Bath & North East Somerset Council

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Date: 8th January 2015
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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, 16th January, 2015

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Friday, 16th January, 2015** 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

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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, 16th January, 2015

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 9 - 26)

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 27 - 66)

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

11. HOMELESSNESS UPDATE (30 MINUTES) (Pages 67 - 72)

The Council delivers support and assistance to people at risk of becoming homeless and people who are homeless by commissioning services, developing effective partnerships with the voluntary sector and having an effective Housing Options Team. This report sets out the most recent information on demand for these services and provides reassurance that the responses currently in place are good and that there are new initiatives planned to further improve the offer.

The Wellbeing Policy Development & Scrutiny Panel is asked to note the contents of the paper.

12. IMPACT ASSESSMENT ON TRANSFER OF ENDOSCOPY SERVICES (20 MINUTES) (Pages 73 - 96)

This report will update Wellbeing Policy Development and Scrutiny panel members on the outcome of the equality, quality and privacy impact assessments completed relating to the proposed transfer of endoscopy services from the Royal National Hospital for Rheumatic Diseases (RNHRD).

Panel members received a briefing in November 2014 setting out the rationale for the proposed transfer of endoscopy services on 1st February 2015 when the acquisition of the RNHRD by the RUH will be completed.

Panel members are asked to note the outcome of the various impact assessments which confirm that the effects of this change are considered to be minimal and that there are a number of positive aspects to the service change. It is therefore recommended that the transfer of the endoscopy services should now proceed.

13. ACTION ON LONELINESS (20 MINUTES) (Pages 97 - 102)

This report updates the Panel on work being undertaken to deliver the Health and Wellbeing Board's priority to increase the resilience of people and communities, including action on loneliness.

The Panel are asked to note the work being undertaken by the Board in delivering this priority and to identify any specific opportunities for promoting this priority through partnership working and engaging with local communities.

14. NHS HEALTH CHECK PROGRAMME UPDATE (20 MINUTES) (Pages 103 - 118)

The NHS Health Check programme is a mandatory universal risk assessment and management programme with the aim of reducing heart disease, stroke, diabetes, kidney disease and certain types of dementia. It aims to do this by increasing uptake of primary prevention interventions including weight management, smoking cessation, physical activity, statins, anti-hypertensives, and improved management of impaired glucose intolerance. This report aims to update the Wellbeing PDS Panel on the progress of delivery of the NHS Health Check programme in Bath and North East Somerset.

The Wellbeing Policy Development and Scrutiny Panel are asked to discuss and consider the contents of this report.

15. SPECIALIST MENTAL HEALTH SERVICES - INPATIENT REDESIGN IMPACT ASSESSMENT AND UPDATE (30 MINUTES) (Pages 119 - 164)

This paper presents the result of stakeholder and staff engagement and impact assessments on transferring Ward 4 dementia inpatient services from St Martin's Hospital to the Royal United Hospital into a new build specialist mental health unit.

The report also includes a draft strategic outline case to be presented to the Clinical Commissioning Group and AWP Executives if the Wellbeing Policy Development and Scrutiny panel agree that all local engagement is adequate to support continued proposal development.

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

- The issues as outlined in the impact assessment documentation and embedded documents.
- The overwhelmingly positive support for the move of Ward 4 - as described above - by stakeholders, staff and Healthwatch.

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

- All local engagement, assessment of impact and support is adequate to enable continued proposal development for a new build mental health and dementia unit on the RUH site.

16. PANEL WORKPLAN (Pages 165 - 168)

This report presents the latest workplan for the Panel.

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

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BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Friday, 28th November, 2014

Present:- Councillors Vic Pritchard (Chair), Sharon Ball, Anthony Clarke, Bryan Organ, Kate Simmons, Neil Butters and Eleanor Jackson

48 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

49 EMERGENCY EVACUATION PROCEDURE

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

50 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillors Hall and Bevan had sent their apologies to the Panel.

Councillor Clarke informed Democratic Services Officer that he would miss the first thirty to forty minutes of the meeting and had sent his apologies in advance of the meeting. Councillor Clarke had arrived at 10:40am.

51 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 Tony Clarke declared an “other” interest in agenda item ‘Royal National Hospital for Rheumatic Diseases Acquisition - briefing paper’ as a representative of the Council on the RNHRD Board.

52 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

The Chairman said that he had not agreed to bring any item under urgent business, though he wanted to discuss an issue around CQC’s quality report on the AWP.

The Chairman said at a recent South West Councils network meeting there was a proposal to form a joint working group to look at the recent CQC quality report on the AWP following an inspection earlier this year.

At the time of the inspection the CQC pointed out its immediate concerns to the AWP. Subsequently, the CQC had issued four warning notices, requiring the Trust to take urgent action to improve.

The objective for participating Local Authorities (potentially it would be Bristol, Wiltshire, Swindon, South Gloucestershire, North Somerset and B&NES) would be to gain a greater understanding at CQC's findings and be assured about AWP's current and planned response.

The Chairman also said that there may be an opportunity to influence the AWP's and the relevant Local Authorities' responses to the CQC report together with accessing the ability to judge any appropriate scrutiny and monitoring.

This could either result in a single report to include findings and/or recommendations for AWP, or individual participants could take their own recommendations away to respond as they might wish.

The Chairman concluded his statement by saying that Wiltshire Council had suggested they would host a one day, or two half days, workshops and provide an officer support. Participating Councils would need to nominate one elected Member to act as their representative.

Members of the Panel felt that this was an extremely important issue to be involved in.

The Panel **AGREED** that Councillor Eleanor Jackson should be put forward as Panel's representative on the Joint Working Group.

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

There were none.

54 MINUTES

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

The Chairman reminded the Panel that a further feedback on rough sleepers from Councillor Allen (Cabinet Member for Wellbeing) had been asked at the last meeting.

The Chairman informed the Panel that he had met with the CQC representative and discussed the issue raised by the Healthwatch at the last meeting. This issue had been reported to the CQC but it wasn't within their remit to deal with this matter, in turn, the CQC had referred this matter to the Local Authority.

55 CABINET MEMBER UPDATE (10 MINUTES)

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

Councillor Allen suggested that the Panel should receive a full report on Rough Sleepers at the next meeting (January 2015) as this month an annual count would be carried out on rough sleepers.

Councillor Organ commented that nationally there had been a lot of talk about people with mental health problems being supported to live in the community and asked if that was the case with B&NES area.

Councillor Allen responded that there had been a range of support for people with mental health problems to live in the community. In terms of people with learning disabilities – nobody from B&NES had been placed in any institutions such as Winterbourne View for quite some time.

Councillor Jackson commented that Bath Chronicle reported how amount of rough sleepers in Bath and area had been on a rise, which had concerned a lot of people.

Councillor Allen replied that he would want to bring an accurate number of the rough sleepers to the Panel in January report. In 2012 the Council changed the way rough sleepers were counted, in order to have more accurate numbers.

The Chairman said that he had attended DHI's Annual General Meeting last week where people who went through the system talked to the audience about their experience, which was quite inspirational. The Chairman said that he had spoken to one of members who was from the AWP and worked with the DHI, and who was under impression that following changes in the way substance services are delivered, they had become more Bath-centric and, in particular, there was reduced access in the Chew Valley area

Councillor Allen responded that whole range of providers had been working across the whole B&NES area. If there had been any changes in the way of working, then Councillor Allen would like to see the evidence to support that change. Jane Shayler explained that substance misuse services had been recommissioned and, as part of the recommissioning, they had been redesigned. There had been three providers as part of the adult pathway which now had been reduced to two and the pathway was not simplified and integrated across children & young people and adults. Overall, the redesign has resulted in significant improvements to access to services, with reduced waiting times and to the outcomes achieved and was getting positive feedback from service users and staff. It certainly was not the intention that the redesign would adversely affect geographical access. Jane Shayler also said that she would like to know if there had been an issue with an access to the service, anywhere in B&NES, so that this could be looked into. Councillor Pritchard said he thought the issue was in relation to the Chew Magna and Chew Stoke area and he suggested that there were a couple of possible community venues that might be used to assist with access in this area. Jane Shayler confirmed that she would ask the Substance Misuse Commissioning Manager, Carol Stanaway, to look into this, discuss with the SDAS service in AWP and with DHI and feedback to Councillor Pritchard.

Councillor Jackson asked Councillor Allen to check if measures put forward in the Youth Homelessness report had contributed to diminishment of homelessness since 2010 (when report was published), and if that has been the case then how those measures could be used for 18-25 year olds.

Councillor Allen responded that he would be looking to include any information on 18-25 year olds at the next Cabinet Member update.

The Chairman thanked Councillor Allen for an update.

56 CLINICAL COMMISSIONING GROUP UPDATE (10 MINUTES)

The Chairman invited Dr Ian Orpen to give and update (attached as Appendix to these minutes).

The Chairman, on behalf of the Panel, congratulated Tracey Cox for an appointment of Chief Officer with B&NES CCG, Corinne Edwards on being shortlisted for Innovator of the Year in the NHS South West Leadership Awards and also to the CCG who were shortlisted for a prestigious HSJ Award in the Managing Long Term Conditions category for their work with Sirona and the RUH to redesign the pathway for heart failure patients.

Councillor Butters expressed his concerns on GP recruitment when shift services become introduced.

Dr Orpen shared Councillor Butters' concerns on that matter saying that the workforce would have to be looked in a different way.

Councillor Jackson expressed her concerns in patient access to GP practices, and asked how realistic would be to expect an improvement in that area.

Dr Orpen responded that, in his view, there might not be any improvement in patient access soon.

The Chairman thanked Dr Orpen on update.

57 HEALTHWATCH UPDATE (10 MINUTES)

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

The Chairman praised the way Healthwatch had been preparing their reports lately. The Chairman said that reports had been concise with good understanding on issues highlighted in the report.

The Panel debated an issue of translator services for public whose English was not the first language.

Tracey Cox (CCG Chief Officer) said that Interpretation Services had been looked by the CCG, and that she would provide more information on this matter at one of future meetings of the Panel.

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

58 ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES ACQUISITION - BRIEFING PAPER (20 MINUTES)

The Chairman invited Kirsty Matthews (RNHRD) and James Scott (RUH Chief Executive) to give the presentation to the Panel.

The following points had been highlighted in the presentation:

- Overview
- Acquisition journey
- Overarching principles
- Benefits
- Service development
- Research and development
- Environment
- Transaction process – indicative timeline
- Endoscopy location change
- Endoscopy service proposal
- Endoscopy proposal benefits to patients
- Endoscopy activity
- Endoscopy engagement process

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

Councillor Organ commented that services at the Mineral Hospital, including endoscopy, had been described by patients as ‘first class’ and he was not convinced that the same services would be provided by the RUH. Councillor Organ expressed his concerns on the loss of well-respected institution in Bath.

Kirsty Matthews responded that endoscopy service had been looked after just one consultant. The same consultant had spent some time in the RUH, over the past two years, where he received clinical supervision and support. It was believed, from clinical point of view, that it would be the best to incorporate all service onto one site. Kirsty Matthews added that equipment at the Mineral Hospital has been seen as ageing and by moving endoscopy to the RUH there would be an opportunity to use their equipment, which has been more modern.

Kirsty Matthews also said that she had had serious discussions with James Scott about ethos and culture of the Mineral Hospital. The advantage of waiting five years to get to this point had been that the RUH had been able to take their time to understand the Mineral Hospital and how they provide their services. It would be in the RUH’s and Mineral Hospital’s best interest to continue to maintain that culture, ethos and approach they have had. Both hospitals would be able to plan ahead

collaboratively, for the best interest of patients, which would also provide much better clinical and patient engagement.

The Chairman commented that both reputations (The Mineral Hospital and RUH) had to be protected. The Chairman said that changes would not be happening straight away as this is a three year acquisition process.

Councillor Clarke commented that, from clinical perspective, he had been convinced with the move of endoscopy services from the Mineral Hospital to the RUH.

Councillor Jackson also supported the move of endoscopy services from the Mineral Hospital to the RUH.

