickly and act to provide translation services, with the consent of the patient.

Some patients would like to be helped to understand 'what happens next' after they are discharged, via verbal discussion rather than written materials.

Recommendations

1. Hospital Trusts to examine how the speed of discharge can be improved. This should take the form of a survey or questionnaire provided to patients so that discharge can be planned in advance, preferably as early as practically possible. Transport, destination of discharge and post-discharge support should all be included in this planning.

Many respondents to the Healthwatch Special Inquiry felt that timely planning in advance of discharge would have helped to improve their experience of the process:

"Involve me and my Carer from the beginning. If discharged after procedures done by a consultant who is not in the hospital then for there to be a forward

plan discussed with me and my carer so that the junior doctor who discharges me knows what the consultant wanted to happen next".

2. Hospital Trusts to outline how they ensure safe discharge when discharge is complex. Several reports were heard by Healthwatch about patients being discharged and discharge notes not getting to their GP. This is often the case in instances where patients are discharged into care homes in other local authority areas or in instances in which staff do not appear to have followed the correct procedure for processing and forwarding discharge notes.

"Discharge into a care home means that sometimes notes about medicines cannot go to a local GP or pharmacist as patient has moved to another location… on each hospital discharge, (carer) has had to chase round the pharmacist to ensure each new medication package is… delivered".

3. Patients and carers should be helped to be aware of what constitutes good quality and safe discharge to encourage them to feel more in control of the process:

"Give patients a written tick list of all the processes/gateways that have to be completed to reach discharge. Make sure that all staff needed to carry out the processes are available at the right time…"

4. Patients have reported that they want to be provided with options for post-discharge support. Healthwatch can provide a free and comprehensive support service via the WellAware database. WellAware leaflets can and should be provided to patients upon discharge. Hospital staff should be trained in what the database does and how to proactively refer into it:

"It would have been nice to be offered support or charities I could contact. But I'm young and savvy so I suppose it wouldn't occur to them…"

5. Where possible and applicable, more time should be taken to make patients and carers feel involved in the discharge process. A discharge liaison employee or similar, or even a trained volunteer in some circumstances, could provide this kind of communication and support.

"I was under the impression I would be in for the weekend from the nurses, but consultant was very keen to discharge me and made me feel pressured and difficult when I was anxious about it…"

Positive Statements / Complements

Positive statements received from the public about their discharge generally corroborate the recommendations taken from the negative or mixed feedback, as above.

For example, we received some feedback about how pleased patients were with family and carer involvement in their discharge, and about how valuable it was to be given some information on post-discharge support. Many people fed back to us about the good quality of care they received from hard-working nurses, doctors and other staff.

Respondents valued being treated compassionately and being made to feel cared-for.

"Staff explored my social and family set-up before discharge"

"I was given excellent information on how to get post-discharge clinical support"

"I was ordered a taxi to get home"

“I received compassionate and effective care”

“I was generally happy with the service”

“The care on the ward was excellent”

“The (hospital) staff were excellent”

“The care agency and nurses made my experience a good one”

2. Complaints Advocacy Feedback

Part of the Healthwatch contract involves supporting patients to make an NHS complaint.

We have not deliberately sought to include information from ongoing complaints in this report, but have provided a summary of the themes taken from ongoing complaints below:

There is a common theme of premature/inappropriate discharge from all acute services, often with very serious outcomes including emergency readmission and in some cases the death of the patient. This theme is particularly prevalent in the elderly population.

Advocacy services are supporting cases in relation to premature discharge of Mental Health service users to primary care. The Independent Mental Health Advocates (IMHA) service has observed that patients under section of the Mental Health Act can sometimes be discharged too early for appropriate arrangements to have been made, such as accommodation or a comprehensive support package.

3. Focus Group Feedback

Carer's Support Centre

Summary

Commentators felt that more care should be taken to involve carers and patients during the discharge process and that discharge should be planned more effectively.

Pre-discharge Communication

More or improved communication between hospital staff/community services staff and patients, carers, neighbours of the patients who can support them.

"Ask the patient/carer, 'is there someone we can notify that you're coming home?'"

Carers would like to be better served by a dedicated staff member in the hospital… who can liaise between staff and the patient/ their carers.

Post-discharge Support

Participants would like post-discharge support to be well-connected and more thorough. There were concerns raised about arrangements around medication post-discharge, as well as a sense that once someone has been discharged, support tails off too quickly.

"Hospital to provide appropriate amounts of equipment and medication for the patient on discharge".

"Hospital should telephone the patient at a pre-determined time one week after their discharge and check that the support in the community that was arranged in the discharge plan is actually being provided. They should ask: How are you? Is the support we included in your discharge plan working? Do you need any signposting to support services..?"

In addition, what could be termed 'customer service' could be better thought-through across sectors.

"Send the prescriptions straight from hospital to GP so patient doesn't have to book an appointment with their GP after discharge".

And;

"Give the patient a number for the ward that they can use if there are any issues after they're discharged".

Finally, participants wanted a single point of access into the Voluntary and Community Sector (VCS), which fitted with an overall desire for services to treat the 'whole person' rather than the specific condition that led to hospitalisation.

"Have one contact number the patient/ carer can contact to find out up to date support available from community and voluntary based services".

And;

"Look at the whole person, not just the specific illness/ injury they've been admitted to hospital for or are receiving treatment in the community for".

Recommendations

Better and timelier planning for what happens when a patient is discharged.

This should include provision of a single point of entry into the VCS for support, better arrangements around medication and the provision of a friendly ‘check-up’ for patients who hospital staff decide would most benefit from this service. This phone call ‘check-up’ could potentially be provided by a trained volunteer.

Headway (Somerset)

Participants had been discharged from a variety of sites, as follows:

Musgrove Park Hospital, Yeovil District Hospital, Bristol Heart Institute, Frenchay, Yeatman Hospital Sherborne, Williton.

Summary

Participants felt that the overall quality of care that they received in hospital was good. However, serious concerns were raised about post-discharge support and planning, and about the sometimes chaotic nature of the discharge process.

“None of the respondents felt well enough and ready to leave hospital when they were discharged. Most individuals… felt disorientated, especially those with brain injuries”.

Post-discharge Planning

Perhaps of greatest concern were reports of a lack of clear instructions around medication.

'…gave me a bag with tablet in but no instructions".

All participants stated that they had not received a treatment or care plan upon discharge, and that no ongoing rehabilitation or therapy services were arranged for them. Those questioned felt that they had no input into the discharge process, and that it was something done to them, rather than with them.

"A score of 1/10 was given when asked if they felt involved in the decision-making process to leave the hospital".

Some participants felt that their discharges had been delayed as they expressed that the nurses were overworked and did not have time. There was no memory of any offer to arrange transport.

When asked if family or community support were asked about on discharge, the universal response was an emphatic 'no'.

Voluntary and Community Sector Support

When the respondents were asked if they had been told about WellAware, or any charities or community groups that could support them after discharge, the collective response was 'no', with the exception of some who had family members who had been put in contact with Headway by the Neurology team at Yeovil District Hospital.

Recommendations

Hospital Trusts to examine whether they are offering appropriate discharge support to patients with a brain injury and their families or carers. This should include referring into the VCS in all instances.

Chinese and Vietnamese Community

Summary

The majority of feedback at this focus group was regarding Bristol hospital services. Many themes that came out of this focus group fit with the general themes that arose from the questionnaire results - for example, a lack of referral to the VCS after discharge and concerns about a lack of involvement in the discharge process.

However, some culturally-specific findings were also uncovered which underpin much of what was discussed, and which are detailed below.

Language Barriers

People from the Chinese and Vietnamese community are not sufficiently supported to understand what is happening during care, discharge from care and post-discharge. Translation services need to be more widely available, including for those who are conversant in basic English, but who struggle with medicalised English. Services should not assume that a person who can hold a basic conversation will understand pharmaceutical or medical terminology.

“When she asked for interpretation the respondent was told that her English ‘is fine’”.

And;

"At first she asked for an interpreter but was told that this service was not provided, there was no budget and she would have to pay. They did eventually get an interpreter but they spoke Mandarin not Cantonese. They had to communicate by writing things down…"

Patient Involvement and Staff Attitude

Feedback regarding the attitude of staff was very mixed. Many participants went to great lengths to praise the quality of some of the staff that had helped them. However, many participants felt that language barriers resulted in more cursory consultation and less involvement in decision-making. Some also felt that they were discharged earlier than was appropriate, without really understanding the process.

Post-discharge Support

Participants felt that it would be good to have a source of culturally-appropriate support after being discharged, that they could access themselves.

"There is only one Chinese link worker for the whole of Bristol and she only works 2 days per week. This makes it difficult for Chinese speaking people to access support after discharge".

Recommendations

Interpretation services should be planned before discharge, and then made available during the process. Staff should take the time to decide with a

patient whether they are able to understand more complex English, including medical and pharmaceutical terminology.

A method of providing culturally-appropriate support following discharge should be made available to Chinese and Vietnamese patients. The WellAware database includes a translation feature which would fulfill this need.

MS Therapy Centre

Summary

Generally, feedback about staff attitudes towards participants was positive, and standards of care were felt to be good. However, participants did feel that consultants were often brusque and did not give them enough time to discuss their health during consultations.

Post-discharge Support

All participants were grateful for continuing support received following discharge, but the provision of and quality of support varied hugely from person to person.

All participants felt that more VCS referral information should have been provided upon discharge to empower them to find out about things like home adaptation services, the MS therapy centre and other services.

Feedback about physiotherapy services was generally poor. Access to the service was said to be difficult, and the waiting list was observed as being too long.

"Another member said they had to break a bone before they could access physio".

Communication

The group discussed specialists and consultants and agreed that these professionals only gave each person 10 minutes of their time. Participants were concerned that a lack of support was contributing to readmission in some instances.

"One person felt 'fobbed off' and was told to direct any questions to the MS Nurse".

One participant thought it was bad that his specialists had not informed him of the diet people with MS should follow. The participant had to research this on their own. He was worried that the time spent not following dietary advice had resulted in poorer health and potential readmission into hospital for MS-related problems.

The Discharge Process / Dignity

One participant had an experience of discharge being delayed for eight hours because of the wait to see the pharmacist. They had been moved out of the hospital bed, and so had to wait in the family room instead.

Another participant said they were discharged only one day after their stoma operation. They said that they were not ok to leave to the Stoma Care Nurses at the BRI and had to learn how to change their stoma on their own.

Recommendations

Better post-discharge VCS support should be provided to patients with MS, and could reasonably be expected to address other issues raised during this focus group - such as a perceived lack of time to discuss health matters and access to physiotherapy.

Stroke Support Group

Summary

The discussions at this focus group were regarding local Bristol hospitals.

Participants shared experiences of discharge which corroborate much of the questionnaire feedback detailed above, such as a desire for better communication from medical staff, and for the discharge process to be streamlined. However, several issues emerged that were of importance to this group, as detailed below:

Medication and Safe Discharge

Three specific concerns were raised around safety of discharge and safe provision of medication.

"Medication was ordered by hospital, GP contacted commentator to tell her it was ready to collect, but… it's the wrong medication. Lots of changes to medication in hospital and after discharge is confusing. Commentator worried she might have started taking wrong medication and been ill".

And;

"Commentator's father was given a double dose of medication on discharge. He was not told it was a double dose. Home care agency were confused by the dosage and had to double check with the hospital".

And;

"Commentator had a stroke in June 2014. He was discharged and went home on the bus. Hospital staff did not check he got home safely even though he travelled home alone".

Post-discharge Care and VCS Referral

Participant feedback about support provided following discharge was mixed. Several felt that they were not sufficiently supported, whereas another participant had an excellent experience of discharge.

"Commentator found it difficult to get through to (hospital) staff on the phone after their discharge from the hospital. They were not given a contact name and this made it hard to speak to someone who could help".

And;

"Commentator had a wonderful discharge experience. First 4 weeks after discharge someone visited her at home every day to help and signpost her to services that could support her. On the day she arrived home, workmen came and made alterations to home. She thinks all this was organised by the hospital following treatment for her stroke. They also referred her for physiotherapy. 'I am so grateful for the care'".

The group was unanimous that there should be a more regular and organised system for referring to the VCS, as any referral that was made appeared to be the result of individual good practice rather than robust systems.

"The HITU receptionist recommended (commentator) went to Headway. Commentator has been volunteering at Headway and has found the volunteer work very beneficial to their recovery. Commentator does, however, worry that if it hadn't been for the receptionist, they would not have got support from Headway. Referral to Headway should be in an official discharge pathway"

And;

"Group felt information about support services (e.g. Voluntary sector services) should be given out on discharge. At the moment group members felt they only found out about support services through word of mouth not from professionals".

Recommendations

All staff involved in discharge should ensure that stroke patients are properly assessed and supported during discharge. Where possible, a check-up phone call or service should be offered to ensure that the patient has been discharged safely.

Referral to VCS support services should be offered to patients who have had a stroke as part of every discharge process. Information could be given to patients and their families or carers about the Well Aware health and wellbeing database which has up to date information and contact details for VCS support services.

People with a hearing impairment, or who are deaf

Summary

We received feedback regarding discharge services from a cohort of people who are deaf and/or have a hearing impairment. This cohort were generally happy with the quality of care received and responses about staff attitudes

and clinical quality were similar to responses received from respondents who are not deaf or hearing impaired.

Several common themes emerged from this feedback which align with the general trends seen throughout the data, such as delays in the discharge process relating to pharmaceutical provision and transport.

However, several cohort-specific issues were also identified, as below.

Information Provision

People who are deaf or who have a hearing impairment reported experiencing particularly poor provision of information throughout their care pathway, and also post-discharge.

“Staff had no idea how to communicate with me”.

And;

“It would be more helpful if the consultant and nurse could inform me of the next stage rather than just move me into a position they want me to be in”.

In addition, some respondents were concerned about a lack of information sharing between agencies and sectors involved in their care.

“Better information sharing. I was told by the optician that I had a low risk of glaucoma, but the hospital didn’t tell me this”

This group reported that they were sometimes unsure about medication, and unsure of what to do in an emergency or where to go to get further information and support.

"I should have been informed of post-discharge support"

Reasonable Adjustments

This group also reported significant frustration over the lack of reasonable adjustments made by hospital services to cater for their requirements.

"The hospital was unable to send texts to arrange for transport home, this is a problem for deaf families".

And;

"It would be helpful if there was an electronic display… as I have to constantly watch out for my name each time the nurse calls out".

And;

"Equipment in the hospital was inaccessible e.g. no subtitles on the TV".

Provision of Interpretation

Several respondents reported that they had not been offered interpretation- in some cases even after specifying that they needed it. It was clear from those who had received this support that it was highly valued.

"Interpreters must be provided for deaf patients".

And;

"I was fortunate that I had a sign language interpreter with me during discharge – this helped. I was able to access information and ask questions".

Recommendations

Trusts should sign up to the Deaf Health Charter which has been locally commissioned by Bristol CCG (Clinical Commissioning Group). Recommendations within the charter should be implemented to ensure that the needs of deaf people are met.

Men

Summary

A proportion of respondents were happy to specify their gender, and as a result it is possible to examine male-specific themes that emerged from the feedback.

VCS and Other Post-Discharge Support

Men were only half as likely as women to be offered a referral into the VCS during discharge (5% of men stated that they had been offered this service, compared to 10% of women).

Follow-up contact from primary or secondary care was very similar regardless of gender, with one third of men and women stating that they had received contact.

Discharge Process – Delays

Men were less likely to experience delay during discharge than women (36% of men reported 'no delay' compared to 27% of women).

4. Healthwatch – Continued Monitoring

Healthwatch will continue to monitor the issues raised within this piece of work as part of our ongoing role as patient and public champion.

We will continue to invite patients and the public to feed back to us their experiences of discharge, and will monitor and publicise improvements that arise from this report.

5. Conclusions and Implementation

Healthwatch is happy to recommend the following to all hospital trusts. We will work with trusts and trust patient experience groups to monitor whether these recommendations are implemented and whether they are having the desired effect.

This report and recommendations will also be publically available and disseminated widely throughout the region.

1. The discharge process for many patients needs to be planned and implemented more efficiently. Where possible, planning should begin early in

the patient pathway, and should include and incorporate all elements of safe discharge to avoid any delays. Where the exact date of discharge is uncertain, as much planning as possible should be completed in advance of discharge.

2. Discharge processes must include a thorough and effective process for ensuring that patients can access voluntary and community sector (VCS) support within their community. Patients should be empowered to maintain and improve their wellbeing post-discharge to avoid the potential for distressing and unnecessary readmissions. Healthwatch can provide a VCS signposting function for local Trusts as part of our commissioned service.

3. Where possible, and especially in circumstances that involve vulnerable and/or older people, the hospital should examine whether they could provide a ‘check-up’ service to patients after discharge. It is clear that many patients will not require this service, so the discharge process should include an assessment as to whether the patient would benefit from a ‘check up’ in order to avoid using resources unnecessarily.

4. Hospitals should consider whether they are doing enough to listen to the views of patients, families and carers during the discharge process. Views should be meaningfully incorporated into decision-making in order to empower patients to feel in control of their care.

This report was produced by Healthwatch Bristol, B&NES, South Gloucestershire and Somerset.

For copies in another format, or to find out more, please contact us using the details below.

6 RATIONALE

7 OTHER OPTIONS CONSIDERED

8 CONSULTATION

9 RISK MANAGEMENT

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

Contact person	**Pat Foster – General Manager** **The Care Forum** **Tel: 0117 9589344** **Email: patfoster@thecareforum.org.uk**
Background papers	*List here any background papers not included with this report because they are already in the public domain, and where/how they are available for inspection.*
Please contact the report author if you need to access this report in an alternative format	

Briefing Paper
Royal National Hospital for Rheumatic Diseases Acquisition
Report to B&NES Wellbeing Policy Development and Scrutiny Panel meeting
28th November 2014

Introduction

Following previous reports from the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RNHRD) to the Panel, this paper updates specifically on progress towards a strategic solution to the long-standing financial challenges that the organisation has faced over recent years. In the context of this, the quality of services at the RNHRD remain highly rated with high patient satisfaction and compliance in all standards during its last inspection by the CQC in December 2013.

The RNHRD first recognised it was too small to be financially stable in the longer term in 2008 and when it started to require financial support in 2011/12 it carried out a rigorous options appraisal exercise identifying that joining with the Royal United Hospital as its preferred strategic solution. In July 2012, the boards of the RUH and RNHRD agreed to develop proposal to come together as a single NHS Foundation Trust. Following enforcement undertakings from the regulator (Monitor) in April 2013 to ensure plans were in place to deal with the continuing financial issues, the strategic intent was reaffirmed in June 2013, with the mechanism identified as acquisition, once the Royal United Hospital had achieved foundation trust status and subject to all regulatory conditions being satisfied.

The Royal United Hospitals Bath NHS Foundation Trust (RUH) was formally authorised on 1st November 2014, moving the proposed acquisition a step closer to being achieved. Letters of support for the transaction, based on the principles for the transaction, have also been received from primary commissioners. The next stages required in the process now include approval of a business case by the Board of Directors of the RUH and recommendation of the Boards of Directors of both Trusts to their respective Councils of Governors to vote in favour of the transaction. A joint application would then be made to Monitor to issue grant documentation to effect the transaction. A timeline has been drawn up to effect these stages with the earliest potential acquisition date now established as 1st February 2015.

Overarching principles

The RNHRD and RUH have agreed a set of overarching principles for the transaction, which have been widely shared:

- ***Brand and reputation***
  We will continue to recognise and build on the national and international reputation which RNHRD has developed as a leading provider of high quality, innovative care for patients with long-term rheumatology, pain and fatigue conditions.
- ***Continuation***
  Using the expertise of our combined teams, our ambition is to ensure the continuation of the high quality innovative care and the advancement of this ground breaking work to improve the care and quality of daily life for our patients.

- ***Partnership***
  The future will remain clinician-led, working in partnership with expert patients and carers, members and commissioners to sustain and further improve service user experience.
- ***Skills and leadership***
  We will benefit from the skills and leadership of a wider multidisciplinary team model which will enhance shared care for individuals with multiple conditions, support community provision and improve access to specialist knowledge and skills across our local health economy and beyond.
- ***Excellence and innovation***
  By combining the RNHRD's enviable specialist research brand and expertise with the RUH's ambitious research agenda, we will create a centre driven by evidence-based clinical excellence and innovation. This will be further enhanced by bringing together the established research networks of the RNHRD and the RUH's scale of patient access and recruitment record, patient safety programme, excellent diagnostics facilities and supporting connections with the Academic Health Science Network.
- ***High quality patient experience***
  Patients can be confident that they will receive the highest quality care delivered by passionate staff. Plans will be developed in partnership with our stakeholders to create purpose designed surroundings with convenient access to purpose designed facilities - ensuring the continuation of a care environment that further enhances patient experience and will allow specialist services and innovation to flourish into the future.

These principles are now being utilised by the RUH in putting together a full business case for the transaction.

Benefits to patients and communities served

The integration of the two Trusts is also anticipated to achieve a number of specific benefits for the patients and communities they jointly serve, principally:

- **Integration**

In joining together, more integrated services will be developed. This will support further expansion of shared care models, particularly for patients with multiple, and complex long term conditions. In time, this is expected to lead to further development of new service models in areas such as therapies and self-management in line with the national direction of travel. Access to specialist expertise and diagnostics will also be extended.

- **Sustainability**

Through integration of service models and closer working with community partners, services will be sustainable for the future, both financially and operationally. All clinical services are expected to continue in line with commissioner requirements.

The ability to fully integrate and align services on a single site and access to a wider range of corporate support for RNHRD clinicians will improve efficiency and effectiveness, maintaining patient experience and quality of service delivery as well as increasing value for the money from the public purse. Risks to ongoing financial stability which are naturally inherent in small scale operations with peaks and troughs of demand and supply will also be significantly reduced.

- **Profile & people**

The profile and brand of the RNHRD is both nationally and internationally recognised. This will continue to be maintained and further developed ensuring that high quality, innovative service models are supported and in turn, promote further research investment in the local area and will ensure that the strong track record of both organisations in recruiting high calibre staff can continue.

Service development

The plans for the future development of services have been produced jointly between the organisations and clinical teams. These plans take into account both local concerns such as ensuring the development and delivery of a long term strategy for valued local amenities eg hydrotherapy as well as the wider direction of travel from commissioners, focusing on:

- Delivering innovative care for patients across our community
- Reducing reliance on bed-based models of care where appropriate
- Increasing self-care through empowering our patients and supporting them with community based delivery
- Delivering quality and operational performance standards across all services, aligned with national best practice
- Through delivery of all of the above, contain costs of service provision now and in the future

Research and Development

The combined organisation will have the second largest R&D portfolio amongst medium-sized hospitals.

As the RUH and RNHRD have very different research areas, the acquisition will result at a simple level in the pure addition of the studies of both hospitals whilst maintaining a recognition of both brands. The joining is however expected to also provide significant growth in research as bid writing, research culture and fund management are further strengthened alongside access to a larger population for clinical trials.

It is hoped to grow other existing research active areas in the RUH, so that each year more areas are made substantive research areas. It is intended to bring much of the good practice of R&D at the RNHRD to the merged hospital, such as a ‘joint’ impressive yearly R&D report and a new external web site dedicated to R&D with monthly R&D newsletters.

Environment

The acquisition affords the opportunity to enhance the quality of the patient environment, ensuring its long term fitness for purpose. It is recognised that whilst the RNHRD building is highly regarded by the patients it serves, it is unlikely to be a cost effective base for high quality service provision in the longer term.

It is expected that services will continue to be delivered from the existing RNHRD building for at least the next three years, but that during this time work will be undertaken within wider estates plans at the RUH to develop purpose designed environments which benefit patient experience and support improved efficiency and effectiveness of delivery through appropriate scaling, workflow design and colocation with other services. Opportunities for branding of elements of the new estate will also ensure that the long term legacy of the RNHRD can be protected.

Patient experience

The only change proposed to patient experience on day one of acquisition is to relocate endoscopy services to the RUH site. This change aims to address challenges to the service which have been outlined to this panel in earlier reports and are detailed in part two of this paper.

Next steps

Detailed integration planning work is currently underway to ensure business continuity and patient experience is maintained across all services and, subject to acceptable business case, we currently anticipate that a proposal will be made to Governors of both organisations to vote on the transaction in December 2014 with a joint submission to follow to Monitor in the early new year 2015.

In addition, and to ensure that patient experience, safety and outcomes are not compromised, the RNHRD and RUH will, in collaboration with the CCG, undertake Equality, Quality and Privacy Impact Assessments. These will identify what effect or likely effect will follow as a result of the implementation of this proposed change.

RNHRD Acquisition Briefing
Part 2: Endoscopy Services Transfer

Background

The Wellbeing Policy Development and Scrutiny Panel were briefed on challenges with declining referrals in Endoscopy services in November 2013 and received a further update on challenges to the service earlier this year. In the light of a proposed acquisition of the RNHRD by the RUH, there is an opportunity to resolve a number of these service challenges through relocation to join with endoscopy services already operating to external accreditation standards on the RUH site. These challenges include:

- Over the last 4 years referrals to the RNHRD endoscopy service have experienced over a 50% reduction.
- Although clinically safe, the equipment in the unit is aging and will require replacement in the near future
- The unit at the RNHRD is staffed by a single handed consultant which risks consistency of service continuity in periods of planned and unplanned absence.

Notwithstanding the above, the RNRHD unit continues to report high levels of patient satisfaction; short waiting times and good patient safety record.

The RUH/RNHRD have commenced a period of patient and GP engagement to gain early feedback on the proposal to relocate the RNHRD endoscopy service to the RUH.

As lead commissioner of services from the RNHRD, B&NES CCG are now seeking support from the panel to proceed with this change of service location subject to appropriate response to any feedback received .

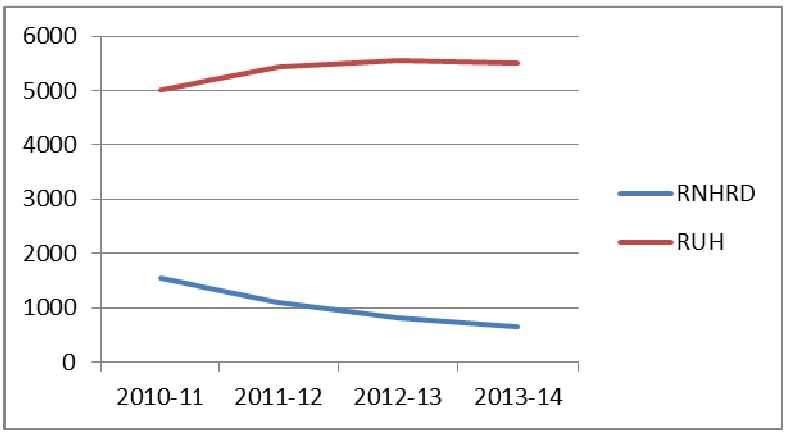
Scale and scope of the service

- The RNHRD service is a small service, comprising 1 Consultant and 3 part time nursing staff, supported by an administrator. It operates from a single day case suite at the RNHRD site at Upper Borough Walls in Bath. It provides general endoscopy diagnostics for patients principally referred from B&NES, Wiltshire and Somerset.
- The RUH service comprises 21 independent endoscopists, including two Specialist Registrars, an Endoscopy Fellow and three nurse endoscopists, supported by a unit nursing team. The Endoscopy Unit comprises four procedure rooms, a two bay recovery area and two

consent rooms on its site at Combe Park in Bath. The RUH service provides general endoscopy diagnostics for patients referred from B&NES, Wiltshire and Somerset. It is fully accredited to provide Bowel Cancer Screening as part of the national cancer screening programme.

- Both units carry out gastroscopies and flexible sigmoidoscopies
- The RUH Endoscopy service also carries out colonoscopies
- The RNHRD runs 3 half day Endoscopy sessions per week, the RUH runs a 5 day elective service. The RUH Endoscopy service for inpatients runs 7 days per week.

Comparative elective activity information is represented in the graph below; the RUH team also performs an additional 3000 endoscopies on non-elective inpatients each year:



Activity carried out in the RNHRD service, by CCG area are outlined below:

CCG	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
NATIONAL COMMISSIONING HUB (NHS England)	9	8	2	3	1	1
NHS BATH AND NORTH EAST SOMERSET CCG	564	560	557	421	405	152
NHS SOMERSET CCG	60	63	100	82	77	22
NHS SOUTH GLOUCESTERSHIRE CCG	36	38	24	12	13	6
NHS WILTSHIRE CCG	961	812	396	284	157	54
Other South West CCGs	8	13	8	4	5	6
Other England CCGs	3	3	0	3	0	0
Unknown	49	37	5	2		
Grand Total	1690	1534	1092	811	658	241

The greatest majority of patients served by the RNHRD come from Wiltshire, B&NES and Somerset CCGs. This is the same catchment population as served by the RUH. Of the number of patients seen in the RNHRD service in

2013/14 – 290 patients (or 44%) are regular attenders to the service, having either annual or bi-annual endoscopy review.

RUH activity is anticipated to increase as the national Bowel Cancer Screening Programme expands and develops, resulting in increasing numbers of surveillance procedures as well as initial referrals for Endoscopy. Patients report a positive experience of the service, waiting times are within national standards (both for cancer, general endoscopy and surveillance scopes) and there is a strong safety record.

Service proposal

As part of the acquisition of the RNRHD, it is proposed that the Endoscopy service and the RNHRD patients using this service are transferred from the RNHRD to the RUH, integrating the two services from the date of acquisition (earliest proposed as 1st February 2015).

The rationale for this is as outlined below:

1. Adherence to external standards: Joint Advisory Group (JAG) on Gastrointestinal Endoscopy accreditation
2. Clinical pathways and service resilience
3. Training and development

JAG Accreditation

The Joint Advisory Group on GI Endoscopy is a national body that quality assures all aspects of endoscopy units, to ensure policies, practices and procedures are compliant with national guidelines for Endoscopy. Units that undertake Bowel Cancer Screening (as part of the national screening programme) are required to be fully accredited with JAG.

- The RUH service is fully compliant and is accredited to carry out Bowel Cancer Screening. The RNHRD service is not accredited by JAG currently, and does not perform any screening.
- For the RUH service to remain accredited and therefore able to continue carrying out bowel cancer screening, all separate Endoscopy services would need to be inspected and accredited by the JAG inspection team, and would need to be compliant with all standards. This accreditation process for a separate Endoscopy service at the RNHRD would not be able to be completed by the proposed service transfer date of 1st February 2015.
- Transfer of the RNRHD service to the RUH site will mean that the current JAG accreditation can be maintained and the RUH can continue to provide bowel cancer screening.

Clinical pathways and service resilience

Consolidating the Endoscopy service on one site will support:

- Faster onward referral to other specialties – for example General Surgery.
- The service will also be more resilient to sickness absence and annual leave staffing fluctuations.
- Patients will have greater choice in appointment time and date as the Endoscopy service at the RUH operates 52 weeks per annum.
- The requirement to replace equipment in the near future at the RNHRD will be resolved

Training and development

The RUH has on-site training and development facilities for all clinical staff. Around 20% of endoscopy lists are dedicated training lists, with lists individually tailored to the trainee. Should the proposal be approved to move the RNHRD service to the RUH, the staff will be able to take advantage of these training opportunities enhancing their skills to enable further improvements in patient care.

Impact for patients

It is expected that the transfer of the services will ensure long term sustainable provision of Endoscopy services for patients. Key aspects of current service delivery that will benefit patients are:

- The RUH service has good access times and meets national best practice standards in service delivery, which will enable the continued provision of high quality care for patients.
- The RUH service has demonstrated it can meet and sustain the rigorous quality assessments required by JAG, providing confidence to commissioners and referrers
- The RUH service operates over 52 weeks per annum – providing patients with choice and low waiting times
- The service has modern equipment with an associated rolling replacement programme, ensuring that patients have access to the most up to date techniques
- There are public bus routes to the RUH, both from the centre of Bath and further afield. The redevelopment of the RUH site at Combe Park over the next 12 months will create additional car parking for patients.
- The site and service are fully wheelchair accessible, with additional support available for patients who are hard of sight or hearing

Engagement timetable

Date	Action
22nd October 2014	Discussion at B&NES GP Forum (63 attendees) – confirmation by those present that they support the transfer
10th November 2014	Informal meeting between Scrutiny representatives, CEOs of B&NES CCG, RNHRD and RUH
19th November 2014	Patient and GP engagement starts
January 2015	Appropriate responses to engagement addressed
1st February 2015	Integrated service commences

Engagement

Patient engagement

As outlined, approximately 44% of patients (290) who attend the RNHRD service are regular users – having either annual or bi-annual endoscopy. These patients will be the target engagement group.

Each patient will receive an individual letter from the Clinical Lead for Endoscopy at the RNHRD. This will outline the proposal to relocate the service. Each letter will invite patient feedback, any concerns or further queries they have with the proposal. Patients will be invited to respond within a 4 week period. Patient feedback will be anonymised, though the first part of the postcode will be recorded on each response form to identify any geographic pockets of particular concern. Patients will also be asked a series of equality questions (age, ethnicity, disability) to ensure that the service change is in line with the Trust's equality duty.

These patients have been selected as the target group as those perceived to be "most impacted" by the proposals. Feedback from this cohort will be responded to and where practical and appropriate, this will be incorporated into the final service transfer plan.

GP Engagement

GPs across B&NES have already been made aware of the proposed service change through the B&NES GP Forum Meeting which took place on 22nd October. 63 GPs from B&NES attended this meeting and were supportive of the proposal. Further updates regarding the transfer will be provided at future meetings.

All regular GP referrers will now be written to invite feedback on the proposals.

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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	28 November 2014
TITLE:	Care Act 2014 – Update and Options for Charging for Services
WARD:	All
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 – Charging for Services – The New Arrangements	

1 THE ISSUE

1.1 The Care Act received Royal Assent in May 2014 and draft guidance on implementation of the Care Act was published by the Department of Health was published in June 2014. Following a period of public consultation, to which the Council made a detailed response, final regulations *("Final Affirmative Regulations Under Part 1 of the Care Act"*) were published 23rd October 2014.

1.2 The Care Act is the main response from the Government on the funding of Adult Social Care following the Wanless and Dilnott reports. These sought to re-set the balance in the funding of adult social care, particularly for older adults. The Act also brought the existing legislation relating to Adult Social Care into a consolidated Act, intending to reduce the number of legal challenges to authorities around the commissioning and delivery of care.

1.3 The role of the local authority has continued to develop with a greater emphasis now on councils providing people with appropriate support as they need it to find their own solutions for engaging their own care. The vision is for the council to act to ensure that local care markets are responsive to individual needs, but not to intervene at an individual level unless asked.

1.4 The Act will be implemented in phases starting in April 2015.

1.5 B&NES Implementation is overseen by a Care Act Implementation Board, with a number of key work streams, each headed up by a member of the Board, with involvement from key partner organisations (primarily Sirona Care & Health and Avon & Wiltshire Mental Health Partnership NHS Trust (AWP). Implementation is supported by a dedicated Care Act Programme Manager.

1.6 This report summarises the key elements of the Care Act and, also, the associated resource implications for Bath & North East Somerset. It goes on to seek a view from the Panel on the Council's policy response to new powers to

introduce charging for certain services as a way of mitigating some of the financial implications of the Council's new duties under the Care Act.

2 RECOMMENDATION

The Panel is asked to:

2.1 Note the general update on the Care Act; and

2.2 Express a view on the options for charging for services summarised in paragraphs 4.7 to 4.11 and detailed in Appendix 1.

3 FINANCIAL IMPLICATIONS

3.1 The new Local Authority duties and individual rights introduced by the Care Act and briefly summarised in paragraphs 4.1 and 4.2, are broadly welcome. In particular, local authorities' new duty to promote people's wellbeing will now apply not just to users of services, but also to carers. This principle resonates strongly with local priorities, including those set out in the Joint Health & Wellbeing Strategy. However, implementation of the Care Act does have significant resource implications for the Council and other partner organisations. However, the exact extent of the additional financial burden for the Council is, as yet, unknown.

3.2 Modelling of the local implications, using nationally recognised and recommended modelling tools, adjusted for local circumstances, has resulted in an estimate of the new financial burdens for the Council from 2015/16 in the region of £1 million. However, this estimate must be treated with caution.

3.3 Whilst every effort has been made to accurately model the financial implications, this modelling is constrained by a number of factors including:

- availability and accuracy of information – particularly in relation to people who are currently privately funding their own care and support services;
- the publication of the final guidance in November 2014;
- the response of the market as the Care Act comes into force;
- the establishment of case law in relation to the Care Act;
- the behaviours of service users and carers; and
- flaws in the modelling tool(s).

3.4 Also, modelling, using national tools, is typically based on the 'normal' distribution of a sample resulting in predictions of change over time. Local figures on the use of services commissioned by B&NES indicate that there is a higher than expected number of short-term care arrangements resulting in a different distribution pattern. It is believed that this is a direct result of initiatives by the Council to better manage the demand for care, but also makes predictive modelling very difficult to achieve accurately.

3.5 The requirement for the Universal Deferred Payment offer is also predicted to have a greater financial impact for the Council than is the case nationally. The relative wealth of the population and scale of those with the means to fund their own care is such that even a fifty per cent uptake by those entitled to have an individual Deferred Payment Agreement would result in a total loan facility of £10m after the first three years of implementation. Whilst individual loans are secured against an asset (the individual's home), any loan facility always has an element of non-collection, which in this case will impact on the amount of debt held by the Council.