The Chairman concluded the debate by saying that he was in favour of the acquisition and supported the move of endoscopy services from the Mineral Hospital to the RUH.

It was **RESOLVED** to fully support Royal National Hospital for Rheumatic Diseases acquisition by the Royal United Hospital Bath.

59 CARE ACT 2014 - UPDATE AND OPTIONS FOR CHARGING FOR SERVICES (30 MINUTES)

The Chairman invited Jane Shayler to introduce the report.

Jane Shayler explained that the original report contained a paragraph related to draft regulation that had been amended as a consequence of issue of final regulation. The Panel had acknowledged that they had received an amended version of the report.

Jane Shayler continued by saying that the Care Act had received Royal Assent in May 2014 and draft guidance on implementation of the Care Act had been published by the Department of Health 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.

The Care Act has been 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.

Jane Shayler invited the Panel to express their view on the options for charging for services summarised in paragraphs 4.7 to 4.11 and detailed in Appendix 1 of the report.

Members of the Panel debated the report and **AGREED** with the following:

- Care Management – the Panel unanimously supported application of a zero charge for managing self-funders individual contracts;
- Deferred Payment Agreements - the Panel unanimously supported application of the maximum interest rate available against the loan value and, also, a charge of £560 for setting up a Deferred Payment;
- Carers Charging – the Panel unanimously supported 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.

It was also **RESOLVED** to note an update on the Care Act.

60 MEDIUM TERM SERVICE & RESOURCE PLAN UPDATE (45 MINUTES)

The Chairman invited Jane Shayler to introduce the report.

The Chairman said that there have been no issues to raise or scrutinise at this meeting considering that no additional savings had been identified.

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

61 ALCOHOL STRATEGY REFRESH (20 MINUTES)

The Chairman invited Cathy McMahon (Public Health Development and Commissioning Manager) to introduce the report.

The Chairman commented that he had attended Alcohol Harm Reduction Scrutiny Inquiry Day (SID) and that he was slightly disappointed that relevant Cabinet Members did not accept every consideration that came up from the SID. The Chairman felt encouraged that this would be revised in 2017. The Chairman also said that he was disappointed with responses from Licensing Team as they had put more effort in what could not be done rather than in what could.

The Chairman expressed his concern in reduction of 'drink-drive' alcohol limit. The Chairman said that he had been aware that similar practice had been exercised in Ireland and Scotland, though he felt it wasn't a good measure to reduce drink driving. The Chairman said that people who have been drinking and have 80mg of alcohol in their blood (2 pints), could drive quite safely. The Chairman said that lowering down limits would criminalise people who had never been in conflict with the law.

Cathy McMahon responded that Licensing Team had not responded accordingly at the SID but since the SID there had been much more response from the Licensing Team on issues that were raised at the SID. The Licensing had become a lot more open and collaborative in their work.

Cathy McMahon also said that, in terms of drink-driving, she had based her opinion on the evidence based that had been put forward by the National Institute for Health and Care Excellence (NICE). NICE recommended lowering the limit because people were three times more likely to be involved in fatal car crash if they had had 50mg of alcohol in their blood, and six times more likely to be involved in fatal car crash if they had had 80mg of alcohol in their blood. Cathy McMahon added that she appreciated that perception from people could be that they were okay to drive, but the evidence showed that risk of being involved in fatality was greater with more alcohol in the system.

Councillor Jackson added that generally people had not been very good judges of their limits. Councillor Jackson expressed her concern in problematic drinking for people over 50 and 60.

Councillor Clarke commented that, similar to the Chairman, he had not believed in prohibition. Councillor Clarke suggested that there should be calorie value attached to each drink.

The Panel asked about road safety figures for European countries. Cathy McMahon responded that she could send these figures to Panel via email.

It was **RESOLVED** that:

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

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

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.

62 TEENAGE PREGNANCY UPDATE (20 MINUTES)

The Chairman invited Paul Sheehan (Public Health Development and Commissioning Manager) to introduce the report.

The Panel welcomed that B&NES had experienced significant success in reducing, and then maintaining low level of teenage conceptions. In numbers, B&NES had 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.

The Chairman commented that deprived areas within B&NES experienced higher level of teenage pregnancies and question whether there should be more support to those areas.

Paul Sheehan responded that the Council would be looking in other interventions in these areas, such as youth services. The key thing would be to keep an eye on data, and not become complacent.

Paul Sheehan explained that asterisk on data sheet meant that there were none or few pregnancies in those wards.

The Chairman summed up by saying that it was encouraging that B&NES teenage pregnancies figures have been lower than national.

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

63 PANEL WORKPLAN

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

- Report on rough sleepers – January 2015
- Endoscopy impact assessment – to be confirmed for January 2015

The meeting ended at 1.55 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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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 – November 2014

Time to Change pledge - tackling mental health stigma

A growing number of organisations are committing to end the stigma and discrimination against people who experience mental health problems and are agreeing to sign up to the 'Time to Change' pledge, established by the charities Mind and Rethink Mental Illness to promote a better understanding of mental health problems and create a positive shift in public attitude. At its November meeting, B&NES Health and Wellbeing Board signed the pledge, committing to work to reduce the stigma associated with mental health problems in Bath and North East Somerset. Work will include: a campaign through community pharmacies, running projects with local college students, working to complete the Workplace Wellbeing Charter and using local media to promote services more.

Update on Wellbeing College Plan

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The Council and Clinical Commissioning Group (CCG) have agreed to fund the development of a Wellbeing College for two years. It is an idea led by a sub-group of the Mental Health Wellbeing Forum, made up of mental health commissioners, organisations providing services for people with mental health needs and service user and carer representative groups.

The emphasis of the Wellbeing College will be on early intervention, prevention and self-management of long term conditions across the wellbeing spectrum, involving both physical and mental health.

The funding will enable:

- The setting up of a small scale college as a pilot using existing and new courses provided by Sirona Care & Health, Avon & Wiltshire Mental Health NHS Partnership Trust (AWP) and Council funded community providers including Second Step, St Mungos and Creativity Works;
- Independent evaluation by an organisation called *Talking Health* of the effectiveness of the courses and the approach, citizen experience and outcomes against agreed criteria;
- Develop the business case for future development;

The idea of a wellbeing college is an expansion of the notion of (mental health) Recovery Colleges and seeks to shift care pathways to prevention, wellbeing, resilience and social

inclusion on a long term basis. The College will offer an educative, co-produced or peer-led supportive course led approach to early intervention and self-management. Subject to evaluation, evidence from mental health Recovery Colleges suggests that the following benefits are likely to be achieved: improved quality of life through improved support for people with long-term conditions; reduced rates of mental ill-health in the longer term; improved skills, education and employment; and increased resilience of people and communities, including reduced loneliness and social isolation.

The launch is planned to take place for January 2015, with several courses confirmed, and up to 15 in a stage of development.

Mental Health Respite Beds

B&NES Better Care Fund Plan identifies funding for the development of Respite Beds (with a community and therapeutic approach) as an additional resource offered through the Sirona Care & Health Mental Health Reablement Service, to help avoid admission to hospital and to prevent crises from occurring.

B&NES has one of only two adult of working age mental health reablement services in the country and the addition of three beds in a community setting would enhance their ability to intervene early without escalation into secondary services.

Learning from other respite facilities has informed the development of the local service. Important factors that these exisiting facilities share are: peer support, a homely welcoming feel and approach, availability of raparative therapies and communal activities and a recovery focus. The recruitment and training of volunteers and peers to work within this facility is being progressed.

Social Prescribing Service

Following a pilot in 3 GP practices in Keynsham, the Clinical Commissioning Group (CCG) have agreed to fund the development of a Social Prescribing Service across the whole of B&NES. This service has the potential to affect both health services usage and outcomes as well as social inclusion and social care outcomes and so the funding has been made available through the joint commissioning arrangements.

Briefly, the aim of the service is to enable clinicians and health workers to redirect suitable patients away from the NHS and towards opportunities in their local community which can support their needs. People referred to the service may have mental health problems, long term conditions, or other practical issues which affect their mental and physical wellbeing, and they may lack support mechanisms in their lives (e.g. friends, family etc). Priority will be given to people who are identified by GPs as frequent attendees, although non-medical support will also be provided to other people where it is assessed that the involvement of the service may reduce future GP / health service attendance.

The new authority-wide service is due to be in operation from January 2015.

Community Links Service

Two Sirona Care & Health provided mental health social care services, the Floating Support and Building Bridges Services, have merged to form a Community Links Service. The aim of the remodelled service is to help establish and develop community networks across B&NES, which are linked by participants' geography or shared interests. These will be peer led networks of support for people with mental health issues living independently in the community, and will incorporate strong elements of social prescribing, peer support and mentoring, with skilled, paid Sirona staff acting as a resource at the heart of the networks, and to help prevent people's mental health deteriorating if this is seen to occur.

To complement the networks, and as a means of preventing crises and maintaining people's mental wellbeing, the Service is currently looking at establishing 'pop-up hubs' in a range of community venues across B&NES. These will provide a drop in facility for people who need advice, information and practical help on issues which may affect their mental wellbeing, without them having to enter a 'service'.

The main focus over the next few months will be the further development of the peer mentoring approach and establishment of peer led community groups and networks.

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CCG Briefing:
Wellbeing Policy Development & Scrutiny Panel Meeting

Friday 28th September 2014

Tracey Cox appointed as Chief Officer

Tracey is a talented and respected leader who has played a key role in the commissioning of NHS services in Bath and North East Somerset since 2001. She joined the NHS in 1990 as a management trainee after graduating from Goldsmith's College, University of London and worked in several London hospitals managing different specialities before moving to the South West in 1997 to manage general surgery and orthopaedic services at the RUH. She has led the commissioning team at the CCG since its authorisation in 2013 and took on the interim role of Acting Accountable Officer in June 2014 following the departure of Dr Simon Douglass.

Tracey's appointment followed a rigorous assessment process that required shortlisted candidates to field questions from CCG staff, representatives from the CCG's 27 member practices as well as leaders from key local stakeholders including B&NES Council, the RUH, Sirona and Healthwatch.

Acquisition of RNHRD by RUH

The CCG continues to work closely with the Royal United Hospitals Bath NHS Foundation Trust and the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust as the process continues for the acquisition of the RNHRD by the RUH. A full presentation will be given to the Wellbeing Policy Development and Scrutiny Panel on Friday 28th November to brief members on the current situation.

The CCG plays a key role in meetings of the Local Health Economy Forum which is a group supporting the acquisition process and we will ensure that patient care and the continuation of services remains the highest priority throughout this transition. In particular, the CCG is responsible for ensuring that appropriate consultation has been carried out regarding the transferral of endoscopy services from RNHRD to the RUH.

Your Care, Your Way: Let's Plan Community Services Together

At the end of January, the CCG and the Council will launch a major programme of public engagement to collect views on how community services could be provided in the future. The project will be branded "Your Care, Your Way"

The CCG Board has given approval for Sirona's contract to be extended by a year to the end of March 2017 to provide enough time for a sufficiently in-depth review to take place.

The engagement will be delivered in three phases:

- Phase 1: Initial Fact Finding (Late Jan – March)
- Phase 2: Presentation of Options (May – June)
- Phase 3: Consultation on Preferred Option (July-August)

An engagement strategy has been developed to ensure that all key stakeholders have an opportunity to provide input to the process. This includes seldom heard groups, clinicians, councillors, staff and current/potential providers.

Referral Support Service

The CCG has commissioned a local provider, Bath and North East Somerset Enhanced Medical Services (BEMS+), to carry out a one year pilot for a new Referral Support Service (RSS). The new service will begin with a soft launch on Monday 1st December with a small number of GP surgeries that have volunteered to participate in the first phase. The pilot will focus initially on five specialities: orthopaedics, ophthalmology, pain clinic, urology and dermatology.

The RSS is designed to provide advice and support to GPs and their patients who require referral for treatment in secondary care. It will utilise the Choose and Book service enhanced with local knowledge to help patients make informed decisions about where they want to receive their treatment. The RSS will be operated from the Riverside Health Centre in Bath by a team of nurses and administrators with support from a GP.