4 THE REPORT

4.1 In April 2015 the following changes will be implemented

- New responsibilities for wellbeing, prevention, information and advice and market shaping
- Introduction of a National Eligibility Criteria
- New duty to make eligibility decisions more transparent
- Provision of support to carers becomes mandatory
- New duty to assess and support people funding their own care
- Safeguarding Adults Boards become a statutory body
- New local authority duty to investigate allegations of abuse of vulnerable adults
- New right to a Universal Deferred Payment Agreement for care costs

4.2 The second phase will involve the changes to the financial relationship that commences in April 2016:

- Introduction of Independent Personal Budgets, Care Accounts and the Care Cap
- A raised Capital Allowance from £23,500 to £118,000

4.3 Unlike health services, adult social care services are not "free at the point of delivery". The principle of "charging" or applying a "means test" for adult social care is well-established. Whilst residential accommodation based social care has been covered by national regulation, non-residential social care services have been the subject of local decisions within a national framework. This has contributed to a lack of consistency and clarity in relation to both the services that will be charged for/subject to a means test and, also, the level of individual financial contribution.

4.4 In accordance with the recommendations arising from the Dilnott Review, the Care Act introduces a charging regime for adult social care that is based on a single approach but with an element of local flexibility about how charging for non-residential services is applied at a local level. The legislative framework is "permissive" in this respect rather than prescriptive.

4.5 The briefing attached as Appendix 1 to this report sets out the new arrangements for charging introduced by the Care Act. Paragraphs 4.8 - 4.10 below summarises those areas that are subject to local flexibility and makes proposals on which the Wellbeing PDS Panel's views are sought.

4.6 **Principles for charging**

The regulations set out key principles for charging:

- Ensure that people are not charged more than it is reasonably practicable for them to pay;
- Be comprehensive, to reduce variation in the way people are assessed and charged;
- Be clear and transparent, so people know what they will be charged;
- Promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control;
- Support carers to look after their own health and wellbeing and to care effectively and safely;
- Be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet their needs;
- Apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings;
- Encourage and enable those who wish to stay in or take up employment, education; and
- Be sustainable for local authorities in the long-term.

4.7 **Care Management**

Although the draft regulations suggested the possibility of charging for all care management services, the final regulations only allowed for charges to be made to cover the cost of contracting and managing an on-going care package for non-residential services. The nature of this is that the costs would be difficult to account for in isolation from the much larger volume of work undertaken for Council funded individuals. **Views of the Panel are sought on the application of a zero charge for managing self-funders individual contracts.**

4.8 **Deferred Payment Agreements**

The regulations make provision for two charges for statutory deferred payments for residential care. From April 2015 the Council can charge interest annually against the loan value and, also, a management charge that reflects the costs incurred in setting up and then managing the agreement.

The maximum interest rate is set as the Market Gilts Rate published by the Office of Budget Responsibility and is revised every six months. For 2015-16 the projection in March 2014 was 3.3% per annum. This is significantly lower than the market rates available to borrowers on the high street. It is also lower than the

borrowing rates available to the Council. It is proposed that this Council charges the maximum rate available as adjusted every six months.

Initially, the Government had indicated that there would be grant funding allocated to Local Authorities to meet some of the associated costs, however, the Government has now confirmed that no grant will be made on the basis that Local Authorities can decide to make a management charge. The cost to the Council for setting up a Deferred Payment is £560 (to include Legal Charge and Land Registry fees) with an annual review cost of £290. **Views of the Panel are sought on the application of the maximum interest rate available against the loan value and, also, a charge of £560 for setting up a Deferred Payment.**

4.8 Carers Charging

The Act provides for charging carers but places a number of tests for authorities seeking to charge. Charges should not have a negative impact on the carer's ability to continue providing care. Individuals need to be considered in their own right within the financial assessment, so it would not be appropriate to undertake a single assessment per household. However there is the opportunity to undertake a 'light-touch' assessment.

4.9 Within the Regulations there appear to be three options in terms of charging carers:

- Opt not to charge any carer for the support they receive because of the contribution that they make towards meeting the care and support needs of the cared for person
- Undertake a light-touch assessment for carers who are supporting someone with an existing care and support package and only seek to levy an additional charge if there are significant additional resources
- Undertake full assessments on all parties and maximise the income to the Local Authority derived from the associated charges

4.10 There is a risk that there will be a significant number of people seeking carer support who are not currently receiving services from the Council. The 2011 Census showed there were 17,585 people in B&NES consider themselves to be carers providing unpaid care and support. There are 1,462 carers currently receiving services from the Council. The entire cohort of 17,585 will be entitled to request an assessment with a proportion of these assessments resulting in a package of support. Modelling estimates that an additional 350 people a year in B&NES would be entitled to a package of support but it is difficult to predict before the Care Act comes into force the actual number of carers who will request an assessment or, indeed, then be entitled to a package of support.

4.11 In this context, **views of the Panel are sought on the adoption of a local policy that enables a charge to be made to Carers for the support they are receiving but set this charge at "£0" in the first instance, subject to review after the first 12-months of implementation** when the financial implications for the Council of this new duty become clearer.

5 RISK MANAGEMENT

5.1 A risk assessment on the implementation has been undertaken in line with the Council systems and processes. The Care Act Implementation Board reviews and updates the key risks and associated actions and mitigations on a monthly basis.

6 EQUALITIES

6.1 An Equalities Impact Assessment has not been completed at this stage.

7 CONSULTATION

7.1 Consultation on any proposed policy changes will be undertaken through targeted service user/public engagement events and presentations to relevant governing bodies and stakeholders as appropriate.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Sustainability; Human Resources; Young People; Human Rights; Corporate; Other Legal Considerations.

9 ADVICE SOUGHT

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

Contact person	Jane Shayler, Telephone: 01225 396120
Background papers	Report to Wellbeing PDS, 17 January 2014, *"Care Bill"*
Please contact the report author if you need to access this report in an alternative format	

Appendix 1

Care Act 2014: Charging for Services – The new arrangements

Under the Care Act the charges for care and support are based on a single approach, but with an element of flexibility as to how they are applied to non-residential services.

All charges are subject to a means test meaning that only those with sufficient income and/or assets will be asked to contribute to all or part of their care costs. Those without assets will pay nothing, as is the situation now. The Care Act changes the way the means test is undertaken to reduce regional variations, this is being set out in statutory regulations. The flexibility is in what services are charged for and how much to charge in relation to the full cost of the service.

Councils are required to provide a list of services that are charged for and the current rate upon which calculations are based. This will give people information on which they can decide whether or not they wish to approach the local authority for support in planning their care.

Existing service users

Existing service users are unlikely to see much of a change from the new regulations, particularly those in residential care homes. Some people will find themselves eligible as a result of the proposed changes in the capital thresholds.

The future charging arrangements are an extension of the existing rules set out in the Charging for Residential Accommodation Guide (CRAG). The Council identifies the cost of care for the person and applies a means test to this figure to identify the individual charge.

For residential services there will be changes to thresholds, but for most people currently receiving services there is no anticipated change. A few people may now find themselves eligible for support, but the numbers are likely to be small. There is no flexibility as to how the rules are applied to this group of people.

For non-residential services the rules will change and become much closer to those used for residential care, with the exception that the person's main home is not included in the capital calculation. For the first time under the new regulations *("Final Affirmative Regulations Under Part 1 of the Care Act")* published 23rd October 2014 non-residential services will be treated as "charged for", rather than made a "contribution towards". The main difference for both Councils and service users in respect of this apparently subtle change is that debts associated with service charges can be recovered in the courts. Detailed regulations around debt recovery have been included in the guidance.

It is possible that the charge for people using non-residential services will increase under the new arrangements, but for this group of people the authority has the discretion to waive charges in whole or in part. This would allow for a transition period for those whose costs might increase. On average, a non-residential package of care is provided over a period of about a year and, therefore, any transitional arrangement would, reasonably be relatively short.

The new rules

In all situations the regulations provide for the means tested charge that an individual can be asked to make, unless they are assessed as being wholly responsible for meeting their own costs in full. However the person funding their own care (usually referred to as “self-funders”) can ask the local authority to set up and manage services on their behalf, for which the authority **may** choose to charge a management fee.

As in the past the authority has no power to financially assess anyone other than the person receiving services according to a care and support plan or a carer with a support plan. However in B&NES we have used the flexibility that a couple may opt to be assessed together and we would use the lowest resulting charge. This is no longer an option under the new Regulations.

The local authority may not charge administrative fees against services it provides on a statutory basis. This includes all situations where the individual receives a subsidy to their care and support, safeguarding investigations and the non-targeted provision of information and advice.

The local authority must not charge for certain types of care and support which must be arranged free. These are:

- Intermediate care including reablement (for up to six weeks).
- Community equipment (aids and minor adaptations). Aids must be provided free of charge whether provided to meet or prevent/delay needs. A minor adaptation is one costing £1,000 or less.
- Care and support provided to people with Creutzfeldt-Jacob Disease.
- After-care services/support provided under section 117 of the Mental Health Act 1983.
- Any service or part of service which the NHS is under a duty to provide. This includes Continuing Health Care and the NHS contribution to Registered Nursing Care.
- More broadly, any services which a local authority is under a duty to provide through other legislation may not be charged for under the Care Act 2014.
- Assessment of needs and care planning may also not be charged for, since these processes do not constitute “meeting needs”.

There does not appear to be any restriction on other services with local items and costs being left to the discretion of the Council.

There are also some exempt groups such as people receiving a Veterans Grant.

Principles for charging

The regulations set out key principles for charging:

- Ensure that people are not charged more than it is reasonably practicable for them to pay;
- Be comprehensive, to reduce variation in the way people are assessed and charged;
- Be clear and transparent, so people know what they will be charged;
- Promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control;
- Support carers to look after their own health and wellbeing and to care effectively and safely;
- Be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet their needs;
- Apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings;
- Encourage and enable those who wish to stay in or take up employment, education; or
- Be sustainable for local authorities in the long-term.

Care Management Charges

Although the draft regulations suggested the possibility of charging for all care management services, the final regulations only allowed for charges to be made to cover the cost of contracting and managing an on-going care package for non-residential services. The nature of this is that the costs would be difficult to account for in isolation from the much larger volume of work undertaken for Council funded individuals. The decision not to allow a charge for assessments will result in the Council needing to make provision for an additional cost of undertaking assessments of approximately £489,000 per annum. However, this shortfall in funding could be mitigated by:

i) Reducing demand for assessments through enabling “self-assessment” using a specifically designed form or on-line self-assessment tool and/or
ii) by allowing self-funders to identify and pay for their own independent needs assessment using Social Work assessor and accepting that assessment for the purposes of establishing individual Care Accounts and Deferred Payment Agreements

It is important, however, to note, that there is, at present, no specific market in B&NES to provide Social Work assessment outside of that commissioned from Sirona Care & Health or provided by mental health practitioners managed by Avon & Wiltshire Mental Health Partnership NHS Trust (AWP). This market would, therefore, need to be developed locally in the longer term. Also, the Council would need to put in place appropriate quality assurance standards, checks and balances, if it were to accept the results of independent needs assessment.

No analysis has been undertaken of the cost of a self-assessment (using the pdf on our website) or an on-line self-assessment in the future. This approach might give people an additional incentive to take control of their own care and support rather than seeking the assistance of the Local Authority.

Deferred payment

The regulations make provision for two charges for statutory deferred payments for residential care. From April 2015 the Council can charge interest annually against the loan value and, also, a management charge that reflects the costs incurred in setting up and then managing the agreement.

The maximum interest rate is set as the Market Gilts Rate published by the Office of Budget Responsibility and is revised every six months. For 2015-16 the projection in March 2014 was 3.3% per annum. This is significantly lower than the market rates available to borrowers on the high street. It is also lower than the borrowing rates available to the Council. It is proposed that this Council charges the maximum rate available as adjusted every six months.

Initially, the Government had indicated that there would be grant funding allocated to Local Authorities to meet some of the associated costs, however, the Government has now confirmed that no grant will be made on the basis that Local Authorities can decide to make a management charge. The cost to the Council for setting up a Deferred Payment is £560 (to include Legal Charge and Land Registry fees) with an annual review cost of £290. In addition there is the cost of the initial assessment, which can be partially mitigated as above.

Charging carers

The Act provides for charging carers but places a number of tests for authorities seeking to charge. Charges should not have a negative impact on the carer's ability to continue providing care.

Individuals need to be considered in their own right within the financial assessment, so it would not be appropriate to undertake a single assessment per household. However there is the opportunity to undertake a 'light-touch' assessment.

Within the guidance to date there appear to be three options in terms of charging carers:

i. Opt not to charge any carer for the support they receive because of the contribution that they make towards meeting the care and support needs of the cared for person;
ii. Undertake a light-touch assessment for carers who are supporting someone with an existing care and support package and only seek to levy an additional charge if there are significant additional resources. Other carers (where there is no existing charge) would be assessed in full; or
iii. Undertake full assessments on all parties and maximise the income to the Local Authority derived from the associated charges.

In reaching a decision, it is important to take account of the risk that there will be a significant number of people seeking carer support who are not currently in touch with the Council. The 2011 Census showed there were 17,585 people in B&NES consider themselves to be carers providing unpaid care and support. There are 1,462 carers currently receiving services from the Council. The entire cohort of 17,585 will be entitled to request an assessment with a proportion of these assessments resulting in a package of support. Modelling of the implications of the Care Act estimates that an additional 350 people a year in B&NES would be entitled to a package of support but it is difficult to predict before the Care Act comes into force the actual number of carers who will request an assessment or, indeed, then be entitled to a package of support.

In this context, the Council might reasonable decide on a policy that enables a charge to be made to carers for the support they are receiving but set this charge at "£0" in the first instance, subject to review after the first 12 months of implementation in order that any decision about a charge can be informed by the extent of the additional financial burden associated with this new duty. This would go some way towards mitigating the financial risk to the Council of the new duties to carers.

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Bath & North East Somerset Council		
MEETING/ DECISION MAKER:	**Wellbeing Policy Development & Scrutiny Panel**	
MEETING/ DECISION DATE:	**28 November 2014**	EXECUTIVE FORWARD PLAN REFERENCE: *[Cabinet reports only]* E
TITLE:	**Medium Term Service & Resource Plan Update**	
WARD:	All [or list specific wards]	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Draft Medium Term Service & Resource Plan Update and Appendices		

1 THE ISSUE

1.1 The draft Adult Social Care Medium Term Service & Resource Plan (MTSRP) update is presented for consideration by the panel to ensure all members of the panel are aware of the context and enabled to comment.

1.2 Following transfer of Public Health responsibilities from BaNES Primary Care Trust (now Clinical Commissioning Group) to the Council in April 2013, Public Health has sat within the remit of the Wellbeing PDS Panel and the Cabinet Member for Wellbeing. The attached Medium Term Service & Resource Plan (MTSRP) does not, however, cover Public Health. This is as a consequence of the fact that Public Health funding is ring-fenced for the duration of the Council's current MTSRP and, also, was not the Council's responsibility when the MTSRP 2013/14-2015-16 was agreed by Council in 2013.

2 RECOMMENDATION

The Panel is asked to:

(1) Comment on the update to the 3 year medium term plan update for Adult Social Care, focusing on matters affecting 2015/16, and note that this will be the third year of the plan.

(2) Identify any issues requiring further consideration and highlighting as part of the budget process for 2015/16.

(3) Identify any issues arising from the draft plan it wishes to refer to the relevant portfolio holder for further consideration.

3 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

3.1 This medium term plan update forms the basis for the budget process for 2015/16 and all relevant statutory matters are either referred to in this update or the original plan approved in 2013 (PDS November 2012).

4 THE REPORT

4.1 This report forms part of the 2015/16 service and resource planning process. As set out in the enclosed medium term plan update), the next steps include:

(1) Panel comments considered by Portfolio Holders.

(2) PDS Resources meeting in February to take an overview of comments from Panels and progress on budget setting.

(3) February Cabinet budget recommendations to Council.

(4) February Council approval of budget and Council Tax setting.

5 RATIONALE

5.1 Where the Panel wishes to either increase expenditure or reduce savings targets alternatives should be proposed.

5.2 The Panel should concentrate only on the parts of the plan relevant to its own remit as the PDS Resources meeting in February will be taking an overview.

6 OTHER OPTIONS CONSIDERED

6.1 This is a package of options as set out in the report and reflects the Council's corporate plan, its vision and values, the medium term plan agreed in 2013, public feedback, changes in legislation and the Cabinet's priorities.

7 CONSULTATION

7.1 The corporate implications of this report have been considered by Strategic Management Team (SMT) including the *Section 151 Finance Officer; Chief Executive & Monitoring Officer*

7.2 Further consultation has took place as part of developing the revised Corporate Plan. Budget fairs have taken place.

7.3 Cabinet has been closely involved in the preparation of this update and in particular the relevant portfolio holder(s)

8 RISK MANAGEMENT

8.1 A risk assessment will be completed as part of the final budget papers and inform the Council's reserves strategy. The main risks relate in the next financial year to:

(1) The robustness of the savings estimates.

(2) The potential for some service levels to deteriorate as a result of the savings, some savings are from service reductions but most savings are directed at efficiencies or increased income.

(3) The implications for staff arising from savings, albeit that the costs of severance will be budgeted for corporately and unions are being consulted together with the affected staff.

(4) The need to maintain a planned and phased approach to savings at a time when pressures are starting to require substantial and immediate cuts.

(5) Equalities impacts of the savings.

Contact person	*Jane Shayler Tel: 01225 396120*
Background papers	*Corporate Plan and 2013/14 budget papers plus medium term plans*
Please contact the report author if you need to access this report in an alternative format	

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MEDIUM TERM SERVICE & RESOURCE PLAN UPDATE

PEOPLE & COMMUNITIES

Adult Social Care

2015-16

Introduction

This is the third year of the period covered by the 2013-14 to 2015-16 medium term plans. The medium term plans were reflected in the budgets approved by Council in both February 2013 & 2014. The original plans can be found on the Council's web site with the agenda papers for the November 2012 PDS panels.

This 2015-16 update is a summary of key changes affecting the plan and does not restate the information contained in the original plan. This update provides important background information to the 2015-16 budget process, which will culminate in a report to the February 2015 meeting of Council. The 2015 February budget report will incorporate assumptions made as part of the three year planning process, together with new planned variations to reflect current circumstances, and approval for those variations. It will also set both the budget and the consequent level of Council Tax for 2015/16.

This document contains the following updates:

- Strategic Context – financial, legal, service and policy headlines
- Structural Changes – summary of the new management arrangements
- Progress Achieved – how the delivery of the 3 year plan is progressing
- Variations to the plan – proposed changes concentrating on 2015-16
- Capital Programme – proposed alterations to the capital programme
- Risks & Opportunities – key risks to delivery of the plan but also opportunities
- Equalities – summary of approach

Strategic Context

The Corporate Plan and refreshed Council Vision remains the main policy context. These documents can be found at http://www.bathnes.gov.uk/services/your-council-and-democracy/vision-and-values

The three year financial challenge was summarised in 2013/14 and this has been updated to take account of subsequent Government funding announcements and policy changes. Over the three-year period of the Medium Term Service and Resource Plan from 2013/2014 to 2015/2016 we estimate at least £30M of savings or additional income will need to have been delivered.