Antibiotic Awareness

Tuesday 18 November was European Antibiotic Awareness Day and the CCG has been encouraging local people to make a pledge as part of the Antibiotic Guardian campaign.

Antibiotics are essential medicines for treating bacterial infections in both humans and animals but they are losing their effectiveness at an alarming rate. Without effective antibiotics many routine treatments will become increasingly dangerous. Setting broken bones, basic operations, even chemotherapy all rely on antibiotics that work. The CCG is asking local people to discuss with their GP whether they really need antibiotics, to take antibiotics exactly as prescribed and to tell their friends and family about the problem. Dr Orpen has been on BBC Bristol and BBC Somerset to talk about antibiotic awareness and the campaign has been featured in the Bath Chronicle and on the Bath Mums website.

Diabetes Survey

The CCG will shortly be commencing a survey of everyone living with Type 2 Diabetes in Bath and North East Somerset. This equates to over 6,000 people. Each person will receive a letter from their GP practice asking them to participate in the survey and they will have the option to complete the survey online or through the post. The results of the survey will be used to improve the different forms of support available to people who have been diagnosed with diabetes so that they can manage their condition better and avoid complications in the future.

Shortlisted for HSJ Awards and NHS South West Leadership Awards

The CCG's work has recently been recognised in two high profile health sector awards.

Our work with Sirona and the RUH to redesign the pathway for heart failure patients was shortlisted for a prestigious HSJ Award in the Managing Long Term Conditions category. The new pathway has resulted in a dramatic reduction in hospital admissions and has enabled patients to receive more treatment in the comfort of their own homes.

Corinne Edwards was also shortlisted for Innovator of the Year in the NHS South West Leadership Awards for her ground breaking work to design and deliver the new model for urgent care in BaNES which has seen the GP Out of Hours Service integrated with a new Urgent Care Centre at the RUH.

Commissioning Intentions 2015/16

The CCG is currently finalising our commissioning intentions for 15/16. They will be circulated to providers and published on our website in the week commencing Monday 1 December.

Phlebotomy Services

Concerns were raised by Cllr Eleanor Jackson regarding disruption and delays in the oncology department on William Budd at the Royal United Hospitals Bath NHS Foundation Trust. This was believed to be because of a reduction in phlebotomy staff from two to one and because of cramped conditions in the unit because of the introduction of new furnishing. It was also reported that the intercom system was no longer in use and that there are delays for patients with no waiting time information being made available to them

The CCG Director of Nursing and Quality has spoken with the RUH Deputy Director of Nursing and Midwifery who is looking into the issues further. The DDoN is grateful that the issues have been brought to the RUH's attention and is sorry that patients have experienced delays

The DDoN has confirmed that phlebotomists are currently being recruited but will confirm if a second phlebotomist is to be recruited into that particular clinic. She advised that the intercom system was discontinued following a recent complaint where it was felt that the system was like being in an 'airport lounge' and was impersonal. The RUH took the decision to stop the intercom and now clinicians come out to call their patients personally which is hoped provides an improved service for their patients. The DDoN does however apologise for the lack of information regarding possible waiting times and will ensure that this is introduced. The DDoN will further review the lone working and health and safety concerns raised

A second concern was raised regarding 'unclean and insanitary conditions' on the Respiratory Ward. The DDoN apologises if the ward was found to be in this unacceptable condition during the individuals in-patient stay. Regular cleanliness audits are undertaken and she will provide a more detailed response to this issue once she has received the most recent audit outcomes.

The CCG works closely with the RUH to monitor and continually improve the quality of care for patients. Both the CCG and the RUH welcomes feedback from patients, their families and the public so that concerns can be dealt with as quickly and as appropriately as possible. More detailed feedback will be shared with the CCG and with the Wellbeing Policy Development & Scrutiny Panel

Bath & North East Somerset Council		
MEETING	**Wellbeing Policy Development & Scrutiny Panel Committee**	
MEETING/ DECISION DATE:	**16 January 2015**	
TITLE:	**Healthwatch Bath and North East Somerset update**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Young Healthwatch Event report		

1 THE ISSUE

1.1 Update report from Healthwatch Bath and North East Somerset

2 RECOMMENDATION

2.1 To note the report.

3 THE REPORT

Report to the Wellbeing Policy Development and Scrutiny Panel 16 January 2015

Young Healthwatch Event

Extract from the report:

On Tuesday 28 October 2014, young people from across Bath and North East Somerset, Bristol, South Gloucestershire and Somerset came together to explore:

What is healthy?

What is happy?

What is it like being you?

What needs to happen to help you be happy and healthy?

In the morning, we learnt circus skills with Circomedia and cooked our own delicious, healthy, quick, cheap and easy lunches with Steen the chef. We blended copious amounts of fruit in smoothies with Juicy Blitz and thought outside the box to generate ideas for tackling unhealthy habits with REACH, SHINE and A'n'K.

After tucking into our yummy lunches and washing them doen with just another smoothie, we all had our say about what healthy, happy, self esteem, wellbeing and mental health mean to us and what support needs to be available to young people to help them to be happy and healthy. We put our ideas onto blogs with Rife magazine and contributed to a You Tube being made by First Born Creatives about young people's health and wellbeing.

We had lots of fun, but also discussed some really important issues.

Feedback from the event:

Mental Health: Young people want commissioners and service providers to know that health and social care services, schools and society need to focus more on supporting young people to build resilience, self esteem and good mental health.

Pressure from peers and the media, anxiety about education and employment and stigma lower young people's emotional wellbeing.

Physical health and mental health are closely linked

Wellbeing support needs to be available before someone becomes mentally ill

From the discussion groups:

REACH, SHINE and A'n'K work with young people across Bath and North East Somerset, Bristol and South Gloucestershire to educate them about healthy eating and help them to develop a healthy lifestyle. The teams asked young people attending the event to come up with project plans foe how to encourage people to eat and live healthily. Here's what they came up with:

Group 1 More Education Awareness

- Breakfast clubs at school and sessions in youth clubs to help pupils achieve and maintain a healthy weight
- Websites with games about healthy living
- Healthier food in schools and free fruit for everyone
- Swap food in vending machines for healthier options
- Afterschool activities offering fun and different forms of exercise
- Encouraging families to cook more of their own food by providing recipe cards
- Putting less pressure on girls to be skinny
- Teaching people about how missing a main meal can lead to snacking

Group 2 Sugar Tax and Better Food Labelling!

- Make healthy food cheaper and introduce a sugar tax on unhealthy food
- Show sugar content of food on the packaging with images of how many tea spoons of sugar are in the food as having the number of grams is meaningless to many people

Group 3 The Health Takeaway shop!

- Price: cheap so people will buy it (£2 - £2.50)
- Location: near schools
- Suggested names: Freshers (something to do with being healthy and fresh)
- Food: sweet potato chips, falafel, burger, (brown bread, veggie burgers) stews, sushi, noodles and stir fry.Meals would all release long lasting energy (eg. using brown bread and brown rice)
- Puddings: ice lollies, frozen yoghurt
- Drinks: Soothies
- Offers: student discounts, meal deals, 10th purchase free
- Apps: link an app to the shop. App would have the recipes and information about nutrition

Group 4 Get Healthy to meet your idol!

- Video footage of famous people / celebrities learning or trying out new sports for fun (saying it's about obesity might put people off so focus should be on enjoyment)
- Monthly challenge: each month one person wins a local or national competition to meet their idol based on how they have started eating more healthily or started a new form of exercise
- 'Healthy 4 A Day' or 'Step Up Today' challenges
- Link promotion of the above with websites with information on local sports centres or clubs
- Public workshops for everyone to try new sports or foods
- Promote all the above on social media, in schools and in communities

Group 5 Lobby Supermarkets!

- Work with supermarkets to make healthy food more convenient and affordable
- Change the way nutritional information is written on packaging to make it clearer

- Provide information on the links between emotion and food

Group 6 Fitness Finder – Free App!

- The app / website would provide the following information about sports groups or health related groups in the person's area: cost, location, who can attend (eg.age), what the activity is, times, price ranges
- App would have details of personal trainers
- People / organisations would pay to advertise their classes
- App would be promoted in schools, social media, leaflets in lots of places
- People could pay so much a month for unlimited classes

Some of the groups also discussed the reasons why people may become unhealthy. Thes are the things they came up with:

Not enough exercise

Unbalanced diet

Medical issues

Emotional / comfort eating

Prices of food

Low calorie and fat foods actually contain more calories or other ingredients that are unhealthy

Motivation

What do you think of our ideas? Could you make them a reality?

During the afternoon the group worked with Rife magazine and journalist Jessica Barrett to begin to get everyone thinking about blog writing.

You can read some of the blogs on the Young Healthwatch Blog at www.healthwatchbristol.co.uk/young-healthwatch

The reports also addresses what young people had to say using word clouds, the more times a word was said the larger the work in the word cloud.

Healthy is – happy, fruit, sports, running, cooking, exercise, gym, green

Happy is – friends, sunshine, Music, Chocolate, Smiling, Cats

Self esteem is – How you feel about yourself, Happy – with myself, Linked with happy and healthy

Wellbeing is- Healthy, How's your life, Mentally stable

One young person fed back " I thought it would be a bit like school but it wasn't there were things to do like circus tricks and cooking, I liked making smoothies and have made some at home since then".

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

4 RISK MANAGEMENT

4.1 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	

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#YHWBeingMe

Young Healthwatch Being Me Event, October 2014

Our Message:

Mental Health and Wellbeing Support for everyone

Healthy-Eating

Mental-Health

Self-esteem

#YHWBeingMe Contents Page:

What we did and said:

Section 1: What was #YHWBeingMe? (page 3) summary of our main message (page 4) and summary of Healthwatch actions from the event? (page 5).

Section 2: What did we do and what did we say? (Page 6)

Section 3: Who came to #YHWBeingMe? (Page 21)

What we want you to know:

Section 4: Our Main Message (Page 24)

Health and Social Care Services, schools and society need to focus more on supporting young people to build resilience, self-esteem and good mental health.

Pressure from peers and the media, anxiety about education and employment and stigma lower young people's emotional wellbeing.

Physical health and mental health are closely linked.

Wellbeing support needs to be available before someone becomes mentally ill.

Section 5: Feedback from other groups who support our main message. (Page 25)

What's next?

Section 6: What happens next? (Page 26)

Section 7: What will you do differently? (Page 29)

Section 8: How to contact Healthwatch. (Page 31)

Appendix: Supporting information. (Page 33)

Section 1: What was #YHWBeingMe?

On Tuesday 28 October 2014, young people from across Bristol, South Gloucestershire, Bath & North East Somerset and Somerset came together to explore…

- What is healthy?
- What is happy?
- What is it like Being You?
- What needs to happen to help you be healthy and happy?

In the morning, we learnt circus skills with Circomedia and cooked our own delicious, healthy, quick, cheap and easy to make lunches with Steen the Chef. We blended copious amounts of fruit into smoothies with Juicy Blitz and thought outside the box to generate ideas for tackling unhealthy eating habits with REACH, SHINE and A'n'K.

After tucking into our yummy lunches and washing them down with just another smoothie (!), we all had our say about what healthy, happy, self-esteem, wellbeing and mental health mean to us and what support needs to be available to young people to help them be happy and healthy. We then put all our ideas into blogs with Rife magazine and contributed to a You Tube video being made by First Born Creatives about young people's health and wellbeing.

We had lots of fun, but also discussed some really important issues. This report will share those issues with you and make suggestions for future improvements in health and social care services.

"I thought it would be a bit like school but it wasn't there were things to do like circus tricks and cooking, I liked making smoothies and have made some at home since then." *(Feedback emailed to Healthwatch by a young person who attended #YHWBeingMe)*

If you don't have time to read the whole report, please look at the following word cloud which sums up the main issue we said Healthwatch and society needs to focus on and then use the contact details at the end of this report to give us your feedback on health and social care services and issues:

Which

health topic

should Healthwatch be focusing on?

Our Main Message:

Health and Social Care Services, schools and society need to focus more on supporting young people to build resilience, self-esteem and good mental health.

Wellbeing support needs to be available before someone becomes mentally ill.

Healthwatch
Next Steps!

Healthwatch will work with young people, schools, community groups, voluntary sector organisations and health and social care services to achieve the following aims:

- provide the opportunity for young people to share feedback and opinions about health and social care services and have their voice heard;
- provide access to wellbeing resources and ideas (such as the Resilience Lab online resource produced by Off the Record);
- empower young people to access services and understand their rights.

Healthwatch has lots of exciting projects planned for the future. Below are the titles of just some of those projects – find out more about them in Section 6 of this report…!

- Young Champion Volunteer Role and Activities
- Young People's Reference Group
- Our Stories and Being Me Workshops
- Schools and Colleges Project
- Healthwatch You Tube Video
- Young Healthwatch Facebook Page
- Somerset Rural Youth Project

Section 2: What did we do?

(*all quotes are feedback given by young people attending #YHWBeingMe)

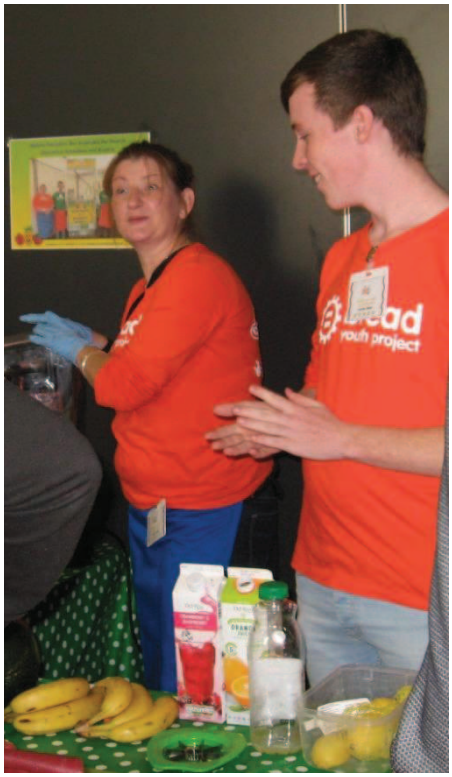
Cooking with Steen the Chef:

“The food was healthy but tasted brilliant.”

Steen taught us that cooking doesn’t have to take a long time, cost a fortune or involve confusing recipes and that food can be both healthy and tasty.

You can find all the recipes for the dishes we made in the Healthwatch Cook Book which is available on the Healthwatch Bristol website on the Young Healthwatch page (http://www.healthwatchbristol.co.uk/young-healthwatch).

Smoothie Making with Juicy Blitz:



"I liked being able to talk to the people making the smoothies and look at all the fruit."

Juicy Blitz kept us refreshed throughout the day by blending lots of fruits together to make delicious smoothies. They didn't add any sugar to their recipes proving that drinks can taste great without any added sugar or sweeteners.

Circus Skills with Circomedia:

"[I enjoyed the] circus because it was energetic."

When we think of exercise we often think of running, gyms or competitive team games and this is sometimes off putting, especially if you're not confident in your fitness ability or skill. Healthwatch invited Circomedia to teach us some basic circus skills and show us that exercise can be fun as well as healthy!

Healthy Eating 'Think Outside the Box' Workshops with REACH, SHINE and A'n'K:

REACH, SHINE and A'n'K work with young people across South Gloucestershire, BANES and Bristol to educate them about healthy eating and help them to develop a healthy lifestyle. The teams asked young people attending #YHWBeingMe to come up with Project Plans for how to encourage people to eat and live healthily. Here's what we came up with:

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- Puddings: ice lollies, frozen yoghurt, sorbet
- Drinks: smoothies

- Offers: Student discounts, meal deals, 10th purchase is free
- Apps: link an app to the shop. App would have the recipes and information about nutrition.

Group 4: **Get healthy to meet your idol!**

- Video footage of famous people/ celebrities learning or trying out new sports for fun (saying it's about obesity might put people off so focus should be on enjoyment)
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Some of the groups also discussed the reasons why people may become unhealthy. These are the things they came up with:

- Not enough exercise
- Unbalance diet
- Medical issues

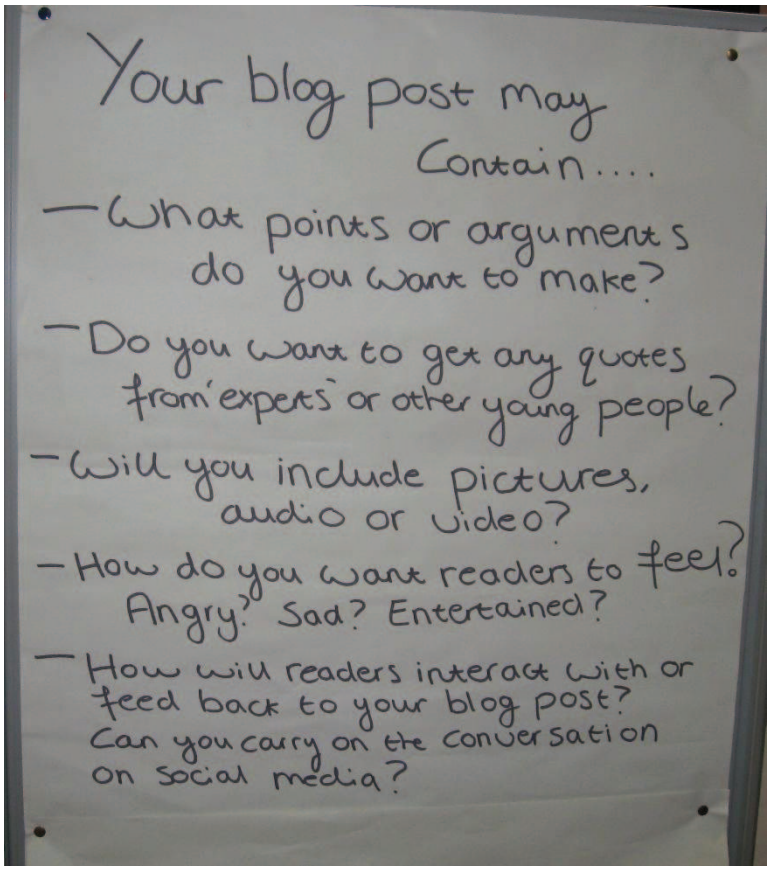
- Emotional/ comfort eating
- Prices of food
- Low calorie and fat foods actually contain more calories or other ingredients that are unhealthy
- Motivation

What do you think of our ideas? Could you make them a reality?

Rife Blog Writing Workshop:

"The thing I enjoyed most about YHWBeingMe was the chance to bounce ideas off other young people around health issues for adolescence."

"I liked the Rife workshop: it helped me to get some ideas for my envision project at college."



After our healthy and balanced lunches, we got down to the serious stuff and engaged in some group discussion around our health. Following the discussion, a young journalist from Rife magazine told us all about the online Rife website and workshops. Jessica Barrett, a journalist, then facilitated a workshop on blog writing and got us all thinking about topics for our blogs. We have all been invited to send our blogs to either Rife or Healthwatch for further support and to publish them. You can read some of our blogs on the Young Healthwatch Blog at: www.healthwatchbristol.co.uk/young-healthwatch

Group Discussion and Our Views:

Word Association Game:

The first activity of the discussion was a game of word association using the following starter words as prompts. The answers generated have all been inputted into word clouds. The larger the word in the word cloud, the more times it was said in our discussions.

1. **When you hear the word ……. what do you think of?**

Healthy

Happy

Self-esteem

Wellbeing

Mental Health

Healthy is…


MIND-SETFOOD
RAINBOWS
IRON
ATHLETICS
ACTIVIA
DIET
CHEESE
LAUGHING
MUSCLES
ANIMALS
CELEBRITIES
BORING
SALAD
ADIDAS
SUN
DRUGS/MEDICINE
FRUITANDVEG
DAVIDBECKHAM
COOKING
SUNSHINE
HAPPY
FRUIT
SPORTS
BALANCED
HEALTHY-WEIGHT
EXERCISE
RUNNING
NIKE
FISH
WATER
VITAMINSA-Z
POTATOES
GYM
GREEN
GOK-WAN
HOSPITAL
GOATS
SEEINGFRIENDS
OMEGA3
SWIMMING
WALKING
YOUTUBE
MINERALS
SHOES
WEIGHT
HERBS

Happy is…


Seaside
Films
Marmite
Angry
Laughing
Bed
Positivity
Smile
Acceptance
Volunteering
Medicine
Alcohol
Kindness
Fresh-air
Tea
Sunshine
Punching-walls
Family
Unicorns
Going-out
Respect
Emoji's
Chocolate
Friendship
Reading
Animals
Nature
Helping-your-friends
Being-us
TheSimms
Art
Walking-the-dog
Smiling
Selfie
Hobbies
TV
Disney
Surroundings
Music
Praise
Good-deeds
Solidarity
Pharrell-Williams
Smiley-face
Creative-writing
Writing
Confidence
Startrek
Games
YouTube
Religion
Comedies
Pixar
Biscuits
Singing
Cats
Cuteness
Individual-uniqueness
Friends
Talking-to-my-granny
Flowers
Pets
Love

Self-esteem is…

"Very high self-esteem is: cocky, arrogant, greedy, popular, treating people like dirt/nothing"

"**Low self-esteem** is: jealousy, depression, anorexia, friends, family, confidence, respect, modest, lonely, no confidence, reflects on how you do things, not trying, scared of rejection."

Well-being is…

- Social health = how you are socially, how comfortable you are in society
- Bullying might be an issue for wellbeing
- Hard to have wellbeing if you're hungry and cold
- Need support to reduce feeling isolated

Mental Health is…

Which health and social care services have we used?

The group discussion gave us the opportunity to speak more about our own experiences of health care. There was also an anonymous feedback poster located in a quiet area of the hall on which we were invited to write which services we'd used. Between us we'd used lots of services including:

Hospital Services: BRI, Bristol Children's Hospital, Southmead Hopsital, Frenchay Hospital, Bristol Eye Hospital, Accident and Emergency, Minor Injuries, Hospital Education Services
Mental Health Services: CAMHS, Riverside Adolescent Psychiatric Unit, Off the Record, School Counselling, Private Counselling, Support Groups
Primary Care Services: GP Practices, Dentists
Other: Sexual Health Services, Allergy testing, Physiotherapy

What do we think of the health and social care services that we have used?

We gave the following comments on some of the services we'd used:

- We get healthy eating lessons in school, but the lessons are not good.
- Counsellors, teaching support and school nurses, are not always welcoming and sometimes not always there.
- Counselling in schools is not always there and is limited to 8 session which isn't enough as you can't talk about your issues if you will have to leave after 8 sessions. Plus there are waiting lists. Private counselling costs and not everyone can afford it.
- "You get pushed up the waiting lists for counselling if you're a priority, but how does that make you feel, if you're not."
- "I saw a nurse after I got in a fight and she spoke to me about why I was in the fight and managing anger."

Who else helps us with our health and happiness?

We also identified the following people and activities as helping us with our health and happiness:

- Family and Friends: "parents and teachers who notice when we're upset and give us praise for our achievements"; "siblings and family who talk to you, encourage you, make you smile"; "talking with my sister"; "spending time with friends".
- Activities: "listening to music"; "being creative"; "dancing"; "music"; "reading"; "watching TV"; "drawing and art"; "diary"; "looking at cute stuff".
- Volunteering and being part of a youth group.
- Relaxation: "sitting in a dark space and focussing on my breathing"; "hypnotherapy helps me relax"; "stroking cats".
- Exercise: "gym"; "going for a walk".

Some coping strategies are unhealthy:

Some people also identified coping strategies that they use when they feel stressed or upset, but which could be judged as unhealthy: "Self-harm"; "alcohol"; "restricting food"; "smoking"; "excessive exercise".

What issues stress us out and what needs to change?