As part of the Budget considerations for 2015/2016, there have been a number of key Government announcements which have an impact on the original plan three-year plan. The most significant of these was the Local Government Finance Settlement announced in Jan 2014 which set out the following provisional figures for 2015/16:

- A 13.5% reduction in the Council's funding assessments - this actually equates to reduction of 27% in Revenue Support Grant.
- A reduction of 20% in the Education Support Grant.
- Council Tax Freeze Grant equivalent to 1% of council tax for councils who freeze their council tax for the year.

The Governments changes to Health and Social Care funding arrangements in the form of the Better Care Fund also present challenges for the Budget. The plan supporting the local arrangements for this fund was originally approved in March 2014 but required revisiting following changes announced by the Government in May 2014. A revised plan which reduces the original level of funding allocated to support community health and social care costs was approved in September 2014 for consideration by the Department of Health. At the end of October 2014, B&NES Better Care Fund Plan was "Approved with Support" by NHS England, which represents a very good outcome in relation to the outcomes of the national assurance process.

In June 2014, the Care Act passed into law with major changes impacting on the provisions and new Local Authority duties in for Adult Social Care. These changes are phased between 1 April 2015 and 1 April 2016 and cover a range of new requirements for Local Authorities from support to carers through to the capping of care costs met by self-funders. The financial implications are considerable and the Council will need to make appropriate provision for any costs not being met by the Government.

These changes, together with the existing savings to be identified and other variations, mean a further funding requirement of £9m for the Council is required to balance the 2015/16 Budget.

For 2015/16 the focus will be on the variations that are needed to the approved medium term plan to deliver a balanced Budget proposal for the Council in February 2015. The Variations section of this update (below) provides further details of the projected Budget Gap for 2015/16 together with proposals to address this.

The Cabinet's aim remains once again to achieve the original three year medium term plan (final year of) with minimal alterations, but at the same time to reflect public feedback together with local and national policy changes. The Council has a good level of reserves and can use these to smooth the effects of policy changes and additional financial challenges. The indication from Treasury figures is that an equally tough set of financial targets will need to be repeated in the next 4 year plan which starts in 2016, and of course at that time the difficulty in meeting the challenge will have increased as efficiency opportunities will be less.

In the case of the Adult Social Care the key policy context changes are:

- Implementation of the Care Act 2014
  In April 2015 the following changes will be implemented
  - New responsibilities for wellbeing, prevention, information and advice and market shaping
  - Introduction of a National Eligibility Criteria
  - New duty to make eligibility decisions more transparent
  - Provision of support to carers becomes mandatory
  - New duty to assess and support people funding their own care

- Safeguarding Adults Boards become a statutory body
- New local authority duty to investigate allegations of abuse of vulnerable adults
- New right to a Universal Deferred Payment Agreement for care costs

The second phase will involve the changes to the financial relationship that commences in April 2016:

- Introduction of Independent Personal Budgets, Care Accounts and the Care Cap
- A raised Capital Allowance from £23,500 to £118,000

- Delivery of B&NES Better Care Plan 2014/15-2018/19.

- A new One Council approach with projects like 10 in 100 to stimulate new thinking and working across departments.

- New Council Procurement strategy, now in its second year, with a "Think Local" theme to encourage local procurement and support for local businesses.

- Publication of the Council's Health & Wellbeing Strategy and also the Joint Strategic needs Assessment that supports it. The new Better Care Plan and Care Act are similarly important and herald significant new responsibilities such as assessments of cumulative care costs and implementation of a cap on these costs to limit the liability of individual recipients of care packages.

- A greater clarity about how to improve links with local communities under the Council's Connecting Communities programme.

Progress Achieved

Delivery of the 2014/15 budget for adult social care and housing is on target. This provides a sound basis for future savings.

Variations to the Plan

The remaining year of the Approved medium term plan (2015/16) is attached at Appendix 1. This includes a more detailed commentary on progress towards delivery of the approved savings and additional income streams for the final year of the plan.

There are a number of variations required to the plan in order to arrive at a balanced Budget these will be set out in more detail as part of the final Budget Proposal in February 2015. Some of the key items currently under consideration are set out below:

<u>Potential Funding Pressures</u>

- Changes in government funding including Revenue Support Grant and Education Support Grant
- New funding burdens including Care Act implications, Social Fund and Deprivation of Liberty Safeguards.
- Changes to original savings proposals – these are set out in the in the update provided at Appendix 1.

- Impact of new Capital Schemes

Potential Funding Opportunities

- Increases in anticipated Business Rate Growth and related Business Rate opportunities.
- New Housing including increasing New Homes Bonus and Council Tax Base.
- Financing opportunities including funding of the Local Government Pension Fund deficit.
- Commercial income, including profit share from the Thermae Spa and income from Green Energy investment.
- The contribution to Community Health and Social Care costs from the Better Care Fund.
- The use of the Financial Planning Reserve.

With the exception of the variations identified above, any further changes considered by the Council will require the identification of further additional savings to balance the Budget.

Capital Programme

A draft summary of proposed variations to the capital programme is attached at Appendix 2. These proposals are at an early stage and will be put forward in more detail for approval as part of the February budget report.

All the Resources schemes are designed to achieve additional savings or new capital receipts for the Council and so have a positive impact on the revenue budgets. The most notable example is the plan to continue with more active commercial estate acquisitions where opportunities arise and where these have excellent returns.

Risks & Opportunities

The adult social care purchasing budget and key partner organisations, including Sirona Care & Health and Avon & Wiltshire Mental Health Partnership NHS Trust (AWP) continue to experience resource pressures arising from demographic change – in particular, the complexity and acuity of people being supported to live in community settings. Whilst, to some extent, the allocation of Section 256 funding and, from 2015/16, the Better Care Fund, against pressures in adult social care has helped mitigate these pressures, this remains a risk.

The Care Act 2014 represents the most significant reform of adult social care in decades. Modelling of the local implications, using nationally recognised and recommended modelling tools, adjusted for local circumstances, has resulted in an estimate of the new financial burdens for the Council from 2015/16 in the region of £1 million. However, this estimate must be treated with caution. Whilst every effort has been made to accurately model the financial implications, this modelling is constrained by a number of factors including:

- availability and accuracy of information – particularly in relation to people who are currently privately funding their own care and support services;
- the publication of the final guidance in November 2014
- the response of the market as the Care Act comes into force

- the establishment of case law in relation to the Care Act
- the behaviours of service users and carers; and
- flaws in the modelling tool(s).

Also, modelling, using national tools, is typically based on the 'normal' distribution of a sample resulting in predictions of change over time. Local figures on the use of services commissioned by B&NES indicate that there is a higher than expected number of short-term care arrangements resulting in a different distribution pattern. It is believed that this is a direct result of initiatives by the Council to better manage the demand for care, but also makes predictive modelling very difficult to achieve accurately.

Delivery of the MTSRP, Better Care Plan, Care Act implementation and other significant commissioning programmes, including the review of Community Health and Social Care Services along with fulfilment of the Council's statutory responsibilities in relation to adult social care, safeguarding and Mental Capacity Act/Deprivation of Liberty Safeguards (DOLS) mean that commissioning capacity is under pressure and a potential risk.

The delivery of B&NES Better Care Plan 2014/15-2018/19, presents the Council and partner organisations an opportunity to further develop integrated commissioning and service delivery to the benefit of people and the communities in which they live.

Equalities

Equalities impacts of key changes are considered as service plans are set and as part of any key management change. The main equalities impacts for Adult Social Care were assessed when the 3 year plan was set.

Appendices

1. Savings details – MTSRP final year progress summary 2015/16
2. Additional Capital Schemes

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MEDIUM TERM SERVICE & RESOURCE PLAN – SAVING DETAILS (2015/16 ONLY)

ADULT SOCIAL CARE

2015-16 Saving £000	How saving to be achieved	Previously Reported Impact to Service Delivery	Director's Update on Saving Proposal for November 2014 PDS Panel
296	Decrease in Sirona contractual values as agreed.	Already accommodated in service planning and contractual arrangements.	This saving is already incorporated in the contract with Sirona.
575	In partnership with Sirona Care & Health further efficiency savings from the contract with 'Sirona' Care & Health. This would be in addition to the £9.0m savings already built into the five year contract between Sirona, the Council and the Primary Care Trust. A recently published Audit Commission report "*Reducing the cost of assessments and reviews"* based on 2010/11 benchmarking information, which pre-dates the establishment of Sirona, suggests that efficiencies from social care processes could be achieved in the medium term. Target is based on bringing B&NES costs closer to the national benchmark. Delivery of the saving would need to be supported by: i) improved access to signposting, provision of advice and information (including to self-funders); ii) policy and process redesign, including increases in self-assessment; and iii) pathway redesign, culture change and skill-mix review.	Any service impacts would need to be assessed in light of the detailed savings plans, to be developed and agreed during 2013/14. The Audit Commission report suggests that savings can be made without adversely impacting on quality. If implemented in the right way, this change could impact positively on service users as a) some service users would self-assess or be signposted to services with no requirement for an assessment; and b) people who 'self-fund' their care services would be able to access advice (particularly financial advice) and, also a 'brokerage' service that would enable them to choose the provider of their service in light of up to date, accurate information on value for money, quality etc.	As set out in the update to Wellbeing PDS in November 2013, delivery of this saving is closely linked to the redesign of the adult social care pathway, which, in turn is linked to the development of community cluster teams and alignment to GP practice clusters. The re-designed adult social care pathway redesign, including the expansion of the integrated reablement and rehabilitation service launched, as planned, on 1st July 2014. Associated savings from efficiency and improvements in outcomes through early intervention and prevention have been incorporated into the contract with Sirona.

2015-16 Saving £000	How saving to be achieved	Previously Reported Impact to Service Delivery	Director's Update on Saving Proposal for November 2014 PDS Panel
455	A planned reduction of spend on purchasing the provision of personal care and support for older people, including those with dementia, adults with mental health needs, adults with learning difficulties and disabled adults, including those with sensory impairment. Primarily achieved by reducing admissions to residential care, particularly for older people, including those with dementia, by improving access to preventative and early intervention and also, by ensuring that signposting, access to universal services and advice to all, including self-funders, is effective. This saving aligns with investment plans to develop preventative services.	Some service users and their families/carers view admission to residential or nursing care as the "safe" (low-risk) option. Our staff will work to ensure that any concerns about community-based alternatives are addressed effectively. In order to reduce such concerns and mitigate any risks, it would be critical to ensure strong, effective preventative and early intervention services, pathway redesign, and improved signposting and access (including to self- funders) to financial advice. Further investment of Section 256 and, from 2015/16 Better Care Fund funding as well as a strategic shift in the investment of a proportion of Supporting People & Communities Funding would be appropriate in supporting the further development of this approach, which is in line with current national and local health and social care strategies. Proposal will increase pressures on Commissioning Team and will require culture change programme for practitioners.	An expansion of access to early intervention and preventative services, in particular integrated reablement and rehabilitation services are in place with future funding identified in B&NES Better Care Fund Plan 2014/15-2018/19 which was agreed by the Health & Wellbeing Board in September 2014. The integrated reablement and rehabilitation service is designed to prevent unplanned admissions to hospital or nursing care and, also to support discharge from hospital. Other preventative and early intervention services being funded through the Better Care Fund Plan include: • Expansion of the Independent Living Service; • Mental Health Reablement beds; • Social Prescribing Service; • Enhanced support for carers; and • Handyperson service, step-down accommodation with care, and intensive home from hospital service, all designed to support hospital discharge.
1,326	**ADULT SOCIAL CARE TOTAL SAVING**		

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Appendix 2

2015/2016 PROPOSED NEW CAPITAL PROGRAMME ITEMS

Wholly Externally / Grant Funded		
Scheme Description	**Estimated Cost £000's**	**Notes**
Adult Social Care Database replacement	942	Funded from the Better Care Fund (BCF) and Transition Grant
TOTAL	**942**	

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Bath & North East Somerset Council	
MEETING/ DECISION MAKER:	**Wellbeing Policy Development and Scrutiny Panel**
MEETING/ DECISION DATE:	**28th November 2014**
TITLE:	**Teenage Pregnancy update**
WARD:	All
AN OPEN PUBLIC ITEM	
List of attachments to this report: No attachments	

1 THE ISSUE

1.1 To update the Wellbeing Policy Development and Scrutiny Panel on teenage pregnancy in Bath and North East Somerset.

2 RECOMMENDATION

2.1 Proposal 1: that the Wellbeing Policy Development and Scrutiny Panel discuss and consider the contents of this report.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 There are no additional resource implications identified by the actions detailed.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 The public health department is responsible for detailing progress against a range of public health indicators as defined in the *Public Health Outcomes Framework.* The actions detailed in this report support progress towards the

under 18 conception rate indicator defined in the *Public Health Outcomes Framework*.

5 THE REPORT

5.1 Reducing the level of teenage conceptions in Bath and North East Somerset (B&NES) has long been a strategic objective, with the adoption of the National Teenage Pregnancy Strategy in 1999.

5.2 It's important to understand how we define "conception". For the purposes of this paper and the information included, a conception includes pregnancies that include one or more live or still births, or a termination of pregnancy (abortion)

5.3 Although the former national strategy came to an end in 2010, the *Public Health Outcomes Framework* established in 2013 recognises that impact that teenage conception has on wider health and wellbeing, attainment and life chances. As a result, the *Public Health Outcomes Framework* includes an indicator on under 18 conceptions with an ambition that Councils continue to reduce the rate

5.4 The development of and actions to support the former National Teenage Pregnancy Strategy has produced a significant evidence base. Of all young people not in education, training or employment, 15% are teenage mothers or pregnant teenagers; teenage parents are 20% more likely to have no qualifications at age 30; teenage mothers are 22% more likely to be living in poverty at 30, and much less likely to be employed or living with a partner; and teenage mothers have three times the rate of postnatal depression and a higher risk of poor mental health for three years after the birth

5.5 Outcomes are also worse for children of teenage mothers. National data suggests that children of teenage mothers have a 63% increased risk of being born into poverty and are more likely to have accidents and behavioural problems; the infant mortality rate for babies born to teenage mothers is 60% higher; and teenage mothers are three times more likely to smoke throughout their pregnancy and 50% less likely to breastfeed, with negative health consequences for the child

5.6 Whilst teenage conception may result from number of causes or factors, the strongest empirical evidence for ways to prevent teenage conceptions is through high-quality education about relationships and sex, and access to and correct use of effective contraception. There is no evidence to suggest that alternative approaches such as abstinence programmes or welfare benefits sanctions have any impact on reducing teenage pregnancy rates

5.7 Across England there has been a 41% reduction in the under 18 conception rate, from 46.6 per 1,000 women aged 15-17 years olds in 1998, to 27.7 per 1,000 women aged 15-17 in 2012. The current rate is the lowest rate since conception data collection began in 1969

5.8 Despite this progress, national levels of teenage conception are still higher than levels experienced by young people in comparable Western European countries

5.9 Reducing teenage conception remains a continuing priority across a range of national policy contexts including the *Framework for Sexual Health Improvement*

in England; the National Healthy Child Programme; the National *Child Poverty Strategy* and priority families work

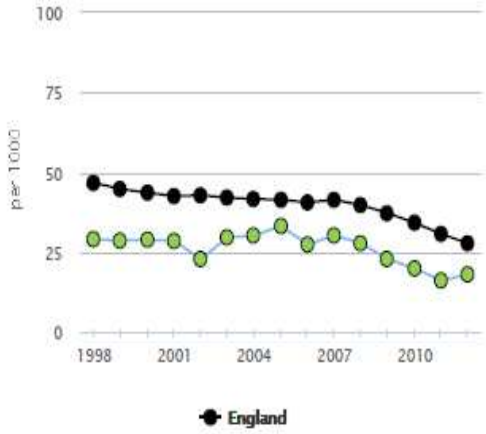
6 RATIONALE

6.1 B&NES has experienced significant success in reducing, and then maintaining that lower level of teenage conceptions. Interventions in Bath and North East Somerset, have been, and continue to be developed and delivered according to national guidance and good practice, and importantly by translating local evidence into local delivery, using local data to inform commissioning and interventions

6.2 B&NES has reduced its level of teenage conceptions from 29 per 1,000 women aged 15-17 in 1998 to 18 per 1,000 women in 2012 as detailed in the table below:

Figure 1

2.04 - Under 18 conceptions Bath and North East Somerset — Crude rate - per 1000



Period	Sig	Count	Value	Lower CI	Upper CI	South West	England
1998		82	29.0	23.1	36.1	39.4	46.6
1999		78	28.5	22.6	35.6	37.5	44.8
2000		78	28.9	22.8	36.1	36.3	43.6
2001		79	28.5	22.6	35.5	37.1	42.5
2002		66	22.8	17.6	29.0	35.4	42.8
2003		87	29.6	23.7	36.6	34.2	42.1
2004		90	30.2	24.3	37.1	34.6	41.6
2005		96	33.2	26.9	40.5	34.6	41.4
2006		76	27.4	21.6	34.3	33.8	40.6
2007		85	30.2	24.1	37.3	36.9	41.4
2008		83	27.7	22.1	34.3	35.3	39.7
2009		71	22.8	17.8	28.8	32.6	37.1
2010		61	19.9	15.2	25.6	30.0	34.2
2011		49	16.2	11.9	21.4	27.3	30.7
2012		53	18.0	13.5	23.6	24.8	27.7

Source: Office for National Statistics (ONS)

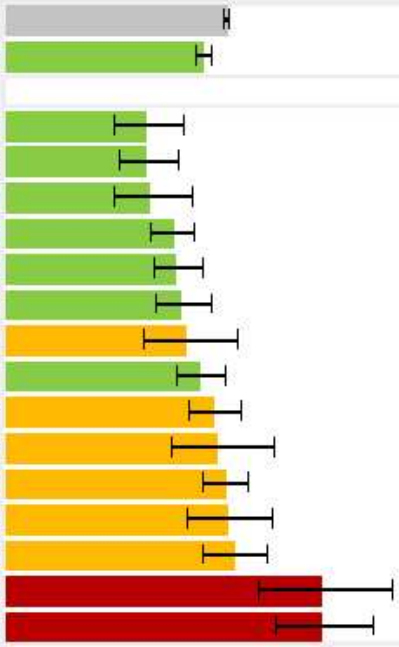
Because of the low numbers of teenage conceptions, we need to be cautious in analysing trends in rates. As you can see from the table above a slight increase in the number of teenage conceptions in one year can mean the rate jumps significantly. For example, the difference between the 2012 rate of 18, and the 2008 rate of 27.7 is accounted for by just 30 individual conceptions.