Through the group discussion, feedback posters and evaluation form that we completed at the end of the day, we identified what issues stress us out or upset us and what needs to change to enable us to feel confident being us. The main themes were:

Stigma and bullying:

- Misconceptions of mental health issues and prejudice towards people with mental health issues
- Disability and "getting called names and being upset"
- "Having to come out" and facing prejudice

Expectations and perceived norms:

- "view of perfect body image"
- "boys view of girls"
- "society's view of and projection of beauty"
- "people's opinions"
- "appearance and how other people see me"

Health related issues:

- There needs to be open ended and free counselling for everyone
- "Dyslexia being overlooked and not diagnosed"
- "Autism – I don't want to have a diagnosis or get a label put on it"
- Coping with having a mental health illness
- Anxiety about food and weight
- Anxiety about social situations, relationships and friendships
- Appointments at the doctors, dentists or hospital
- "Feeling alone"

Education, employment and the future:

- Career choices: "the possibility of failing education and not doing something I love or being happy with my life"
- Homework, coursework and exams
- Meeting expectations from teachers and family to get good results
- "School work can stress me out sometimes when you have lots to do and you just want to relax after a busy day at school"
- Getting into crime

Family:

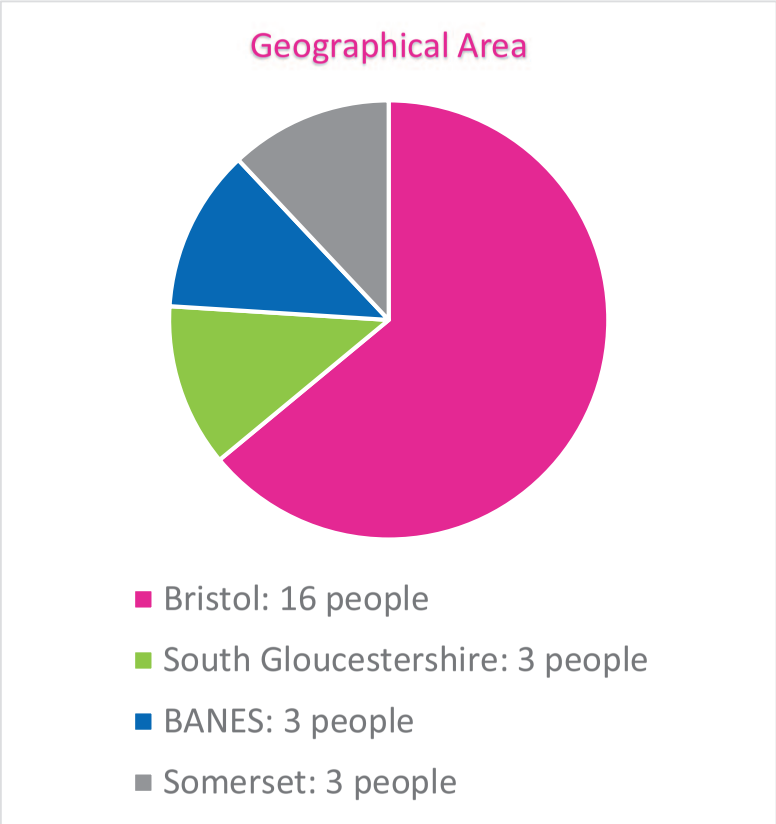
- "Being a young carer"
- Parents' expectations

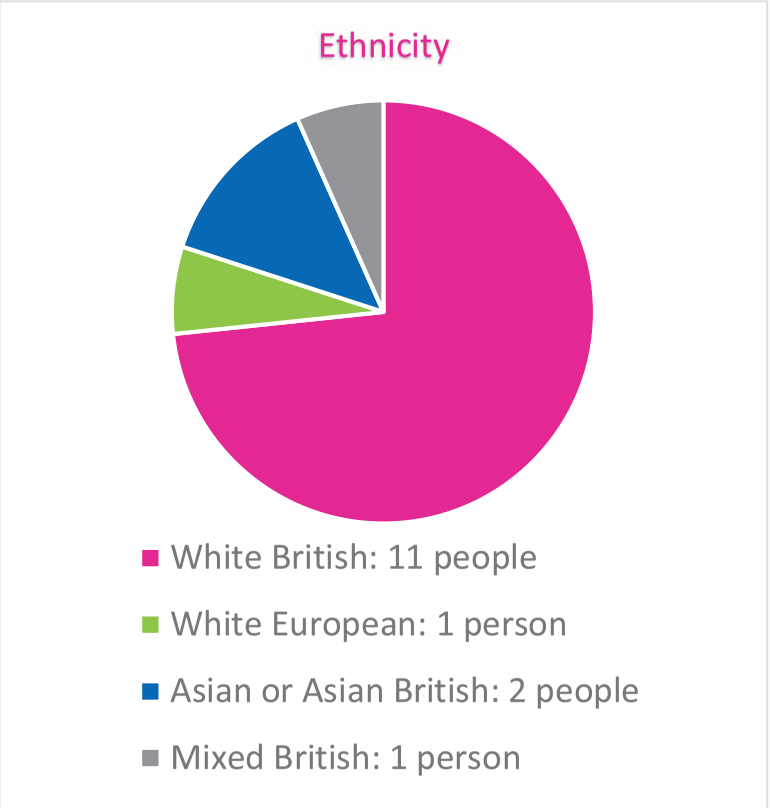
Social Media:

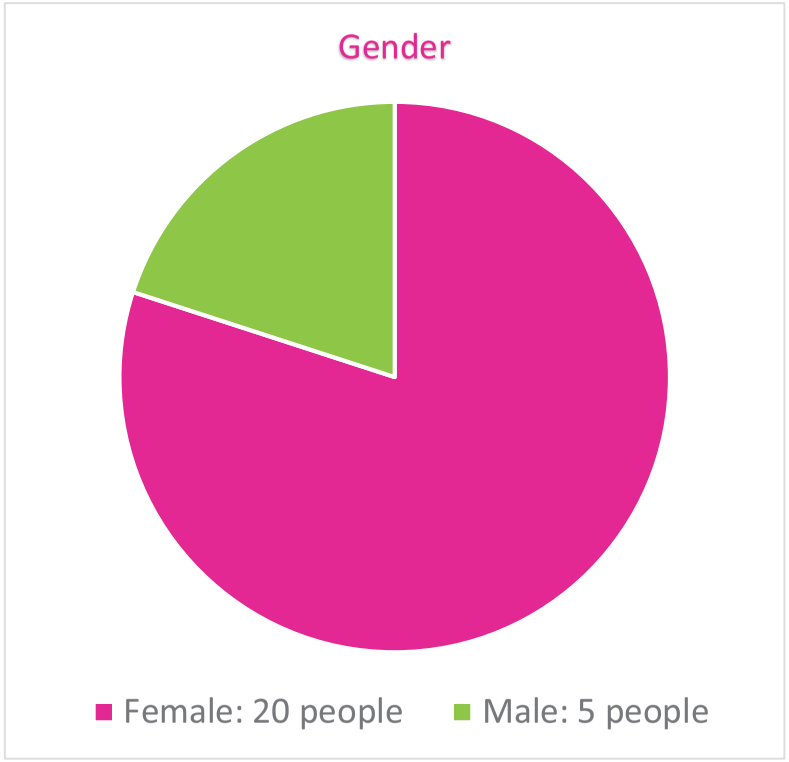
- “Everyone’s Facebook and Twitter obsession – I don’t use it and get annoyed by everyone talking about it.”
- “Friend requests from people I don’t know on Facebook.”
- “Social media is scary if you don’t know how to use it properly.”
- “Social media gives a false sense of reality, feel like if something isn’t on Facebook it didn’t really happen.”
- Worries about privacy settings on social media and apps
- Cyber bulling
- False information
- Spread misconceptions
- “I think social media has its pros and cons. It embraces freedom of your opinions; connection with new people; new friendships and such. However it makes you an easy target for hate, bullying and abuse. It changes your views on yourself, life and people around you.”
- “It can be good for spreading knowledge and helping each other, but there’s pro ana social stuff and it’s awful for my health; it’s been helpful for support.” *(*Pro Ana Social Sites are websites or forums that promote restrictive eating and excessive exercise and share photographs of extremely thin men and women with the aim of encouraging viewers to lose weight.)*
- “Like everything else, has amazing potential for good and bad – depends how you use it.”

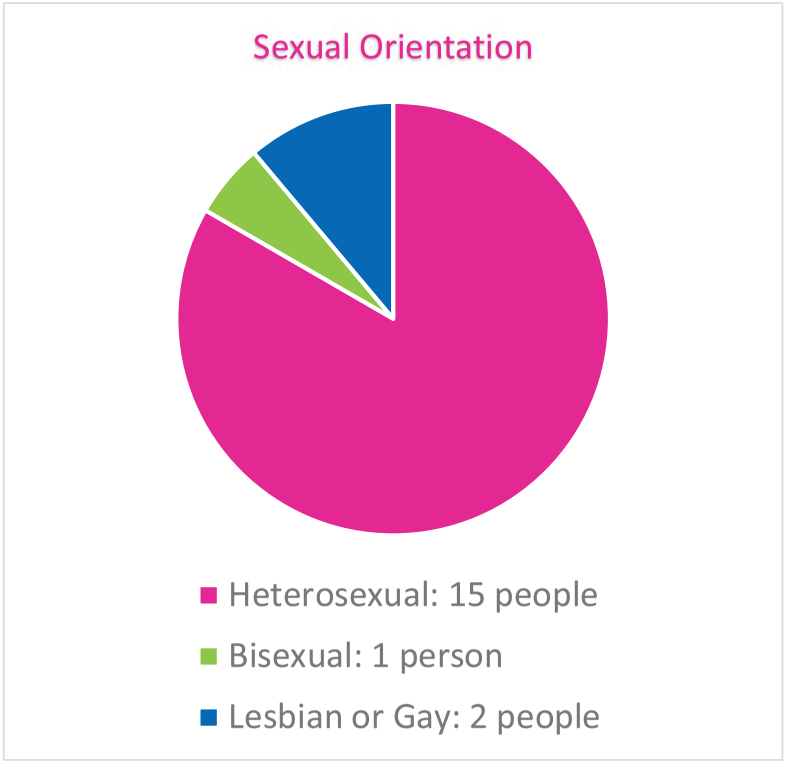
Section 3: Who came to #YHWBeingMe? Demographic Information:

25 young people attended the event. Everyone was asked to complete an equalities monitoring form at the end of the session. Some people chose not to complete every section.





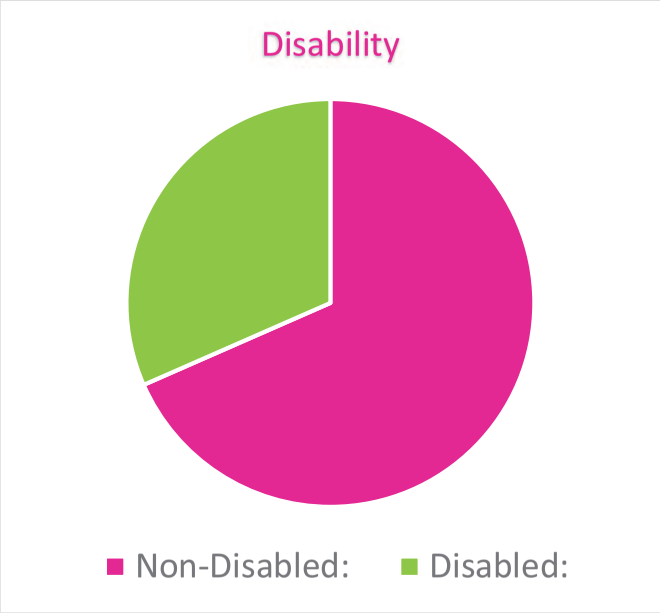


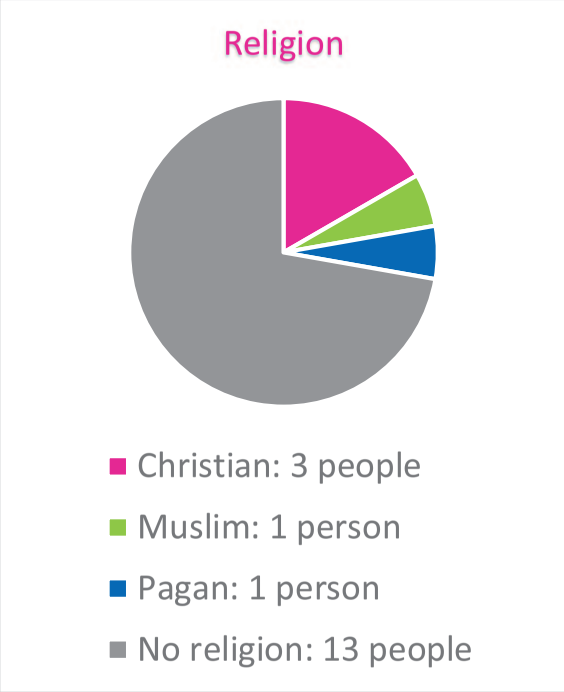


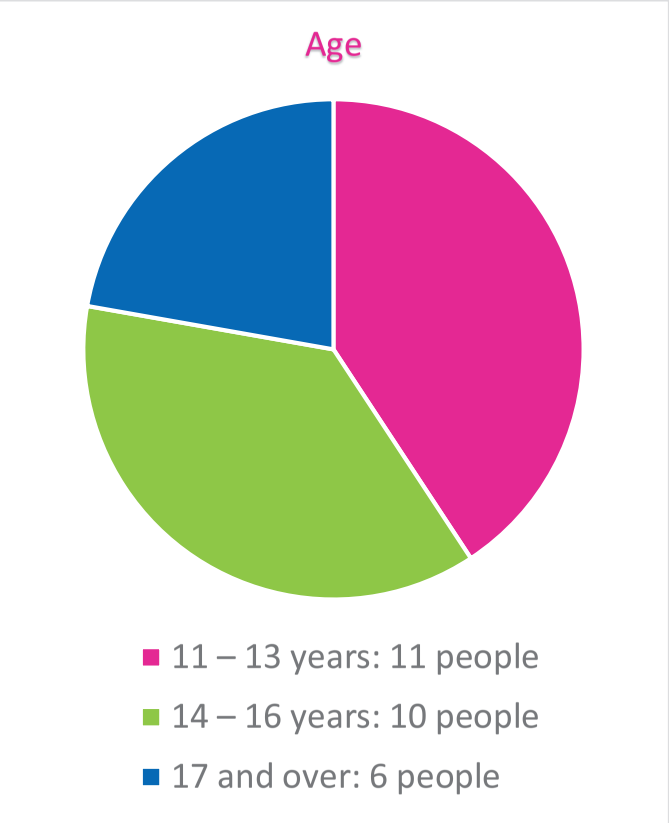
Gender:
Although many boys booked places on the event, not all of them attended on the day. In future, Healthwatch will work to attend groups where boys are already meeting to hear their views. In previous engagement work, Healthwatch has been able to hear from boys and some of their feedback can be read in section 5.

Disability:

Non-Disabled:	13 people
Visual Impairment:	2 people
Learning Disability:	1 person
Mental Illness:	1 person
Other Disability:	2 people







Disability: Healthwatch has received feedback from pupils, parents and teachers at Claremont School (a school for children with complex needs) that self-esteem is an issue for them. Healthwatch will be working with Claremont School and pupils in 2015 to hear more about what they need from health and social care services.

Section 4: Our Main Message

Mental Health and Wellbeing Support for everyone:

- Young People attending #YHWBeingMe wanted Healthwatch and society in general to focus on issues to do with self-esteem and mental health. This point is most clearly represented in Word Cloud One.
- Pressure from peers and the media, anxiety about school, exams and future career options and stigma and prejudice were identified as factors which affect emotional wellbeing and raise stress levels.
- There was a clear understanding among the attendees that physical and mental health are closely linked with each other. The ideas generated during the Healthy Living Workshops reveal that young people feel there needs to be more education about healthy eating and exercise and that this education needs to be provided not only to pupils in school, but also to families, through the media and in supermarkets or on the high street. There is also a focus on exercise and healthy eating being promoted as enjoyable and sociable activities that everyone, from children to adults to celebrities, can engage in.
- There was a call for attention to be moved away from a focus on diagnoses and labels for mental health illnesses or other health conditions, and for support to instead be given to everyone before a mental health illness develops or in the early stages of its development. This support should be available to all and should not be time limited.

Section 5: Previous Healthwatch Engagement Work which supports the findings of the #YHWBeingMe Event.

The feedback given by young people attending the #YHWBeingMe event echoes the feedback that young people have given Healthwatch during focus groups facilitated by Healthwatch during 2014. The #YHWBeingMe event was attended by young people aged 11-19 years of age, but Healthwatch had heard similar feedback from young people attending groups that cater for 16-25 year olds. The following reports are included in the appendices of this report as supporting material:

Healthwatch and Kids Company

28.07.14: Kids Company Bristol provides a comprehensive package of care to exceptionally vulnerable young people. The Healthwatch report is based on the feedback given by approximately 40 young men and women who were between the ages of 19 and 25 years who attended the drop in. The main themes of the report are:

- **CAMHS is inaccessible to many young people**
- **A&E departments need to have more awareness of mental health needs and give people attending A&E support with their mental health**
- **Young People value the support offered by the Kids Co Drop In as they feel listened to**

1625 Independent People's Youth Forum.

28.08.14: 1625ip support young people (aged 16-25) who are at risk of becoming homeless or are already homeless. Healthwatch spoke to approximately 20 people and five 1625ip staff members attended the Youth Forum. Of the young people attending all but two attendees were male.

- **Health Professionals (including GPs and A&E staff) do not refer young people to mental health services and when referrals are made, the waiting times were too long.**
- **Looking past appearances:** staff should try to see the patient as a whole person and not judge them based on prejudice or stereotyping. Staff should also listen to the patient instead of basing decisions on physical test results alone.

Section 6: What happens next?

Healthwatch encourages young people to make a change themselves:

Based on the feedback given by young people at the #YHWBeingMe event and through focus groups and our other feedback mechanisms, Healthwatch has developed a volunteering project for young people.

Volunteering opportunities for young people – Young Champions:

Young People wishing to get involved with Healthwatch and have a say in the future of health and social care services, are invited to become Young Champions. In this role, they will be given training and support and can choose to take part in activities such as:

- **Young Champion:** Speak to your peers (at a youth group or in school) and tell them about Healthwatch and how they can get involved. Let Healthwatch know what your peers say about their experience of health and social care services.
- **Young Commentator**: Young people can blog for us about the #YHWBeingMe event or about a health and social care issue that is important to them.
- **Young Commissioner**: Young people can volunteer as a Young Commissioner with the CCG **Young People's Reference Group**. In this group they can have a direct impact on the recommissioning of Children's Community Health Services in Bristol, South Gloucestershire and North Somerset.

Healthwatch develops projects for the future:

Healthwatch Projects:

1. **Our Stories and Being Me Sessions:** Healthwatch will continue to invite people of all ages to share with us their stories and experiences of using health and social care services. Healthwatch will work with young people, voluntary sector services, community groups and health and social care services to facilitate 'Our Stories and Being Me' sessions which will aim to:
    1. provide the opportunity for young people to share feedback and opinions about health and social care services and have their voice heard;

2. provide access to Wellbeing resources and ideas (such as the Resilience Lab online resource produced by Off the Record);
3. empower young people to access services and be involved in making decisions about their care.

2. **Develop a Schools and Colleges Project**: Healthwatch will offer schools and colleges a two sessions programme to enable students to voice their opinions and experiences of health and social care services and issues and develop their awareness of wellbeing and build resilience. (Bristol and South Gloucestershire)

3. **Work with voluntary sector organisations and community groups** to speak to more young people about their health and wellbeing through focus groups and workshop activities.

4. **You Tube Video:** Work with First Born Creatives to produce and release a You Tube video based on the footage recorded at the #YHWBeingMe event and at other events. (Bristol and South Gloucestershire)

5. Work with **Bristol Children's Hospital** to develop blogs and video stories about looking after your mental health and wellbeing whilst in hospital.

6. **Future Events:** Have a follow up BeingMe event for children and young people with a disability or long term illness.

7. **Share the findings within this report with**:
   - **Healthwatch Network of Networks**
   - **Bristol Young People Friendly**
   - **NHS Youth Forum**
   - **Resilience Lab**: Healthwatch to share the ideas given by young people for relaxation and happiness with Off the Record and their on-line Resilience Lab. Healthwatch to promote this report and Off the Record's Resilience Lab to all the young people

who attended the BeingMe event and other young people organisations.

- **Clinical Commissioning Group**: Healthwatch to write to Bristol, South Gloucestershire and North Somerset Clinical Commissioning Groups – who are currently recommissioning Children's Community Health Services – to notify them of the findings in this report and recommend that they commission services that provide support to build resilience and wellbeing to all young people.

8. **Young Healthwatch Facebook Page:** Healthwatch will use its Young Healthwatch Facebook Page to share information about mental health, wellbeing and support services with its followers and promote, through example, a healthy way of using social media.

9. In **BANES**, Healthwatch and Bath Area Play Project are working together to speak to children and young people from across the district, including people that are accessing Voluntary and Community Sector services through the Children and Young People's Network; younger residents from the rural parts of BANES, particularly the Somer and Chew Valleys, and those using services that will be involved with the recommissioning of Children's Community Health.

10. In **Somerset**, Healthwatch works with Somerset Rural Youth Project to engage with and support young people. Their website is: http://www.sryp.org.uk/

Section 7: What will you do differently?

Healthwatch hopes that the event held on 28 October 2014 will act as a catalyst for further work, by both ourselves and other organisations, with children and young people to promote health and happiness. Following the event, Healthwatch has already received comments from the young people in attendance about what they will do differently as a result of the day's activities. We invite you, as readers, to follow their example and make a pledge to look after your health or help others to do so. For some inspiration, have a look at what the young people who attended have said they'll do differently from now on….

"[I will] think more deeply about what we call 'wellbeing' and other phrases."

"I will start getting involved with Rife."

"[I will be more] open with food and talk about health."

"[I'll] keep listening."

"Maybe join NHS University Hospital Bristol Youth Council."

"Eat more healthy stuff."

"I will start blogging about mental health."

"[I will] look into more about obesity and healthy eating and perhaps look to encourage that as the Executive Officer at my sixth form."

"I think I will be more healthy."

"[I'll start] making homemade smoothies."

"[I'll be] making different/ new foods."

"I think our views will be heard."

Section 8: Contact Details for Healthwatch.

We want to hear from you about your experiences so that we can tell services your needs to create the best local services.

Whether you are a young person, parent, health and social care worker or teacher, we want to hear about your experience of GPs, hospitals, community services and social care.

- **Do you agree with the findings in this report?**
- **Do you have your own ideas and opinions to add to the report?**
- **Would you like to make a pledge to take care of your own or someone else's wellbeing?**

Please use the contact details given below to get in touch with us or go to our websites to find information about our Facebook, Twitter and text contact details.