6.3 B&NES has performed well in comparison to both our local neighbours and the England average. B&NES had the third lowest rate of teenage conception across the South West in 2012 and was significantly lower than the England rate as detailed in the table below:

Figure 2

Under 18s conception rate / 1,000 (PHOF indicator 2.04) 2012

Area	Count	Value
England	26,157	27.7
South West	2,292	24.8
Isles of Scilly	-	*
North Somerset	62	17.5
South Gloucestershire	88	17.6
Bath and North East Somer...	53	18.0
Gloucestershire	226	20.9
Wiltshire	197	21.5
Dorset	157	22.1
Poole	59	22.7
Somerset	244	24.4
Cornwall	242	26.1*
Bournemouth	68	26.6
Devon	347	27.4
Swindon	106	27.8
Bristol	188	28.5
Torbay	88	39.5
Plymouth	167	39.5

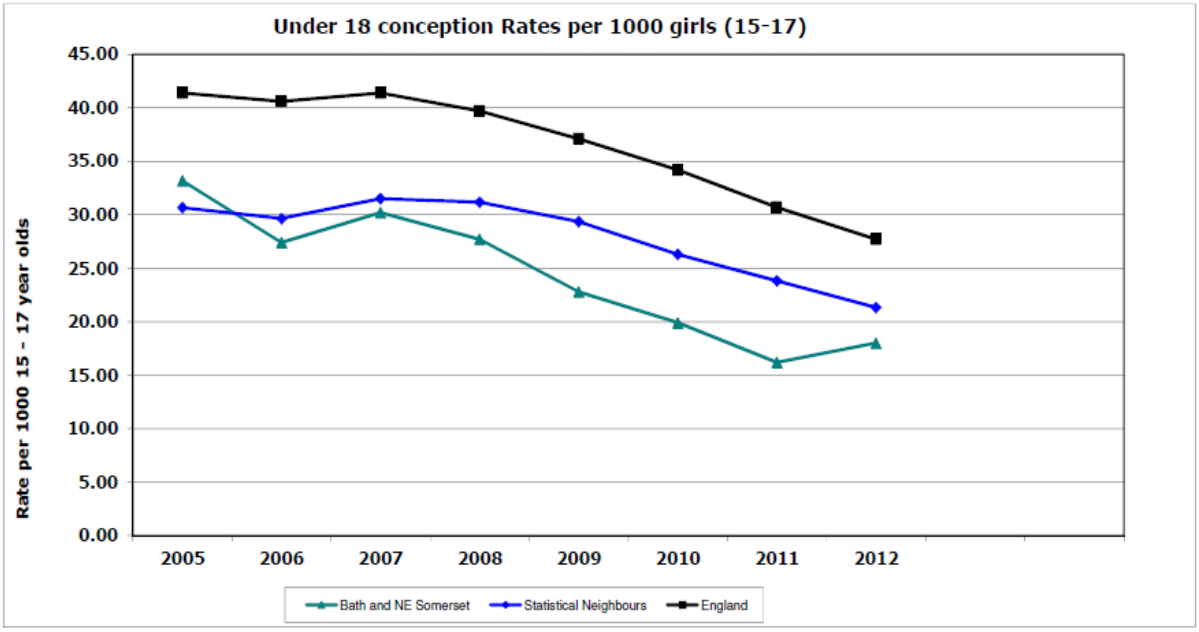


Source: Office for National Statistics (ONS)

Over the past three years B&NES had the lowest number of teenage conceptions across the South West region.

6.4 B&NES also compares well to our statistical neighbours across England when looking at teenage conceptions. There are ten local authorities that are utilised for statistical comparison with B&NES, including Wiltshire, North Somerset, Devon and Hampshire. The table below shows that B&NES compares very well in this regard:

Figure 3



Source: Office for National Statistics, 2014

6.5 The number of teenage conceptions varies across the different wards of B&NES. The table below identifies the spread of teenage conceptions during 2009 – 2011. In some areas the rate is so low it has been suppressed to protect the identities of individual women. The five wards with the higher rates of teenage conceptions across this two-year period are Kingsmead, Twerton, Walcot, Southdown and Midsomer Norton North. Although these wards are the highest for teenage conceptions, its important to note that actual numbers remain low ranging from 18 conceptions in Twerton and less than 10 in Kingsmead during this period:

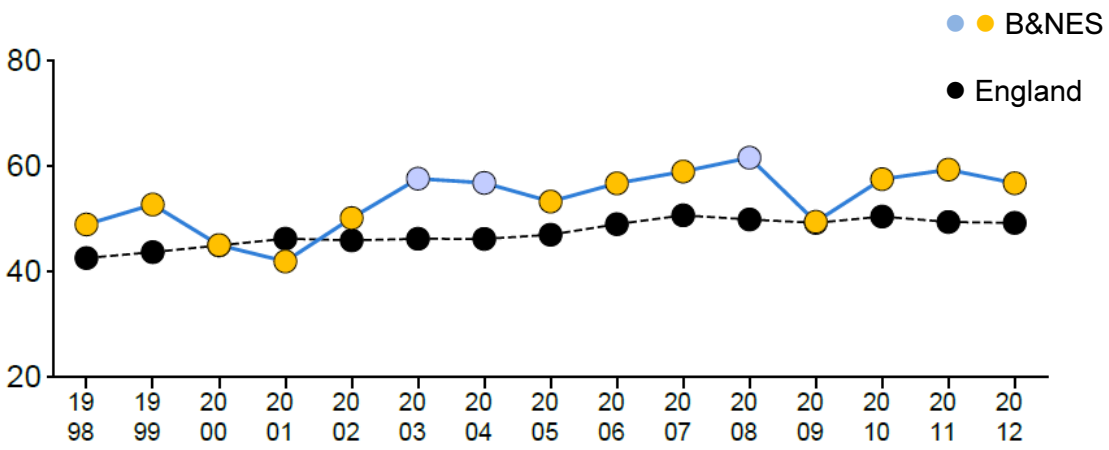
Figure 4: Rates of Under 18 conceptions per 1,000 women aged 15-17, by ward, 2009 – 2011

Ward	Rate of under 18 conceptions per 1,000 women aged 15-17	Ward	Rate of under 18 conceptions per 1,000 women aged 15-17
Kingsmead	56	Combe Down	*
Twerton	52	Bathavon West	*
Walcot	47	Chew Valley South	*
Southdown	40	Bathwick	*
Midsomer Norton North	35	Chew Valley North	*
Paulton	34	High Littleton	*
Radstock	28	Lansdown	*
Westfield	23	Clutton	*
Keynsham North	23	Lyncombe	*
Oldfield	22	Farmborough	*
Odd Down	22	Midsomer Norton Redfield	*
Keynsham South	22	Publow and Whitchurch	*
Mendip	21	Timsbury	*
Peasedown	19	Lambridge	*
Keynsham East	19	Newbridge	*
Bathavon North	17	Saltford	*
Abbey	*	Westmoreland	*
Bathavon South	*	Weston	*
		Widcombe	*

Source: Office for National Statistics, 2014

6.6 As detailed previously, not all teenage conceptions result in a live birth. The majority lead to a termination of pregnancy (abortion). In 2012, the proportion of under 18 conceptions that lead to a termination of pregnancy was 56.6%. This figure is higher than the England average of 48.7%, and the South West average of 48.9%. The higher rate in B&NES is not statistically significant due to the very low numbers of women accessing a termination of pregnancy. The table below shows the changes since 1998:

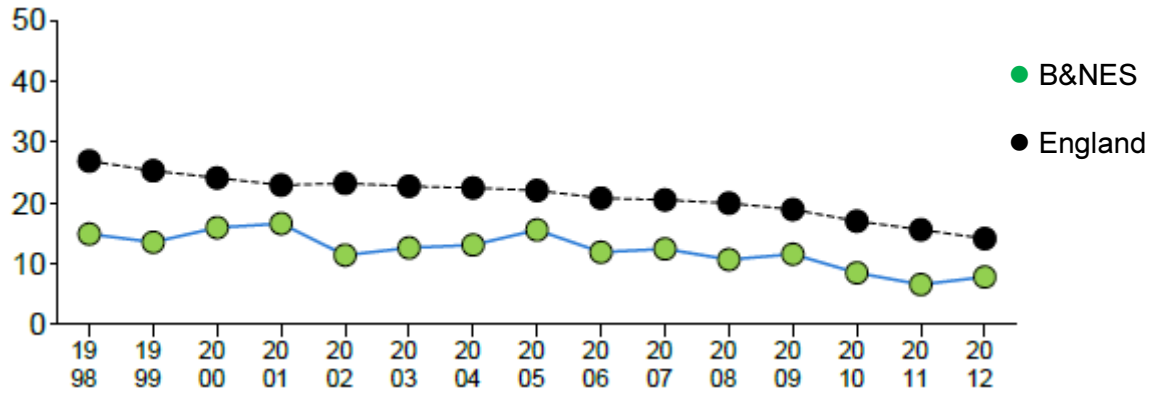
Figure 5: Percentage of under 18 conceptions leading to abortion, B&NES and England, 1998 – 2012



Source: Office for National Statistics, 2014

6.7 The actual number of teenage conceptions that end in a live birth remains consistently low across B&NES as detailed in the table below:

Figure 6: Number of live births to women under 18, by year, B&NES and England



Source: Office for National Statistics, 2014

6.8 The overall picture regarding teenage conception in B&NES is therefore very good. However we do not want to be complacent and are undertaking measures to ensure that our rates remain low. We can translate the evidence of what works into nine factors for a whole systems approach to reduce teenage conceptions. The table below highlights these factors and shows what we are doing B&NES to address these factors:

Factor	B&NES work
Sex and relationships education in schools and colleges	All secondary schools provide Sex and Relationships Education (SRE) in consultation with the Personal Social and Health Education (PSHE) Lead and school nurses and as part of their PSHE Programme. An emphasis is always on healthy relationships (for example, recent resources provided on Child Sexual Exploitation and pornography) To date, 200 teachers, nurses and other professionals have completed the accredited PSHE programme (with a focus on SRE) and all but two secondary schools have *at least* one accredited PSHE trained teacher
Young people friendly Contraceptive and Sexual health services, and condom schemes	All commissioned services are expected to comply with our Sexual health Advice for Everyone (SAFE) accreditation. SAFE is a long established local brand well evaluated by young people which represents services which are confidential, have friendly staff, provide up to date information and resources, and which are accessible to young people Our condom scheme (the C-Card) has been in place for several years and we are currently re-commissioning our contraceptive and sexual health service, which will also be SAFE accredited
Targeted prevention for young people at risk	There are a range of services and interventions that are commissioned to target prevention for those most at risk, including provision through Youth services, school nursing and specialist outreach sexual health services. The C-card programme specifically targets venues and services where young people at risk access.
Support for parents to discuss relationships and sexual health	Sessions are provided as part of the Sexual Health Training programme, based on the principles of the nationally evaluated Speakeasy programme. Referral for support is also available to professionals working with parents such as teachers, children's centre and social care staff. All Children's Centres and Compass (who offer parenting courses with parents whose children are at risk of offending) are provided with the Speakeasy resource to work through with vulnerable parents.
Training on relationships and sexual health for health and non-health professionals	We have a long established sexual health training programme which is available for both health and non-health professionals. Courses cover issues such as the law and confidentiality, STIs, supporting the needs of people with learning disabilities, brief alcohol interventions, working with LGBT young people and contraceptive choices amongst many other courses. Requests for bespoke training are also considered
Advice and access to contraception in non-health youth settings	We have a range of services in place that provide advice and access across Youth Services, schools and colleges including direct support, C-card access and MediVend machines
Consistent messages to young people, parents and practitioners	Over time B&NES has reiterated the same messages to key audiences: these that sexual health services and interventions are free and confidential; that SAFE accredited services can be trusted; and that a range of different professionals can be approached to discuss sexual health issues including teenage conception
Dedicated support for teenage parents, including SRE and contraception	A range of measures are in place. The Family Information Service provide all midwives in B&NES with a young parents pack which is provided at the booking appointment to all young parents aged 19 or under. The sexual health team provides the information that is included in the pack around local services and contraceptive choices. We also work closely with the Family Nurse Partnership who work with all young parents/parents to be to ensure they are aware of who to refer to regarding sexual health and contraception
Strong use of data for commissioning and monitoring of progress	The B&NES Sexual Health Board is overseeing the development of a sexual health needs assessment which will include teenage conception data. The needs assessment will enable us to evaluate, plan and commission services and interventions across B&NES to better meet needs

7 OTHER OPTIONS CONSIDERED

7.1 Not applicable in this report

8 CONSULTATION

8.1 As this paper is an update no consultation is required. The actions we are taking to reduce teenage conceptions are based in accordance with national guidance, good practice and local evidence. As part of the development of our local sexual health needs assessment we will further review these elements to examine what further or additional actions we can undertake. Our recently reformed Sexual Health Board features all key clinicians and commissioners, and will be a key driver to reduce the level of teenage conceptions in B&NES.

9 RISK MANAGEMENT

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

Contact person	Paul Sheehan, Public Health Development and Commissioning Manager Public Health Team People and Communities Department paul_sheehan@bathnes.gov.uk; 01225 394065 Dr. Bruce Lawrence Director of Public Health Public Health Team People and Communities Department Bruce_lawrence@bathnes.gov.uk
Background papers	DH (2013), *Public Health Outcomes Framework,* Department of Health, London; available at:

	https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency
Please contact the report author if you need to access this report in an alternative format	

Wellbeing Policy Development and Scrutiny (PDS) Panel

28th November 2014

Risk Assessment for Item 14: Teenage Pregnancy update

Proposed recommendation(s) of report:

- That the wellbeing policy development and scrutiny panel discuss and consider the contents of this update

Risks relating to proposed recommendation(s)
No significant risks identified

Risks of not taking proposed recommendation(s)
Not applicable - the report is written to provide an update to a range of measures and initiatives being undertaken by B&NES Council to reduce the rate of teenage conceptions.

Actions to manage risks of not taking proposed recommendation(s)
Not applicable - the report is written to provide an update to a range of measures and initiatives being undertaken by B&NES Council to reduce the rate of teenage conceptions

Contact person	Paul Sheehan, Public Health Development and Commissioning Manager Public Health Team People and Communities Department paul_sheehan@bathnes.gov.uk; 01225 394065

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Bath & North East Somerset Council		
MEETING/ DECISION MAKER:	**Wellbeing Policy Development & Scrutiny Panel**	
MEETING/ DECISION DATE:	**28th November 2014**	EXECUTIVE FORWARD PLAN REFERENCE: E
TITLE:	**Alcohol Strategy**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Draft B&NES Alcohol Harm Reduction Strategy 2014 - 2019		

1 THE ISSUE

1.1 The current B&NES Alcohol Harm Reduction Strategy (2012) was adopted by B&NES Council in April 2012. A commitment to refresh the Strategy in light of national and local developments was agreed with Wellbeing Policy, Development and Scrutiny Panel in May 2012. A Joint Scrutiny Inquiry Day in October 2013 and its subsequent recommendations have informed the Strategy refresh, alongside national and local developments since 2012.

2 RECOMMENDATION

2.1 Proposal 1: The Wellbeing Policy Development and Scrutiny Panel support the Alcohol Harm Reduction Strategy for Bath and North East Somerset (2014 – 2019) and agree that it is taken forward for endorsement by B&NES Council Cabinet.

2.2 Proposal 2: The Strategy is refreshed in 2017 to update priorities and recommendations to ensure relevance to emerging local, regional and national issues.

2.3 Proposal 3: The Wellbeing Policy Development and Scrutiny Panel actively engage in the call for evidence based national initiatives to support local delivery such as minimum unit pricing, a reduction in blood alcohol levels for driving, a public health objective in the licensing act and restrictions on advertising and sponsorship by the alcohol industry.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 The Council currently contribute financially towards the delivery of the Alcohol Harm Reduction Strategy predominantly from the Public Health Grant, Adult Health and Social Care and from across other Council departments. B&NES Clinical Commissioning Group also contribute towards prescribing costs and hospital based services. Probation and Wiltshire Drug and Alcohol team contribute to the treatment budget. Levels of

expenditure and contribution will be kept under review given the wider position re public finances over the next three to five years.

3.2 Strategy delivery is reliant on cross agency working and we aim to influence the work and use of resources of partners and key stakeholders to make best use of existing resources and lever in additional funding where possible. Strategy delivery is subject to ongoing financial support from partners and the Council.

3.3 The Strategy contributes towards the delivery of B&NES Clinical Commissioning Group Strategic plan and joint working on shared outcomes will contribute towards reduced costs across the health and social care system

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 Public Health and Inequalities, Crime and Disorder, Children

4.2 There are significant inequalities in the impact of alcohol misuse across Bath and North East Somerset. The Strategy aims to address these inequalities through targeting of specific groups including children and young people, men, those with mental health problems and those living in more deprived areas.

5 THE REPORT

5.1 Alcohol is the third greatest overall risk to health after smoking and raised blood pressure (WHO 2009). Overall our alcohol consumption is reducing but we are still drinking twice as much compared to 1960's levels. 91% more alcohol was consumed in 2010 compared to1960. Alcohol contributes to over 60 different types of diseases and injuries. Impact on health and health services is evident through the rising number of alcohol related hospital admissions nationally and locally.

- Admissions for alcohol related conditions have risen by an average of 12% each year since 2002/03 in line with national trends, but remain lower than regional and national rates.

- People living in the most deprived areas of Bath and North East Somerset are significantly more likely to be admitted for an alcohol related condition than those living in the least deprived areas.

- Bath and North East Somerset has significantly higher rates of under 18's admitted to hospital for alcohol specific conditions than nationally.

5.2 The harm from alcohol impacts not only on the individual but society as a whole. The total estimated cost in B&NES of the harm arising from alcohol-use disorders is some £45.0 million a year, of which £21.3 million is a result of crime and £5 million healthcare costs. (Cabinet Office 2003)

5.3 The refreshed Alcohol Harm Reduction Strategy outlines the key structural and service developments locally which will contribute to and influence delivery. Its structure reflects the B&NES Council and B&NES Clinical Commissioning Group intention to apply an Outcomes Based Accountability model to commissioning and performance management.

5.4 The Strategy builds on the good progress that has been made since 2012 across a number of areas including building awareness, skills and confidence amongst frontline professionals to address alcohol misuse, increasing the focus and capacity of the

treatment system to respond to alcohol clients and proactive management of the night time economy to address crime and anti-social behaviour. Key actions since 2012 include:

- The training of over 700 local professionals to use evidence based tools for alcohol misuse identification and brief advice
- The introduction of systematic screening for alcohol misuse in the NHS Health Check and as part of the inpatient and community mental health services contract from 14/15
- Re-commissioning of the Drug and Alcohol Treatment Services to include a Single Point of Access for clients and professionals, a dedicated alcohol team and additional capacity for community detoxification.
- A new Alcohol Liaison Service at the Royal United Hospital, funded by B&NES CCG and Wiltshire Drug and Alcohol team
- Young Carers group set up for children affected by parental substance misuse
- Families also matter (FAM) service developed by DHI to support those affected by someone else's substance misuse
- Retaining Bath City Centre's Purple Flag status year on year
- Midsomer Norton Community Alcohol Partnership introduced a range of town management initiatives to reduce antisocial behaviour and underage drinking in the high street.