Bath and North East Somerset

Telephone us:	01225 232 401
Email us:	info@healthwatchbathnes.co.uk
Visit our website:	www.healthwatchbathnes.co.uk
Write to us:	Healthwatch Bath and North East Somerset, The Care Forum, The Vassall Centre, Gill Ave, Fishponds, Bristol, BS16 2QQ

Bristol

Telephone us:	0117 2690400
Email us:	info@healthwatchbristol.co.uk
Visit our website:	www.healthwatchbristol.co.uk

Write to us:	Healthwatch Bristol, The Care Forum, The Vassall Centre, Gill Ave, Fishponds, Bristol BS16 2QQ

Somerset

Telephone us:	01823 751403
Email us:	info@healthwatchsomerset.co.uk
Visit our website:	www.healthwatchsomerset.co.uk
Write to us:	Healthwatch Somerset, Somerset Rural Youth Project, Unit 2 Suprema Estate, Edington, Bridgwater, TA7 9LF

South Gloucestershire

Telephone us:	01454 543402
Email us:	info@healthwatchsouthglos.co.uk
Visit our website:	www.healthwatchsouthglos.co.uk
Write to us:	Healthwatch South Gloucestershire, The Care Forum, The Vassall Centre, Gill Ave, Fishponds, Bristol BS16 2QQ

Appendix:

Websites for organisations mentioned in this report:

Steen the Chef: https://www.facebook.com/Steenthechef

Juicy Blitz: http://www.breadyouthproject.org.uk/juicy-blitz/

Circomedia: http://www.circomedia.com/

A'n'K (Bristol): http://www.ank.uk.com/

REACH (South Gloucestershire): http://www.southglos.gov.uk/health-and-social-care/children-and-family-care/reach/

SHINE (BANES): http://www.bathnes.gov.uk/services/public-health/public-health-strategies-and-policies#Managing

RIFE Magazine: http://www.rifemagazine.co.uk/

Thank you to all the organisations who ran activities and offered support at the event. Healthwatch would also like to thank HITZ Rugby Bath, Time to Change, SEAP, Off the Record, 4YP and Arthritis Care for bringing information along to the event.

Other Healthwatch Children and Young People Reports:

To read the Healthwatch Reports on engagement with Kids Co, 1625ip, St Mary Redcliffe and Temple School and Bristol Children's Hospital, please use the following link: http://www.healthwatchbristol.co.uk/find-services/resources

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Bath & North East Somerset Council		
MEETING	**Wellbeing Policy Development & Scrutiny Panel**	
TITLE:	**Homelessness Update**	
MEETING/ DECISION DATE:	**16 January 2015**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: None		

1 THE ISSUE

1.1 The Council delivers support and assistance to people at risk of becoming homeless and people who are homeless by commissioning services, developing effective partnerships with the voluntary sector and having an effective Housing Options Team. This report sets out the most recent information on demand for these services and provides reassurance that the responses currently in place are good and that there are new initiatives planned to further improve the offer.

2 RECOMMENDATION

2.1 The Wellbeing Policy Development & Scrutiny Panel is asked to note the contents of the paper.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 There are no direct financial implications arising from this report. The report is approved by the Council's s151 Finance Officer.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 The delivery of services for homeless people has implications for statutory considerations such as equalities, crime and disorder, safeguarding children and public health and inequalities.

4.2 In addition the Housing Act 1996, and the Homelessness Act 2002, place statutory duties on local housing authorities (the Council) to ensure that advice, assistance and other housing duties are available to households who are homeless or threatened with homelessness.

5 THE REPORT

Value for Money

5.1 The Housing Options Team, within Housing Services, is the Council's frontline service for people at risk of homelessness and for those who are already homeless. The team provides specialist advice and assistance and has access to a number of practical options and resources to prevent homelessness.

5.2 The CIPFA Value for Money analysis for frontline services (2013/14 data) showed that the unit costs of the Housing Options Team are significantly lower than the average across other unitary authorities and the 15 nearest statistical neighbours. Compared to other West of England authorities Bath and North East Somerset Council has a relatively low unit cost homelessness service. Performance against two indicators was rated as excellent and overall the service was rated as 'Good'.

5.3 In 2014 the Housing Options Team participated in a peer review sponsored by the Department of Communities and Local Government and achieved an overall rating of 73%, well above the baseline threshold of 60%. Housing Services has submitted further information and is currently applying for the National Practitioner Prevention Partnership Gold Standard which demonstrates its commitment to continuous service improvements.

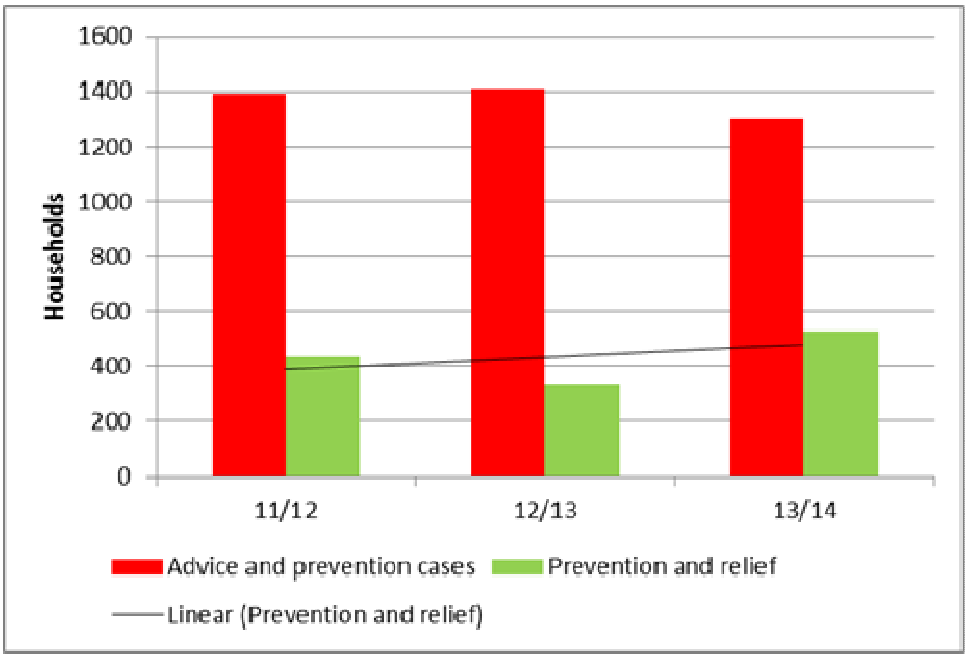
Effective Prevention

5.4 Welfare reforms are bringing significant changes to the cost of renting social housing and to benefit entitlement for under 35 year olds as well as making Housing Benefit recipients responsible for paying rent. These changes correlate with increased risk of homelessness for poorer households. Housing Services has developed a Homelessness Strategy in partnership with local service providers including Curo to prevent homelessness through early interventions.

5.5 The Housing Options Team provides early and expert advice and is a signpost for other services such as debt and family mediation. This type of work has remained relatively consistent over the last three years. However the team also

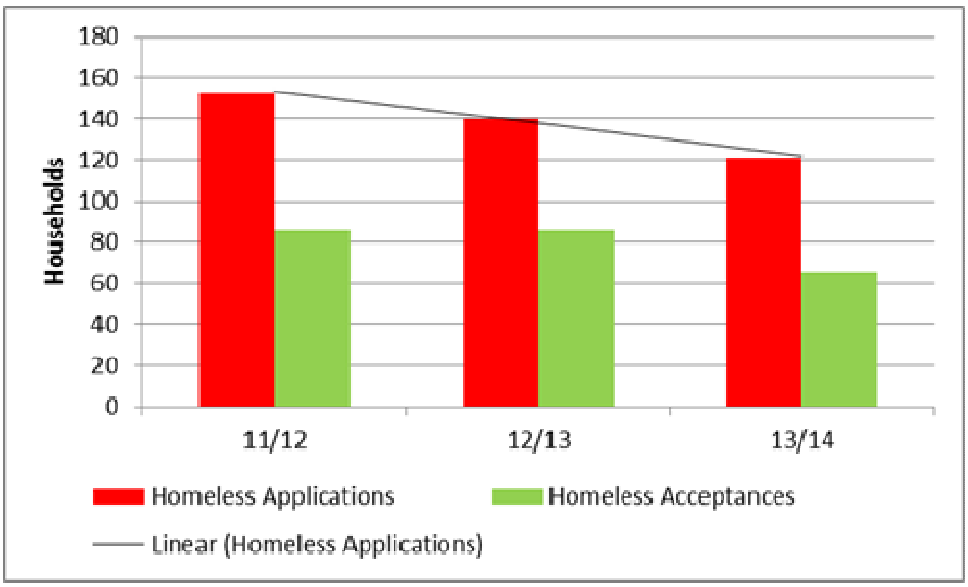
deals with more intensive casework to prevent and relieve homelessness and the number of these cases has gradually increased over the last three years as shown in the chart below.

5.6 Chart 1 Homelessness Preventions



5.7 Effective homelessness prevention and relief casework means that fewer people actually become homeless. The rate of homelessness presentations and acceptance of the statutory accommodation duty has decreased over the last three years as shown in the chart below.

5.8 Chart 2 Homelessness Applications and Acceptances.



5.9 Sometimes homelessness cannot be prevented or people are already rough sleeping (rough sleeping means someone has been unable to use or have access to accommodation for at least one night).

5.10 The most common causes of homelessness during 2013/14 in Bath and North East Somerset were loss of private rented accommodation, parents no longer willing or able to accommodate and having to leave home because of relationship breakdown.

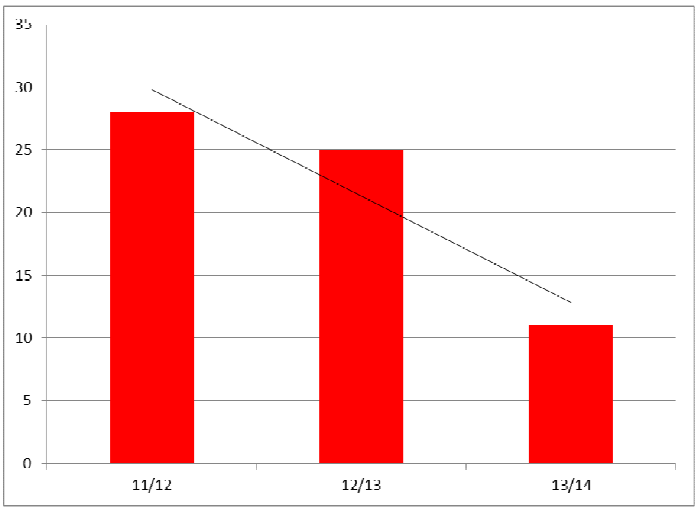
5.11 Housing Services assess the level of statutory homeless service to be provided and decide if it is appropriate to secure accommodation for those with a priority need and a local connection or to provide advice and assistance to those without or who are intentionally homeless.

5.12 People have a priority need if they have children, are aged 16 or 17 or have a disability or illness that makes them particularly vulnerable. Being homeless with a priority need triggers a requirement for the authority to provide temporary accommodation pending enquiries.

Temporary Accommodation

5.13 The current preventing homelessness strategy has been highly effective in reducing the use of temporary accommodation (TA) in Bath and North East Somerset as shown in the chart below. TA is commissioned from Curo Choices who provide 24 self-contained units in Bath and dispersed accommodation in the district as needed, Bed and Breakfast is only used in emergency situations.

5.14 Chart 3 Households in Temporary Accommodation (number per night)



5.15 Households provided with TA usually have priority on the housing register, Homesearch, and move into social housing tenancies. They are also provided with support to access private rented tenancies or supported or shared housing if this is a more suitable option for them.

Early Interventions

5.16 The Council's Advice & Information Strategy 2014-2017 identifies housing and homelessness as a priority and the Council commissions accommodation based and floating support services to prevent homelessness and support homeless people via the Supporting People & Communities programme.

5.17 The Council's private rented sector access scheme, Homefinder, is delivered by Housing Services in partnership with voluntary and community

sector organisations such as the Bristol Credit Union, Bath & District Citizens Advice Bureau and Swan Housing Advice. The Bristol Credit Union is commissioned to provide and maintain repayable loans for rent in advance, deposit and any agency fee to facilitate access to private rented tenancies. In 2012/13, Homefinder prevented homelessness for 78 households who were enabled to choose and rent a private sector home. Since April 2014, a further 57 households have gone on to use the service successfully.

Rough Sleeping

5.18 Bath and North East Somerset Council and other local partners provide services, including health, welfare, housing and employment services to help rough sleepers make a transition into safer and healthier lives. The housing related services include:

- Provision of 29 units of modern high quality accommodation with on-site medical provision. (20 direct access & 9 move-on units in self-contained, supported housing where residents develop skills and confidence to live independently.)

- Reach Floating Support Service – provides individual rough sleepers with assertive help & support

- All day drop in centre –providing help, advice & assistance, hot meals, meaningful activities services etc.

- Supported Housing Gateway – web-based single access point for supported housing schemes.