5.5 The high level priorities within the refreshed Strategy aim to ensure adequate emphasis is given to prevention and early detection of alcohol misuse and that there is greater ownership of the agenda and vision amongst the residents, businesses and visitors to Bath and North East Somerset. The main priorities are:

- Greater emphasis on prevention of alcohol harm through national and local policy
- Developing a clear narrative about what a healthy drinking environment in B&NES looks and feels like
- A local licensing policy that considers a broader range of issues and impacts including health
- Embedding screening and brief advice across the system
- Ensuring high quality accessible treatment services, which have recovery at their heart.

5.6 The National Institute for Health and Care Excellence (NICE PH 24) recommends the following evidenced based approaches to reducing alcohol related harm in the population:

- Price increases
- Restricting physical availability
- A reduction in drink drive alcohol limits
- Control on advertising
- Identifying problems sooner
- Good quality treatment services
- Good quality communication/education programmes

5.7 The top four of these recommendations are predominantly reliant on action at a national level and reiterate the importance of lobbying national government on the key issues of price, availability, advertising and regulation.

5.8 Effective local approaches to tackling alcohol related harm are identified in the 4 Outcome Frameworks which are at the heart of the Strategy. The 4 outcomes the Strategy is aiming to achieve are:

- Children grow up free from alcohol related harm
- Communities are safe from alcohol related harm
- People can enjoy alcohol in a way that minimises harm to themselves
- People can access support that promotes and enables sustained recovery

5.9 Priority actions identified for 14/15 are:

- Refresh of Children and Young People Substance Misuse needs assessment
- Improved understanding of Under 18's Alcohol Specific Hospital Admissions
- Developing and communicating a vision of the Night Time Economy for B&NES
- Introduction of screening for alcohol misuse across mental health services and RUH Emergency Department
- Increasing alcohol treatment capacity and the percentage of people who successfully complete treatment
- Developing a local response to treatment resistant drinkers

5.10 The indicators we will monitor to measure progress related to each outcome are:

- Alcohol Specific Hospital Admissions of under 18 year olds
- Night time economy related crime and disorder (8pm – 4am)
- Alcohol related hospital admissions (18yrs+)
- Percentage of people leaving treatment successfully

5.11 The B&NES Alcohol Harm Reduction Steering Group will co-ordinate delivery of this Strategy through a Outcomes Action Plan. Each outcome has a lead officer who will take responsibility for driving forward the relevant actions. The Group will co-ordinate directly with key partnerships on delivery of action plans including the Young People's Substance Misuse Group, Night Time Economy Group, the Responsible Authorities Group and the Joint Commissioning Group for Substance Misuse.

5.12 Governance and reporting

The Group will report to the Responsible Authorities Group twice yearly
The Group will also report to the Children's Trust Board twice yearly within the context of the Children and Young People's Plan.
The Group will report to the Health & Wellbeing Board twice yearly and via the Board's Joint Annual Account.

5.13 Review timetable

This Strategy will be reviewed after 3 years to ensure it continues to reflect local and national priorities.

6 RATIONALE

6.1 Reducing alcohol-related harm, by encouraging a more sensible drinking culture, will help to achieve a range of indicators outlined in the Public Health Outcomes Framework for England 2013 – 2016. These include reducing the number of:

- people killed or seriously injured on our roads
- alcohol related hospital admissions
- falls and injuries among the over-65s
- deaths from cardiovascular disease (including heart disease and stroke), cancer and liver disease
- low birth weight babies
- violent crimes (including sexual violence) and domestic abuse
- pupil absences
- chlamydia diagnoses among young people aged 15–24 years

6.2 The recommendations contribute to the delivery of the outcomes of the Joint Health and Wellbeing Strategy, in particular under the theme of 'Helping people to stay healthy' and the specific objective to reduce rates of alcohol misuse.

7 OTHER OPTIONS CONSIDERED

7.1 None

8 CONSULTATION

8.1 The Strategy has been developed in consultation with B&NES Alcohol Harm Reduction Steering Group and the B&NES Night Time Economy Group. Membership of these groups includes Police, Fire and Rescue Service, Royal United Hospital, University representation, resident association representation, Bath Transport Police, Bath Business Improvement District, Licensing, Community Safety, Public Health, Drug and Alcohol Service commissioners and providers, Avon and Wiltshire Mental Health Trust, children's services, housing and probation services.

8.2 The Strategy priorities are directly informed by the Scrutiny Inquiry Day on Alcohol held in October 2013 hosted jointly by 3 B&NES Council Policy Development and Scrutiny panels representing Wellbeing, Economic and Community Development and Early years, children and youth policy in October 2013. 68 people including councillors, officers, stakeholders and residents attended.

8.3 During November 2014 the Strategy has also been presented for consultation to the Health and Wellbeing Board and the Responsible Authorities Group.

9 RISK MANAGEMENT

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

Contact person	*Cathy McMahon 01225 394064*
Background papers	*None.*
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset
Alcohol Harm Reduction Strategy

October 2014 - 2019

Background

This document is a refresh of the Alcohol Harm Reduction Strategy 2012 (Milner et al 2012). The 2012 Strategy identified the key needs, gaps and priorities for Alcohol Harm Reduction in B&NES through extensive consultation and stakeholder engagement. Eight service and organisational development activities were prioritised in the Strategy and Appendix 1 outlines the significant progress that has been made across all eight areas over the past 2 years.

This Strategy refresh takes into account the recommendations of the following key documents:

- The Governments national Alcohol Strategy 2012 (March 2012)
- The recommendations from the Joint Scrutiny Inquiry Day on Alcohol Harm Reduction in B&NES (Oct 2013)
- The recommendations from the LGA Peer Challenge Report on B&NES Health & Wellbeing Board (Feb 2014)

High level recommendations include:

- Greater emphasis on prevention of alcohol harm through national and local policy
- Developing a clear narrative about what a healthy drinking environment in B&NES looks and feels like
- A local licensing policy that considers a broader range of issues and impacts including health
- Embedding screening and brief advice across the system
- Ensuring high quality accessible treatment services, which have recovery at their heart.

This document outlines the key structural and service developments locally which will contribute to and influence delivery of this Strategy. Its structure reflects the B&NES Council and B&NES Clinical Commissioning Group intention to apply an Outcomes Based Accountability model to commissioning and performance management.

National Context and Trends

Alcohol is the third greatest overall risk to health after smoking and raised blood pressure (WHO 2009)

Reducing alcohol-related harm, by encouraging a more sensible drinking culture, will help B&NES Council meet its statutory duty to achieve the indicators outlined in the Public Health Outcomes Framework for England 2013 – 2016. These include reducing the number of:

- people killed or seriously injured on our roads
- alcohol related hospital admissions
- falls and injuries among the over-65s
- deaths from cardiovascular disease (including heart disease and stroke), cancer and liver disease
- low birth weight babies
- violent crimes (including sexual violence) and domestic abuse
- pupil absences
- chlamydia diagnoses among young people aged 15–24 years

Overall alcohol consumption is reducing but we are still drinking twice as much compared to 1960's levels. 91% more alcohol was consumed in 2010 compared to 1960

Alcohol was 45% more affordable in 2011 compared to 1980 – as real household income has risen significantly

Mortality from liver disease is regarded as one of the best barometers of alcohol related ill health. Between 1970 and 2000 UK deaths from liver disease in people aged under 65 years increased fivefold, while death rates from other diseases have declined.

The majority of drinking takes place in the home.

Nationally violent crime has been reducing since 2001

The Governments Alcohol Strategy (March 2012) strengthened and extended powers for local areas to restrict alcohol sales late at night and the option to introduce a late night levy on premises.

There is a growing number of older people with increasingly complex issues.

The clustering of unhealthy behaviours such as smoking, unhealthy eating, alcohol misuse and lack of physical activity are widening health inequalities.

There is significant cross over between mental health issues and alcohol and substance misuse.

Local Developments supporting delivery of this Strategy

Joint Health and Wellbeing Strategy 2013 – 2016 – This Strategy prioritises alcohol harm reduction within its theme of Keeping People Healthy. In April 2013 a Joint Working Framework was agreed between the Council and the CCG, setting out the mechanisms that will deliver integrated commissioning of services across health, public health, adults and children's services. This aims to improve outcomes and service user experience across the system, make the most efficient and effective use of our combined commissioning resource and to help delivery the Joint Health and Wellbeing Strategy.

Connecting families programme has been introduced to engage with 215 of the most complex families living in the local area to support them to make positive change and live full and active lives. Substance misuse, domestic violence and mental health problems are among the issues families are dealing with. This programme will support reduction in substance misuse amongst adults and children in these families and facilitate access into treatment where appropriate.

Domestic violence
Working with the Interpersonal Violence and Abuse Strategic Partnership (IVASP) B&NES Council is taking a whole system approach towards developing a new model of helping victims of domestic abuse. This work is aligned with new Police neighbourhood-based operating models, the PCC's Integrated Victims strategy and approach ('Lighthouse') and B&NES work to developing a Multi-Agency Safeguarding Hub.

The Family Nurse Partnership (FNP) was introduced in 2013. FNP is an intensive preventative programme for teenage mothers. Starting in early pregnancy and based on a therapeutic relationship, it supports the clients' intrinsic desire to be the best mother that she can be by offering holistic support and guidance until the child is two years old. The team screen for alcohol use and drug use on entry to the service and work with clients to reduce consumption to safe levels.

Integrated Commissioning of Substance Misuse Services

Substance misuse services were re-commissioned during 12/13. The process was a joint one between children's services and adult services. This has enabled a more integrated service to be designed with a single point of access and improved transition between children and adult services for example.

The Local Picture

Admissions for alcohol related conditions have risen by an average of 12% each year since 2002/03 in line with national trends, but remain lower than regional and national rates. 60% of all alcohol related hospital admissions are people over 60

People living in the most deprived areas of Bath and North East Somerset are significantly more likely to be admitted for an alcohol related condition than those living in the least deprived areas.

Bath and North East Somerset has significantly higher rates of under 18's admitted to hospital for alcohol specific conditions than nationally. Approximately 45% of young people's admissions are children under 16 and the majority of admissions are girls.

60% of adults seen by the RUH alcohol liaison service (from Dec – June 2013) were also experiencing mental health issues.

The total estimated cost in B&NES of the harm arising from alcohol-use disorders is some £45.0 million a year, of which £21.3 million is a result of crime and £5 million healthcare costs. (Cabinet Office 2003)

There has been a 26% reduction in the number of crimes linked to the Night Time Economy in B&NES between 2008 and 2013

24% of the B&NES adult population is estimated to be drinking at increasing or high risk levels, which is similar to national estimates.

The estimated number of people in B&NES dependent on alcohol is 6,854 of all people aged 18 - 64 years. During 12/13 there were 388 people in treatment for alcohol misuse in B&NES. This represents 5.7% of the estimated population of dependent drinkers locally. Numbers in treatment have risen significantly since 2009 and this trend has continued in 13/14.

In 2013, 22% of B&NES secondary school pupils (Yr8 and Yr10) reported 'drinking alcohol in the last week' compared to 30% in 2011.

Community Voice

There is a significant difference in self-reported exposure to alcohol (drinking in the last week) for primary school pupils who qualify for free school meals compared to those who do not qualify for free school meals.

Girls self-report higher levels of drinking and are over represented in treatment services for alcohol misuse and also in alcohol related hospital admissions.

Qualitative feedback from young people using treatment services (Project 28) is consistently positive and satisfaction is high

High self-esteem amongst B&NES secondary school girls dropped from 42% in 2011 to 33% in 2013.

When asked in 2012 about drunk and rowdy behaviour in public places in their local area, 21% of voice box survey respondents believed it was either a very big problem, or a fairly big problem.

For further detail on local needs go to www.bathnes.gov.uk/jsna

Gaps in services and commissioning

68 people including councillors, officers, stakeholders and residents attended a Scrutiny Inquiry Day in Oct 2013 where a range of recommendations were made under the following themes:

- More education programmes that encourage a voluntary shift in attitude toward alcohol
- Improved and more frequent alcohol screening mechanisms
- Greater emphasis on prevention of alcohol harm through national and local policy
- More accessible training that emphasises issues and the effects of alcohol related harm
- Improved engagement at local level through more positive and proactive information sharing and publicity
- Community safety approaches that encourage collective and integrated working across partners and stakeholders

What works in preventing alcohol related harm

The National Institute for Health and Care Excellence (NICE PH 24) recommends the following evidenced based approaches to reducing alcohol related harm in the population:

- Price increases
- Restricting physical availability
- A reduction in drink drive alcohol limits
- Control on advertising
- Identifying problems sooner
- Good quality treatment services
- Good quality communication/education programmes

The top four of these recommendations are predominantly reliant on action at a national level and reiterate the importance of lobbying national government on the key issues of price, availability, advertising and regulation. Effective local approaches to tackling alcohol related harm are identified in the Outcomes Frameworks below.

Strategic Vision:

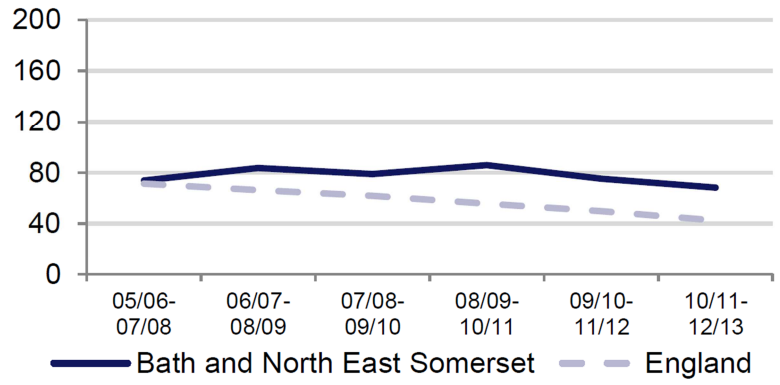
A cultural environment where everyone can have fun and enjoy themselves safely, with or without alcohol.

Outcomes we want to achieve:

- Children grow up free from alcohol related harm
- Communities are safe from alcohol related harm
- People can enjoy alcohol in a way that minimises harm to themselves
- People can access support that promotes and sustains recovery

Each of the above outcomes and their associated indicators for monitoring progress are outlined in the Outcome Framework below:

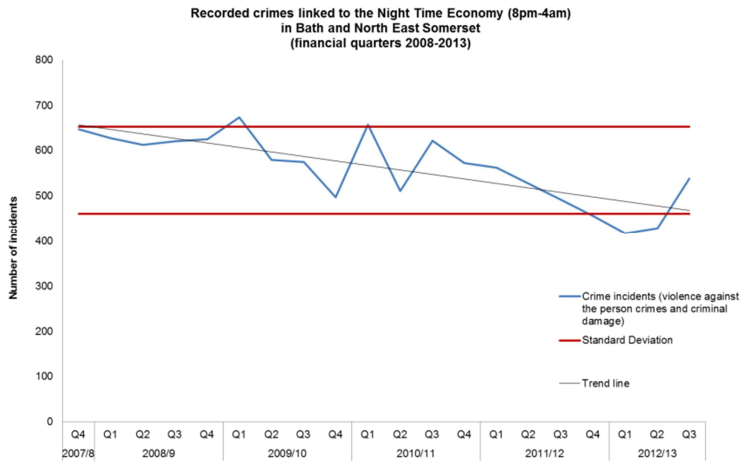
Outcome Framework: Children grow up free from alcohol related harm

Outcome & Indicator	Baseline and story behind it	Partners	What works to do better locally?
Outcome: Children grow up free from alcohol related harm **Indicator:** Alcohol specific hospital admissions to U18's **Population:** B&NES residents population under 18 yrs	**Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)**  	Children & Families services Schools Colleges Parent support organisations Connecting families team Social care teams RUH License holders Retailers Parents Youth services Sexual health services Drug and Alcohol service providers Voluntary orgs CAMHS School nursing & health visiting Children's centres Maternity services Community Alcohol Partnership MSN	Screening for alcohol misuse in young people's settings Targeting of high risk /vulnerable groups Support to children whose parents misuse substances. Multi agency working strategically, with families and in communities Holistic approach to health education in schools via PSHE/DPH award Social marketing campaigns aimed at parents/carers and young people Enforcement of underage sales, proxy sales and responsible retailing law
Data issues/gaps: Are high admissions a result of lower thresholds or protocol at RUH? School survey data shows reduced levels of reported drinking and drunkeness amongst young people during period 2011 to 2013 Missing ED attendances therefore underestimating scale of alcohol misuse What % of those being admitted are: known to services Repeat attenders access or need treatment Looked after children	**Story behind the baseline: (examples of contributory factors)** Alcohol seen as a supermarket commodity - normalised Fall in price of alcohol Alcohol drug of choice - rise in binge drinking culture amongst girls in particular Pre-loading culture Trend towards stronger drinks and larger glasses Marketing of alcohol to children (alco-pops etc) Deprivation link – young people in most deprived quintile of B&NES are significantly more likely to be admitted to hospital for alcohol specific condition than those in the least deprived quintile. Levels of self-reported drinking have reduced amongst B&NES secondary school pupils. Girls are over represented in drinking and smoking behaviours, hospital admissions for alcohol and in treatment services for alcohol misuse. Girls also over represented in self-harm admissions MSN and Radstock higher rates of admissions		**Commitment to lobby on:** Minimum unit pricing Restrictions on advertising and sponsorship of alcohol

Outcome Framework: Children grow up free from alcohol related harm

Current good practice in B&NES on protecting children from alcohol related harm	Gaps/Needs Identified
• Holistic approach to promoting health and wellbeing across educational settings in B&NES through the Director of Public Health Award and PSHE& Drugs Consultant • Specific resources developed for primary schools on alcohol and campaigns/initiatives such as alcohol drama project for Secondary Schools • High Quality Treatment services delivered through DHI/Project 28, including family support and supported transition from children to adult treatment services. • Drink Think Alcohol Screening Tool and Training Programme – embedding screening on alcohol misuse amongst the children and young people workforce – working especially well amongst school nursing and sexual health services. • Young carers support group. • B&NES Connecting Families programme working intensively to support 200 most vulnerable families • The Family Nurse Partnership working closely with up to 100 young pregnant women (under 25's) to support health in pregnancy • Self-harm register introduced at RUH with the aim of reducing repeat attendances for self-harm	• Strengthen preventative work which targets both young people and parents/carers. • Develop targeted education programmes for specific vulnerable groups, including: younger children by encouraging schools to start introducing topics sensitively from primary school age and encourage schools to facilitate further work through Personal Social Health Education. • Better knowledge of the causes of self-harm through alcohol use. • Mainstream screening and brief advice across key children's services providers. • Develop a clear referral pathway for children's workforce when working with young people misusing alcohol. • Prioritise support to children whose parents are misusing alcohol. • On-going commitment to enforcement of underage sales, responsible retailing and action on irresponsible promotions.
Key Priorities • Improved understanding of U18's hospital admissions – why is B&NES an outlier on this indicator? • Better knowledge of self-harm through alcohol use • Refresh drug and alcohol needs assessment for children and young people	

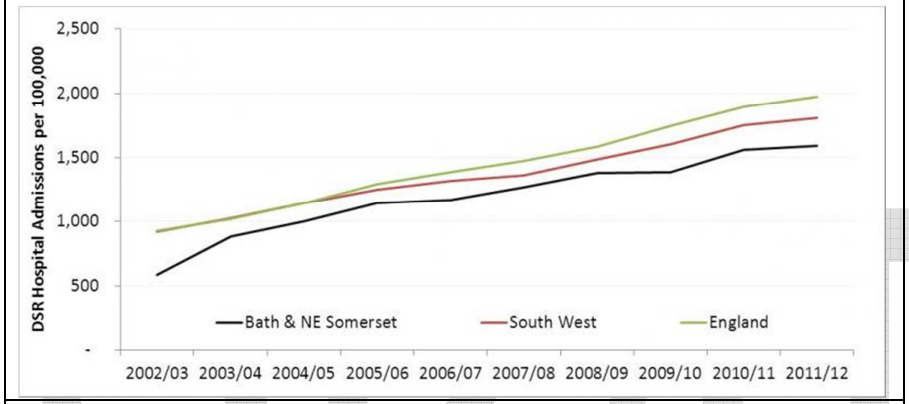
Outcome Framework: Communities are safe from alcohol related harm

Outcome & Indicator	Baseline and story behind it	Partners	What works to do better locally?
Outcome: **Communities safe from alcohol related harm** Indicator: **Night Time Economy related Crime and Disorder** Population: B&NES residents population 18+yrs Offences of violent crime and criminal damage occurring between the hours of 20:00 and 04:00 taking place outside of the home not otherwise defined as domestic violence or hate crime **Data issues/gaps:** This definition is designed purely to assess levels of offending within the public realm where alcohol can be deemed likely to have been a contributing factor with a moderate degree of statistical certainty Data needed on assaults presenting at RUH & location	 **Story behind the baseline: (examples of contributory factors)** Relaxation of regulation on availability/sales over time Increase in licensed outlets Fall in price of alcohol Increase in drinking in the home/pre-loading Population drinking twice as much per head than in 1960 Trend towards stronger drinks and larger glasses Higher proportion of young people (aged 18 – 21) in B&NES due to student population Attracts large numbers of people from surrounding areas due to range of offer 80% of crimes committed by Men, majority aged 16 – 27yrs 60% of offenders have problem with alcohol misuse. There has been a 26% reduction in the number of crimes linked to the Night Time Economy in Bath and North East Somerset over the 5 year period between 2007/08 - 2012/13. Downward trend in drink driving offences from 177 in 10/11 to 142 in 12/13	Police Transport Police Licensing Environmental Health Trading Standards Community Safety License holders Bath Improvement District Avon Fire & Rescue Probation Road Safety DV support organisations Social services D&A Treatment providers Assc. Of Town Centre Management Tourism & Leisure Universities & Colleges Student Community Partnerships Youth Offending teams Connecting families team	Multi agency working strategically and in communities Best practice schemes with licence holders e.g.Night watch/Pub watch Proactive management of the Night Time Economy Enforcement of underage sales and responsible retailing regulations Licensing policy to reflect health and community impact. Working with offenders Drink Driving campaigns & enforcement Working with Domestic violence perpetrators **Commitment to lobby on:** Health objective in Licensing Act Reduction of blood alcohol levels for driving

Outcome Framework: Communities safe from alcohol related harm

Current Good Practice on Alcohol Related Community Safety in B&NES	Gaps/needs identified:
• Active multi-agency partnership focussing on the Night Time Economy with governance links to Responsible Authorities Group • A range of good practice initiatives to manage the night time economy including Taxi Marshalls, Safe and sound paramedic response team, Street Pastors, Pubwatch and Nightwatch. • Bath City Centre has retained its Purple Flag Status since 2010. The Purple Flag status is similar to Blue Flag for beaches, it indicates that Bath City Centre is a safe, inclusive and diverse entertainment centres for all visitors. • Midsomer Norton Community Alcohol Partnership has made significant improvements to the night time economy in MSN through community focussed activity, awareness raising, working with traders and license holders and introduction of Street Marshalls and Designated Public Place Order. • Training programme delivered by the Drug and Alcohol Action Team including 'Toxic Trio' training • Alcohol Treatment Orders implemented via the probation service alongside a range of behaviour change programmes with offenders • A River Safety working group which co-ordinates action to improve safety along the Avon. • Avon Fire & Rescue Service campaign and schools work with young people and students on alcohol and water safety	• Develop a vision of what B&NES' night time economy will look like (including an overview of cultural expectations). This high-level vision to be supplemented by district level aspirations (such as Bath, Keynsham, Midsomer Norton, Radstock) • Appraisal of the impact of Night Time Economy initiatives in reducing alcohol related crime and anti-social behaviour • Refresh the B&NES licensing policy to acknowledge prevention of alcohol harm • Explore the option of including a condition in a license around minimum unit pricing, high strength alcohol restrictions and/or irresponsible promotions where the evidence suggests this would be appropriate. • Improve the information available to residents about making complaints and contributing to licensing reviews. • Refresh existing information about licensing contacts and processes in the B&NES Connect magazine and on the B&NES website. • Extend existing initiatives, or foster new approaches in encouraging collective working between all alcohol traders (both on and off-trade). • Ongoing commitment to enforcement of underage sales, responsible retailing and action on irresponsible promotions.
Key Priorities - Developing a vision of the B&NES Night Time Economy Joint Strategic Needs Assessment update for Night Time Economy B&NES Licensing Statement Review	

Outcome Framework: People can enjoy alcohol in a way that minimises harm to themselves

Outcome & Indicator	Baseline and story behind it	Partners	What works to do better locally?
Outcome: Safe, healthy and responsible alcohol consumption amongst B&NES population **Indicator:** Alcohol Related Hospital admissions **Population:** B&NES residents population 18+	B&NES Alcohol Related Hospital Admissions 02/03 – 11/12  **Story behind the baseline: (examples of contributory factors)** Relaxation of regulation on availability/sales over time Increase in licensed outlets Fall in price of alcohol Increase in drinking in the home Population drinking twice as much per head than in 1960 Trend towards stronger drinks and larger glasses Marketing of alcohol to women and children (alco-pops etc) Older population - living longer with increasing complexity of conditions Clustering of risk behaviours (smoking/drinking/obesity) Deprivation link - People in most deprived quintile of B&NES are more than 4 times more likely to be admitted to hospital for alcohol specific conditions than those in the least deprived quintile.	CCG/primary care Sirona AWP RUH Drug & Alcohol Treatment providers Mental health service providers Public Health Older people's services Employers	Making every contact count - Routine screening and brief advice for alcohol misuse across frontline services Alcohol liaison services in hospital Improving access to treatment services Targeting of high risk /vulnerable groups Multi agency working strategically and in communities Workplace initiatives Social marketing campaigns Licensing policy to reflect health and community impact
Data issues/gaps: Missing ED attendances therefore underestimating impact on health services and opportunities for earlier intervention (est 15-20% of ED attendances alcohol related) Local prevalence data for adult drinking patterns not collected.			**Commitment to lobby on:** Minimum unit pricing Health objective in Licensing Act Restrictions on advertising and sponsorship of alcohol

Outcome Framework: People can enjoy alcohol in a way that minimises harm to themselves

Current Good Practice in B&NES	Gaps/needs identified:
• Annual Training programme for frontline staff focussing on Identification and Brief Advice – over 400 people trained in 2013/14 • Alcohol Liaison Service introduced at Royal United Hospital in 2013 which aims to reduce bed days, attendances, admissions and increase engagement with community based treatment services. The service contributed towards a 65% reduction in patient hospital spells following intervention. • Screening for alcohol misuse introduced into the NHS Health Check programme from April 2014 – approximately 6000 people aged 40 – 74 will be screened annually. • Screening for alcohol misuse has been introduced into community and inpatient services in Avon and Wiltshire Partnership Trust. • Healthy lifestyle services and physical activity teams using evidenced based screening tool (AUDIT) as part of their client assessment.	• The Every Contact Counts approach to mainstreaming screening and brief advice on alcohol misuse needs supporting across the key service providers in acute care, social care, community service and mental health. This approach needs to be implemented across both adult and children and young people's services. • Develop targeted education programmes for specific vulnerable groups, including older working age and over 65's • Encourage improved workplace health by developing a simple toolkit that local employers can use in the workplace. This initiative seeks to raise awareness about alcohol use in employees and colleagues • Training need for professionals around preventing and minimising the harm of alcohol misuse in older age. • Increase social marketing campaigns using innovative approaches eg scratch cards/apps to encourage self-assessment of drinking levels. • Improve the quality of data on alcohol related attendances from RUH
Key priorities Introduction of screening and brief advice across mental health services Introduction of screening within RUH Emergency Department Improved data on alcohol related hospital attendances at RUH	

Outcome; People can access support that promotes and enables sustained recovery

<table>
<tr><th>Outcome & Indicator</th><th>Baseline and story behind it</th><th>Partners</th><th>What works to do better locally?</th></tr>
<tr>
<td rowspan="2">Outcome:

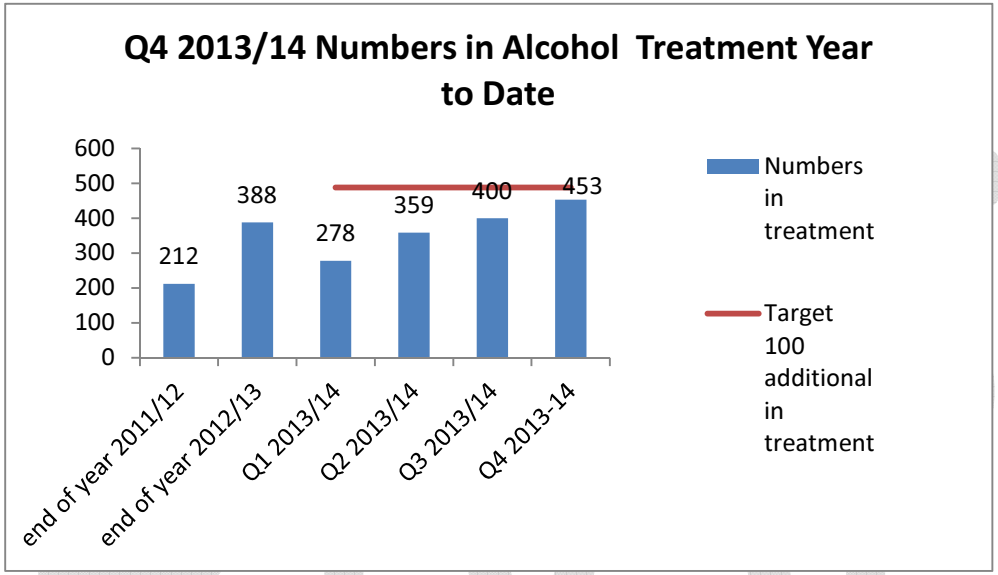
People can access support that promotes and enables sustained recovery

Indicator:
Numbers in treatment: increase by 100 by Q4 2014-15 (baseline 2012-13 = 388)

40% of alcohol clients will successfully complete treatment (baseline 2012-13 = 30.1%)

Population:
All B&NES resident population</td>
<td>

Numbers in treatment over time – adults/children
Trend over time and comparison to national



<u>Story behind the baseline: (examples of contributory factors)</u>
Numbers of opiate users in treatment declining
Numbers of alcohol users increasing
Increasingly complex clients – mental health problems/poly drug use
Recovery based model introduced nationally and locally
Capacity to work with treatment resistant drinkers limited
Welfare benefit changes have increased stress on families & individuals
Stigma attached to ‘needing help’ from services for alcohol misuse
Older people - loneliness and isolation could lead to increased alcohol misuse
% of those who have both drug & alcohol problem in treatment higher in B&NES
% of male deaths due to alcohol are higher in B&NES than regional average (LAPE 2014)
</td>
<td rowspan="2">Primary Care/CCG
Sirona
AWP & other mental health providers
Connecting families team
Social care teams
RUH
Probation
Universities
Workplaces
Housing services
Youth services
Sexual health services
Drug and Alcohol service providers
Voluntary orgs
CAMHS
School nursing & health visiting
Children’s centres
Maternity services
Children & Families services</td>
<td rowspan="2">

Routine screening for alcohol misuse in frontline services
Clear pathways into treatment – inc hospital liaison services
Recovery at the heart of the treatment model
Mutual Aid – SMART, AA etc.
Working with families/carers
Targeting of high risk /vulnerable groups – mental health, homeless, offenders, domestic violence perpetrators
Develop approaches to working with treatment resistant drinkers
Commitment to aftercare, housing, employment etc

Commitment to lobby on:

Minimum unit pricing
Restrictions on advertising and sponsorship of alcohol

</td>
</tr>
<tr>
<td>Data issues/gaps:

% dependent population accessing treatment – no agreed way to calculate this figure</td>
</tr>
</table>

Outcome Framework: People can access support that promotes and sustains recovery

Current good practice in B&NES	Gaps/needs identified
• Integrated commissioning model for both Adult and Children's treatment services. • Single point of entry and effective partnership working between main providers • Increased capacity for alcohol treatment since 2013 • Alcohol Liaison Service introduced at Royal United Hospital in 2013 which aims to reduce bed days, attendances, admissions and increase engagement with community based treatment services. • Good cross-council working e.g between drug and alcohol team and housing to support community detoxification • Investment in community based detoxification facilities has recently strengthened as a cost effective approach to treatment that supports earlier discharge from hospital and more seamless care. • Annual training programme for GP's, pharmacists and other frontline health and social care workers	• Increased referrals to alcohol team via RUH and GP's - capacity issues likely to be an issue longer term • Explore options to working with treatment resistant drinkers, including training, pathways and commissioning of services. • Accessibility of services for specific groups - e.g. older people, working adults; men • Increase referrals from those working with DV perpetrators • Dual diagnosis - training need for professionals • Embed the use of World Health Organisations alcohol 'AUDIT' screening tool at assessment and at review for all drug and alcohol clients.

Key Priorities
Capacity and Engagement: Increase alcohol treatment capacity and engagement by priority group alcohol clients
Client outcomes: Increase the % of alcohol clients who successfully complete treatment
Support the workforce: Drug and alcohol training programme focus – alcohol & mental health, older people
Treatment resistant drinkers project – complete workshops and respond to findings/recommendations

Key Indicators we will monitor to measure progress on this Strategy:

Alcohol Specific Hospital Admissions of under 18 year olds
Night time economy related crime and disorder (8pm – 4am)
Alcohol related hospital admissions
Percentage of people leaving treatment successfully

How will this be delivered:

The B&NES Alcohol Harm Reduction Steering Group will co-ordinate delivery of this Strategy through a Outcomes Action Plan. Each outcome will have a lead officer who will take responsibility for driving forward the relevant actions to achieve the outcome. The Group will co-ordinate directly with key partnerships on delivery of outcome action plans including the Young People's Substance Misuse Group, Night Time Economy Group and the Responsible Authorities Group, Joint Commissioning Group for Substance Misuse.

Governance and reporting

The Group will report to the Responsible Authorities Group twice yearly
The Group will also report to the Children's Trust Board twice yearly within the context of the Children and Young People's Plan.
The Group will report to the Health & Wellbeing Board twice yearly and via the Board's Joint Annual Account.

Review timetable

This Strategy will be reviewed after 3 years to ensure it continues to reflect local and national priorities.

References

For more information on local statistics quoted in this report please visit the Bath and North East Somerset Joint Strategic Needs Assessment Wiki page at www.bathnes.gov.uk/jsna

Milner er al. (2012) Alcohol Harm Reduction Strategy for Bath & North East Somerset

Cabinet Office Strategy Unit, London, 2003. Alcohol misuse: how much does it cost?

World Health Organisation (2009) Global Health Risks: Mortality and Burden of Disease attributable to selected major risks

The Governments Alcohol Strategy (March 2012)

A Review into Alcohol Harm Reduction in B&NES (2013) B&NES Scrutiny Team

National Institute for Health and Care Excellence (PH24) Alcohol Use Disorders – preventing harmful drinking

Appendix 1 Service & Organisational Development Recommendations (2012) and Actions completed

Service and Organisational Development Recommendations (2012)	**Actions completed**
Increase alcohol treatment capacity for people in B&NES who misuse alcohol	Drug and Alcohol Treatment services were re-commissioned from April 2013 and included the development of a dedicated Alcohol Team and additional capacity for community based alcohol detoxification. An Alcohol Liaison Team based at the RUH has been funded by the CCG from April 2013. This team also provides additional capacity within recovery services to facilitate access to community treatment. There has been a significant rise in numbers of people accessing treatment services for alcohol misuse in 13/14 and also an increase in client outcomes with more clients successfully leaving treatment having addressed their alcohol misuse.
Roll-out of identification of people in B&NES who misuse alcohol and are offered brief interventions	Identification and brief advice training for alcohol misuse has been delivered to over 700 local professionals since 2011/12 including GP's, pharmacists, health, housing and social care workers. Alcohol screening has been introduced into the NHS Health Check from April 2014 which means over 6000 40 -74 year olds will be screened each year. Screening has been introduced into inpatient and community mental health services from April 2014.
Identification, risk reduction and support of children of problem drinkers	Hidden Harm work with CYPS and the DAAT to safeguard children Young Carers Support Group set up by DHI/Project 28 to support young people affected by parental alcohol and drug misuse FAM (Families Also Matter) support services set up by DHI to support the families who are affected by alcohol and drug misuse
Set up Alcohol Harm reduction Group	The Alcohol Harm Reduction Steering Group has been in place since April 2011. The group has driven Strategy implementation and has co-ordinated the multiagency response to local challenges and opportunities. The Group reports directly to the Health and Wellbeing Board and from April 2014 will also report directly to the Children's Trust.

Clear and consistent messages around alcohol and the behaviour expected of B&NES citizens and visitors that the local statutory agencies expect	The B&NES Night Time Economy Group has championed the Purple Flag as the vehicle for promoting Bath City Centre as a diverse and well managed town centre at night. Bath has achieved Purple Flag Status for 3 years in a row and in 2013 celebrated Purple Flag Week through a range of high profile events and publicity to celebrate those achievements as well as conveying important safety messages. This included the development of a 'Great Night Out' leaflet highlighting harm reduction messages and local facilities such as taxi ranks.
Local Indicators and information sources for alcohol misuse priorities identified through the Joint Strategic Needs Assessment	Local data on hospital admissions, crimes in the night time economy, treatment outcomes and community feedback have been collated and presented within the Joint Strategic Needs Assessment Wiki page on Alcohol. The Councils Joint Strategic Needs Assessment is highly accessible to local partners and regularly updated.
A comprehensive care pathway for people with alcohol misuse in B&NES that is clear to users, citizens, commissioners and providers.	The re-commissioning of drug and alcohol treatment services emphasised joint working across the treatment system and the development of a single point of entry for both the public and professionals. Training for professionals on pathways and referral processes has been extensive since April 2013 including a Treatment system launch conference and Focus on Recovery Conference.
Big Society initiatives and engage local communities and citizens on reducing alcohol related harm	The Midsomer Norton Community Alcohol Partnership is a key example of how a local community has taken ownership of a problem and drawn in resources from a range of agencies and sources with the aim of tackling underage drinking and anti-social behaviour in the MSN night time economy. A range of effective interventions have been delivered including training for local license holders, a Designated Public Place Order and Street Marshall initiative. Multi agency working has also increased the reach and impact of a range of harm reduction campaigns that have been run annually, including Dry January, Love Your Liver, Make it a night to remember and 'Don't make river water your last drink'

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Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Equality Impact Assessment / Equality Analysis

Title of service or policy	B&NES Alcohol Harm Reduction Strategy (2014 – 2019)
Name of directorate and service	People and communities – Public Health
Name and role of officers completing the EIA	Cathy McMahon, Public Health Development and commissioning manager
Date of assessment	6th November 2014

Equality Impact Assessment (or 'Equality Analysis') is a process of systematically analysing a new or existing policy or service to identify what impact or likely impact it will have on different groups within the community. The primary concern is to identify any discriminatory or negative consequences for a particular group or sector of the community. Equality impact Assessments (EIAs) can be carried out in relation to service delivery as well as employment policies and strategies.

This toolkit has been developed to use as a framework when carrying out an Equality Impact Assessment (EIA) or Equality Analysis on a policy, service or function. It is intended that this is used as a working document throughout the process, with a final version including the action plan section being published on the Council's and NHS Bath and North East Somerset's websites.

1.	**Identify the aims of the policy or service and how it is implemented.**	
	Key questions	**Answers / Notes**
1.1	Briefly describe purpose of the service/policy including • How the service/policy is delivered and by whom • If responsibility for its implementation is shared with other departments or organisations • Intended outcomes	The purpose of the Strategy is to reduce alcohol related harm across Bath and North East Somerset. The Strategic vision is 'a cultural environment where everyone can have fun and enjoy themselves safely, with or without alcohol'. Its intended outcomes are: • Children grow up free from alcohol related harm • Communities are safe from alcohol related harm • People can enjoy alcohol in a way that minimises harm to themselves • People can access support that promotes and enables sustained recovery The B&NES Alcohol Harm Reduction Steering Group will co-ordinate delivery of this Strategy through a Outcomes Action Plan. Each outcome will have a lead officer who will take responsibility for driving forward the relevant actions to achieve the outcome. The Group will co-ordinate directly with key partnerships on delivery of outcome action plans including the Young People's Substance Misuse Group, Night Time Economy Group and the Responsible Authorities Group, Joint Commissioning Group for Substance Misuse.
1.2	Provide brief details of the scope of the policy or service being reviewed, for example: • Is it a new service/policy or	This Strategy is a refresh of the B&NES Alcohol Harm Reduction Strategy (2012).

	review of an existing one? • Is it a national requirement?). • How much room for review is there?	
1.3	Do the aims of this policy link to or conflict with any other policies of the Council?	Reducing alcohol-related harm, by encouraging a more sensible drinking culture, will help to the Council to achieve a range of indicators outlined in the Public Health Outcomes Framework for England 2013 – 2016. These include reducing the number of: • people killed or seriously injured on our roads • alcohol related hospital admissions • falls and injuries among the over-65s • deaths from cardiovascular disease (including heart disease and stroke), cancer and liver disease • low birth weight babies • violent crimes (including sexual violence) and domestic abuse • pupil absences • chlamydia diagnoses among young people aged 15–24 years The Strategy contributes to the delivery of the outcomes of the Joint Health and Wellbeing Strategy, in particular under the theme of 'Helping people to stay healthy' and the specific objective to reduce rates of alcohol misuse. The Strategy contributes towards the delivery of B&NES Clinical Commissioning Group Strategic plan and joint working on shared outcomes will contribute towards reduced costs across the health and

		social care system.

2. Consideration of available data, research and information

Monitoring data and other information should be used to help you analyse whether you are delivering a fair and equal service. Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data** (including ethnicity, gender, disability, religion/belief, sexual orientation and age)
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
- Recommendations of **external inspections** or audit reports

	Key questions	**Data, research and information that you can refer to**
2.1	What is the equalities profile of the team delivering the service/policy?	Consideration of equalities issues and addressing health inequalities form part of the Contracts of all service providers delivering services related to Alcohol misuse.
2.2	What equalities training have staff received?	Staff are required to have generic equalities training as part of their mandatory induction training and to supplement this with additional training in specialist areas where appropriate.
2.3	What is the equalities profile of service users?	60% of all alcohol related hospital admissions are people over 60 People living in the most deprived areas of Bath and North East Somerset are significantly more likely to be admitted for an alcohol related condition than those living in the least deprived areas.

		Bath and North East Somerset has significantly higher rates of under 18's admitted to hospital for alcohol specific conditions than nationally. Approximately 45% of young people's admissions are children under 16 and the majority of admissions are girls. 60% of adults seen by the RUH alcohol liaison service (from Dec – June 2013) were also experiencing mental health issues. The estimated number of people in B&NES dependent on alcohol is 6,854 of all people aged 18 - 64 years. During 12/13 there were 388 people in treatment for alcohol misuse in B&NES. This represents 5.7% of the estimated population of dependent drinkers locally. Numbers in treatment have risen significantly since 2009 and this trend has continued in 13/14. In 2013, 22% of B&NES secondary school pupils (Yr8 and Yr10) reported 'drinking alcohol in the last week' compared to 30% in 2011.
2.4	What other data do you have in terms of service users or staff? (e.g results of customer satisfaction surveys, consultation findings). Are there any gaps?	There is a significant difference in self-reported exposure to alcohol (drinking in the last week) for primary school pupils who qualify for free school meals compared to those who do not qualify for free school meals. Girls self-report higher levels of drinking and are over represented in treatment services for alcohol misuse and also in alcohol related hospital admissions. Qualitative feedback from young people using treatment services (Project 28) is consistently positive and satisfaction is high When asked in 2012 about drunk and rowdy behaviour in public places in their local area, 21% of voice box survey respondents believed it was either a very big problem, or a fairly big problem.

2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	The Strategy has been developed in consultation with B&NES Alcohol Harm Reduction Steering Group and the B&NES Night Time Economy Group. Membership of these groups includes Police, Fire and Rescue Service, Royal United Hospital, University representation, resident association representation, Bath Transport Police, Bath Business Improvement District, Licensing, Community Safety, Public Health, Drug and Alcohol Service commissioners and providers, Avon and Wiltshire Mental Health Trust, children's services, housing and probation services. The Strategy priorities are directly informed by the Scrutiny Inquiry Day on Alcohol held in October 2013 hosted jointly by 3 B&NES Council Policy Development and Scrutiny panels representing Wellbeing, Economic and Community Development and Early years, children and youth policy in October 2013. 68 people including councillors, officers, stakeholders and residents attended. In November the Strategy will also be presented for consultation to the Responsible Authorities Group and Wellbeing Policy Development and Scrutiny Panel.
2.6	If you are planning to undertake any consultation in the future regarding this service or policy, how will you include equalities considerations within this?	There are significant inequalities in the impact of alcohol misuse across Bath and North East Somerset. The Strategy aims to address these inequalities through targeting of specific groups including children and young people, men, those with mental health problems and those living in more deprived areas. Ensure that specific strategies are used to engage effectively with minority groups and vulnerable clients e.g young girls, older people

3. Assessment of impact: 'Equality analysis'

	Based upon any data you have considered, or the results of consultation or research, use the spaces below to demonstrate you have analysed how the service or policy: • Meets any particular needs of equalities groups or helps promote equality in some way. • Could have a negative or adverse impact for any of the equalities groups

		Examples of what the service has done to promote equality	**Examples of actual or potential negative or adverse impact and what steps have been or could be taken to address this**
3.1	**Gender** – identify the impact/potential impact of the policy on women and men.	High quality treatment services are available for adults and young people in B&NES. Treatment services have tailored support for victims (most likely to be women) and perpetrators of domestic violence (predominantly men) Campaigns to highlight the potential harms of alcohol misuse are relevant to both men and women but do give gender specific advice on alcohol units for men and women and young people and pregnant women.	Reducing alcohol misuse in young people should benefit girls more than boys as more girls are drinking than boys Potential for work targeting girls specifically to reduce prevalence in this group. The majority of adults accessing treatment services are men and more men are presenting with alcohol related conditions at hospital.
3.2	**Pregnancy and maternity**	There is a specialist midwife with a remit for substance misuse. The Family Nurse Partnership works intensively with young pregnant women on a range of issue including alcohol use. General awareness raising work on the impact of drinking in pregnancy.	Targeting pregnant women who drink alcohol will have a positive effect on the health of the baby and the woman.
3.3	**Transgender –** – identify the impact/potential impact of the policy on transgender people		Reducing alcohol consumption will improve the health of all increasing or high risk drinkers
3.4	**Disability** - identify the impact/potential impact of the policy on disabled people (ensure consideration both physical and mental impairments)	Mental health service providers are being trained to effectively identify alcohol misuse amongst clients and offer tailored support and referral where	Reducing alcohol consumption will improve the health of all increasing or high risk drinkers. There is significant cross over between mental health

		appropriate.	issues and alcohol and substance misuse.
3.5	**Age** – identify the impact/potential impact of the policy on different age groups	PSHE leads in schools are trained to deliver high quality substance misuse lessons in schools A drama project has been designed to teach secondary school pupils the risks of alcohol misuse. Regulation of underage sales of alcohol is ongoing and is a key element of restricting supply to children. High quality treatment services are available for young people in B&NES.	Reduction of alcohol misuse amongst children and young people will ensure they grow up healthy, happy and free from alcohol related harm. The effects of alcohol misuse in old age are exacerbated by both physical, mental and social changes as we get older.
3.6	**Race** – identify the impact/potential impact on different black and minority ethnic groups	All providers of services must demonstrate equality of access to all members of the community through policy and practice. Use of services is monitored by ethnic background	Reducing alcohol consumption will improve the health of all increasing or high risk drinkers
3.6	**Sexual orientation -** identify the impact/potential impact of the policy on lesbians, gay, bisexual & heterosexual people	All providers of services must demonstrate equality of access to all members of the community through policy and practice.	Reducing alcohol consumption will improve the health of all increasing or high risk drinkers. Reducing alcohol misuse amongst adults will have a positive impact on their life expectancy and quality of life. Young people and adults who are lesbian, gay, bisexual or heterosexual are more likely to suffer from mental health issues which can be exacerbated by alcohol misuse.
3.7	**Marriage and civil partnership –** does the policy/strategy treat married and civil partnered people equally?	Yes Strategy has a population approach and does not differentiate based on marital status/civil partner	Reducing alcohol consumption will improve the health of all increasing or high risk drinkers

		status.	
3.8	**Religion/belief** – identify the impact/potential impact of the policy on people of different religious/faith groups and also upon those with no religion.		The policy will not have any negative impact on people of different religious/faith groups as it will have a positive impact on adults and children regardless of religion or belief.
3.9	**Socio-economically disadvantaged** – identify the impact on people who are disadvantaged due to factors like family background, educational attainment, neighbourhood, employment status can influence life chances	Specialist services work with job centre plus, housing providers and a range of other support providers to ensure the most vulnerable are supported to access the treatment they need. Young people's treatment services work with both the young person and the family to ensure holistic support is provided.	Targeting socially and economically disadvantaged areas will support a reduction in inequalities as there are significantly more alcohol related hospital admissions for those people living in the more deprived areas.
3.10	**Rural communities** – identify the impact / potential impact on people living in rural communities	Treatment services operate from a Hub in Midsomer Norton to increase accessibility. Young people's treatment services also carry out outreach work in local communities.	Looking at options to increase the accessibility of support services including outreach and online support will enable more people from rural areas to access the services.

4. Bath and North East Somerset Council & NHS B&NES
Equality Impact Assessment Improvement Plan

Please list actions that you plan to take as a result of this assessment. These actions should be based upon the analysis of data and engagement, any gaps in the data you have identified, and any steps you will be taking to address any negative impacts or remove barriers. The actions need to be built into your service planning framework. Actions/targets should be measurable, achievable, realistic and time framed.

Issues identified	Actions required	Progress milestones	Officer responsible	By when
Better understanding of the needs of young girls regarding alcohol misuse	Incorporate into the Children and Young people's substance misuse needs assessment	Agree scope and timescale for work	Cathy McMahon/Rosie Dill	March 2015
Better understanding of alcohol specific hospital admission to under 18's	Incorporate into the Children and Young people's substance misuse needs assessment	Working group set up to investigate	Cathy McMahon/Rosie Dill	March 2015
Older people's access to treatment services	Training of workforce to better understand alcohol misuse issues in old age and how to support people	Incorporated into Drug and Alcohol Training programme for 2015	Cathy McMahon	2015

5. Sign off and publishing

Once you have completed this form, it needs to be 'approved' by your Divisional Director or their nominated officer. Following this sign off, send a copy to the Equalities Team (equality@bathnes.gov.uk), who will publish it on the Council's and/or NHS B&NES' website. Keep a copy for your own records.

Signed off by: Bruce Laurence (Divisional Director or nominated senior officer)
Date:

Wellbeing Policy Development and Scrutiny (PDS) Panel

28th November 2014

Risk Assessment for Item 15: B&NES Alcohol Harm Reduction Strategy

Proposed recommendation(s) of report:

1.1 The Wellbeing Policy Development and Scrutiny Panel support the Alcohol Harm Reduction Strategy for Bath and North East Somerset (2014 – 2019) and agree that it is taken forward for endorsement by B&NES Council Cabinet.

1.2 The Strategy is refreshed in 2017 to update priorities and recommendations to ensure relevance to emerging local, regional and national issues.

1.3 The Wellbeing Policy Development and Scrutiny Panel actively engage in the call for evidence based national initiatives to support local delivery such as minimum unit pricing, a reduction in blood alcohol levels for driving, a public health objective in the licensing act and restrictions on advertising and sponsorship by the alcohol industry.

Risks relating to proposed recommendation(s)

No significant risks identified

Risks of not taking proposed recommendation(s)

The risks of not taking the proposed recommendations are that B&NES Council will lack a coherent, up to date, evidence based strategy in attempting to reduce the harm to individuals, families and the community from alcohol misuse.

Without a co-ordinated multiagency approach to alcohol related harm which incorporates the full range of activities including prevention, regulation and enforcement, treatment and support it is unlikely that B&NES council will be able to effectively tackle alcohol misuse locally

Without a clear understanding of the local needs and what works to prevent alcohol misuse B&NEs council will struggle to prioritise cost effective action to protect children and young people, reduce antisocial behaviour and crime and commission treatment and support services to meet local need.

Without multiagency working and an agreed strategy we will be unable to influence resource allocation across agencies to ensure cost effective use of limited resources. Equally we are less likely to be able to attract additional funding from external sources without being able to demonstrate cross agency working and a joined up approach.

Without a clear message to central government on effective, evidence based population approaches to alcohol misuse it is unlikely that national initiatives will be prioritised thereby minimising the impact of local work.

Actions to manage risks of not taking proposed recommendation(s)

B&NES Health and Wellbeing Board have prioritised the reduction of alcohol related harm in their Joint Health and Wellbeing Strategy which ensures that the issue is high priority locally and has commitment from the range of agencies represented on the Board including B&NES Council, B&NES CCG, and the local HealthWatch.

The B&NES Alcohol Harm Reduction Steering Group will continue to co-ordinate and facilitate joint working on this agenda to ensure best use of resources and encourage innovation and leadership across agencies.

Contact person	Cathy McMahon Public Health Development and commissioning manager 01225 394064 Cathy_mcmahon@bathnes.gov.uk

Bath & North East Somerset Council

WELLBEING PDS FORWARD PLAN

This Forward Plan lists all the items coming to the Panel over the next few months.

Inevitably, some of the published information may change; Government guidance recognises that the plan is a best assessment, at the time of publication, of anticipated decision making. The online Forward Plan is updated regularly and can be seen on the Council's website at:

http://democracy.bathnes.gov.uk/mgPlansHome.aspx?bcr=1

The Forward Plan demonstrates the Council's commitment to openness and participation in decision making. It assists the Panel in planning their input to policy formulation and development, and in reviewing the work of the Cabinet.

Should you wish to make representations, please contact the report author or Jack Latkovic, Democratic Services (01225 394452). A formal agenda will be issued 5 clear working days before the meeting.

Agenda papers can be inspected on the Council's website and at the Guildhall (Bath), Hollies (Midsomer Norton), Riverside (Keynsham) and at Bath Central, Keynsham and Midsomer Norton public libraries.

Wellbeing PDS Forward Plan

Bath & North East Somerset Council
Anticipated business at future Panel meetings

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 28TH NOVEMBER 2014				
28 Nov 2014	**Wellbeing PDS**	**Update from the RNHRD (20 minutes)**	Kirsty Matthews and James Scott	
28 Nov 2014	**Wellbeing PDS**	**Care Act implementation (30 minutes)**	Jane Shayler Tel: 01225 396120	
28 Nov 2014	**Wellbeing PDS**	**Medium Term Service and Resource Plan update (45 minutes)**	Jane Shayler Tel: 01225 396120	Ashley Ayre
28 Nov 2014	**Wellbeing PDS**	**Teenage pregnancy (20 minutes)**	Paul Sheehan	Bruce Laurence
28 Nov 2014	**Wellbeing PDS**	**Alcohol Strategy Refresh (20 minutes)**	Cathy McMahon	
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 16TH JANUARY 2015				
16 Jan 2015	**Wellbeing PDS**	**Update on Dementia**		

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
16 Jan 2015	**Wellbeing PDS**	**Mental Health update**	Andrea Morland	Jane Shayler
16 Jan 2015	**Wellbeing PDS**	**Loneliness and Isolation**	Officer to be confirmed	
16 Jan 2015	**Wellbeing PDS**	**NHS Healthchecks**	Cathy McMahon	
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 13TH MARCH 2015				
13 Mar 2015	**Wellbeing PDS**	**An update from Care Quality Commission**	Care Quality Commission officer	
13 Mar 2015	**Wellbeing PDS**	**NHS 111 update**	Clinical Commissioning Group	
13 Mar 2015	**Wellbeing PDS**	**Non-Emergency Patient Services update**	Clinical Commissioning Group	
FUTURE ITEMS				
	Wellbeing PDS	**Dentistry - after May 2015**	To be confirmed	

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
	Wellbeing PDS	**Homecare Review update (for May 2017)**		
The Forward Plan is administered by **DEMOCRATIC SERVICES**: Jack Latkovic 01225 394452 Democratic_Services@bathnes.gov.uk				