- Priority on Homesearch Scheme for people in supported housing, and in some cases rough sleepers.

- Homefinder scheme - provide homeless people with funding for advance rent and deposit to access private housing. as well as people actually rough sleeping

- A Task & Targeting multi-agency group that shares information on and identifies solutions for named, entrenched rough sleepers.

- A Strategic Homelessness Partnership of local providers, commissioners and other interested parties to consider services and plan resources.

5.19 The number of rough sleepers in the area is estimated every autumn in accordance with best practice. In 2014 it was estimated that there were 27 people sleeping rough on a single night in Bath and North East Somerset (one in three did not have a local connection with the area). The previous year the estimate was 33 and in 2012 the estimate was 22 so the position has remained relatively similar over the last three years.

5.20 Julian House provides the direct access hostel in Bath. It is usually fully occupied and the move-on provision rarely has a void bed for more than one or two nights.

5.21 The hostel is one of only six direct access hostels in the region; the others are located in Bristol, Yeovil, Taunton, Bournemouth and Winchester and it attracts rough sleepers from the surrounding areas.

5.22 Newly-arrived rough sleepers without any local connection are reconnected to their home area wherever it is safe and reasonable. This ensures that accommodation available in their home town is not lost and that vital support services continue. Rough sleepers can decline a reconnection which ends their entitlement to local services and can mean they continue to rough sleep.

New Initiatives

5.23 No Second Night Out was a Government initiative to assist rough sleepers to access accommodation and support by part funding voluntary agencies to deliver an outreach service. This funding ended on 31st December 2014 but alternative funding has already been secured and the service will continue to be provided.

5.24 Bath and North East Somerset Council have successfully bid for money from a Help for Single Homeless fund with North Somerset Council and Bristol City Council to provide a "rapid response and outreach" service to identify and assist rough sleepers. The funding is £239K between the three authorities and runs until April 2016.

6 RATIONALE

6.1 N/A

7 OTHER OPTIONS CONSIDERED

7.1 None

8 CONSULTATION

8.1 The report aims to provide a briefing only and does not make recommendations for changes to provision service delivery or policy. A full stakeholder consultation on the report has therefore not been undertaken.

9 RISK MANAGEMENT

9.1 N/A

Contact person	Ann Robins 01225 396288 Mike Chedzoy – 01225 477940
Background papers	none
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council		
MEETING:	Wellbeing Policy Development and Scrutiny Panel	
MEETING DATE:	16th January 2015	**AGENDA ITEM NUMBER**
TITLE:	Impact Assessment on Transfer of Endoscopy Services from Royal National Hospital for Rheumatic Diseases (RNHRD) to Royal United Hospitals Bath Foundation Trust (RUH)	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
Attachments to this report: Appendix 1: Equality Impact Assessment Appendix 2 : Quality and Privacy Impact Assessment		

1 THE ISSUE

1.1 To update Wellbeing Policy Development and Scrutiny panel members on the outcome of the equality, quality and privacy impact assessments completed relating to the proposed transfer of endoscopy services from the Royal National Hospital for Rheumatic Diseases (RNHRD).

1.2 Panel members received a briefing in November 2014 setting out the rationale for the proposed transfer of endoscopy services on 1st February 2015 when the acquisition of the RNHRD by the RUH will be completed.

2 RECOMMENDATION

2.1 Panel members are asked to note the outcome of the various impact assessments which confirm that the effects of this change are considered to be minimal and that there are a number of positive aspects to the service change. It is therefore recommended that the transfer of the endoscopy services should now proceed.

3 FINANCIAL IMPLICATIONS

3.1 None to note as part of this briefing paper.

4 THE REPORT

4.1 The RNHRD endoscopy service is a relatively small service consisting of 1 Consultant and 3 part-time nursing staff. In 2013/14 658

patients were treated but referrals have been falling on an annual basis and the forecast out-turn for 2014/15 are much lower patient numbers. Following the acquisition of the RNHRD by the RUH on the 1st February 2015 there are 3 main reasons to support the proposed transfer of the endoscopy service to the RNHRD:-

i) The need to maintain Joint Advisory Group on Gastrointestinal Endoscopy accreditation for the RUH endoscopy service which otherwise will be affected as the RNHRD's service is currently not accredited and it would take some time to complete accreditation requirements.
ii) The new arrangements will help improve Clinical pathways and service resilience with faster onward referral to other specialities, greater choice of appointment times.
iii) The RUH service has access to training and development opportunities which RNHRD staff will be able to take advantage of.

4.2 The CCG in conjunction with the RNHRD has engaged with GPs and patients to seek their views on the proposed transfer and has completed various assessments to review the impact of the proposed transfer.

4.3 All existing 289 patients who currently attend the service for annual or bi-annual endoscopy appointments were written to during December to seek their views. 73 patients responded.

4.4. A summary of responses and findings are included in the attached Equality Impact Assessment. Overall the comments were in the majority positive.

4.5 Patients were also invited to provide some free- text comments on the proposal. A range of comments were received, the main area of concern related to car parking at the RUH. A selection of comments included the following:-

I have always had excellent treatment at the RNHRD from the consultants and nurses etc, and I am very grateful for that. I hope the move to RUH gives the same good service. The only downside to coming to the RNHRD is the parking, although parking at the RUH is not much better, but they have a larger parking area. Good luck with the changeover - hope it goes well.

The service was very good at the RNHRD. If this is maintained at the RUH with the same excellent staff then I can understand the merging of services. This being both from an economy of scale perspective and also the ability to offer a 7 day week, 24 hour a day service to an ever growing population.

I think the proposal is sound but obviously will be less personal and intimate than that provided by the RNHRD. The service has been excellent - why change?

It is a pity in your rationale that you failed to mention 'savings' because we all know that is the main motivation.

I do not mind where I have to go to have my endoscopy as long as the service is as good as I have always received. I have always been treated with the utmost kindness and consideration for what is not a very pleasant thing to experience, as I am very nervous; you all put me at ease.

5 RISK MANAGEMENT

5.1 Risk management processes and systems remain in place as part of routine and standard governance arrangements to monitor the effectiveness of Endoscopy services.

6 EQUALITIES

6.1 The attached equality impact assessment has been completed by the CCG's commissioning team.

7 CONSULTATION

7.1 This paper has been prepared in consultation with the RNHRD.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Not applicable to this report.

9 ADVICE SOUGHT

9.1 Not applicable to this report.

Contact person	*Tracey Cox, Chief Officer B&NES Clinical Commissioning Group. Telephone 01225 831736* *Email : tracey.cox@nhs.net*
Background papers	RNHRD Update Paper to Well-being & Policy Development Panel *in November 2014*
Please contact the report author if you need to access this report in an alternative format	

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Appendix 1

NHS
Bath and
North East Somerset

Combined Tool:
Equality Impact Assessment / Equality Analysis

Please refer to the combined guidance document for any assistance in completing this

Title of service or policy	Endoscopy Service
Name of directorate and service	Royal National Hospital for Rheumatic Disease NHS Foundation Trust (RNHRD)
Name and role of officers completing the Impact Assessments	Amanda Pacey Head of Nursing and Operational General Manager (RNHRD) Dawn Clarke- Director of Nursing and Quality BaNES CCG
Date of assessment	December 2014

Equality Impact Assessment
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 NHS Bath and North East Somerset CCG's website.

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 greatest majority of patients served by the RNHRD come from Wiltshire, BANES and Somerset CCG's. In 2013 – 4 this number totalled 658, 44% of these patients are regular surveillance attenders. 289 number of patients attend the Endoscopy service at the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RNHRD) as part of an annual or bi annual surveillance programme As a result of significant and longstanding financial challenges the RNHRD cannot continue in its current form and needs to become part of a larger organisation. The RNHRD Trust Board has outlined a strategic intent to be acquired by the Royal United Hospitals Bath NHS Foundation Trust (RUH). The RNHRD Board agree that this is the best opportunity to ensure the future provision and continuity of the RNHRD's high quality patient services. The RNHRD is proposing to transfer its Endoscopy service to the Royal United Hospitals Bath NHS Foundation Trust (RUH) as a result of the proposed acquisition, with a view to integrate the two services from 1st February 2015.
1.2	Provide brief details of the scope of the policy or service being reviewed, for example: • Is it a new service/policy or review of an existing one?	This is an existing service within the RNHRD that is to be transferred and absorbed into the existing RUH service on 1st February 2015. This is a local requirement driven by 3 issues: JAG accreditation, clinical

	• Is it a national requirement?). • How much room for review is there?	pathways and service resilience and training and development of staff.
1.3	Do the aims of this policy link to or conflict with any other policies of the CCG?	Links to CCG Five Tear Plan. Patients can be assured that they will continue to have access to an endoscopy service. The proposed transfer will ensure service continuity and that patients will benefit from the added assurance of externally accredited standards of care. (Joint Advisory Group (JAG) Accreditation https://www.rcplondon.ac.uk/projects/JAG

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?	We assess the RNHRD E & D work force statistics annually, no issues have been identified for 2013-14 , this is available on the

<table>
<tr><td></td><td></td><td>RNHRD website. Due the service only contracting 4 employees, to release the information for the service would be identifiable.</td></tr>
<tr><td>2.2</td><td>What equalities training have staff received?</td><td>Equality and diversity training every three years.</td></tr>
<tr><td>2.3</td><td>What is the equalities profile of service users?</td><td>The population age and sex profile in B&NES remains largely consistent compared with previous years, with a 49%/51% male/female split. The age profile is largely consistent with the UK as a whole, except for the 20-24 age bracket which accounts for 10% of the population as opposed to 7% seen nationally. A larger proportion of people are in this age bracket range are as a result of the student population at two universities in BaNES.[1] The 2011 census showed our population to be 90% White British, with the next two largest groups being 3.8% (approx 6,600) Other White, and 2.6% (approx 4,500) Asian or Asian British descent. Bath and North East Somerset is less ethnically diverse than the UK as a whole but more so than the South West.

<table>
<tr><th>Ethnic Group</th><th>Patients</th><th>(%)</th></tr>
<tr><td>Any other Asian background</td><td>1</td><td>0.4</td></tr>
<tr><td>Any other white background</td><td>6</td><td>2.1</td></tr>
<tr><td>British</td><td>267</td><td>95.0</td></tr>
<tr><td>Not Given</td><td>1</td><td>0.4</td></tr>
<tr><td>Irish</td><td>4</td><td>1.4</td></tr>
<tr><td>Pakistani</td><td>1</td><td>0.4</td></tr>
<tr><td>Unknown</td><td>1</td><td>0.4</td></tr>
<tr><td>Grand Total</td><td>281</td><td>100.0</td></tr>
</table>

<table>
<tr><th>Sex</th><th>Patients</th><th>(%)</th></tr>
<tr><td>Female</td><td>85</td><td>30.2</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td></td><td>
<table>
<tr><td>Male</td><td>196</td><td>69.8</td></tr>
<tr><td>Grand Total</td><td>281</td><td>100.0</td></tr>
</table>
<table>
<tr><th>Age Group</th><th>Patients</th><th>(%)</th></tr>
<tr><td>30 to 39</td><td>6</td><td>2.1</td></tr>
<tr><td>40 to 49</td><td>16</td><td>5.7</td></tr>
<tr><td>50 to 59</td><td>63</td><td>22.4</td></tr>
<tr><td>60 to 64</td><td>45</td><td>16.0</td></tr>
<tr><td>65 and Over</td><td>151</td><td>53.7</td></tr>
<tr><td>Grand Total</td><td>281</td><td>100.0</td></tr>
</table>
</td></tr>
<tr><td>2.4</td><td>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?</td><td>There are no concerns about the quality of care provide by the RNHRD Endoscopy service, the unit continues to report high levels of patient satisfaction, short waiting times and a good patient safety record.

Service user views have been sought via a patient questionnaire on the proposed transfer to which 73 patients replied.</td></tr>
<tr><td>2.5</td><td>What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?</td><td>Stake holders consulted with are the patients and the GP’s.

Communicated at GP Forum on 22/10/14. 63 GP attendees at this meeting with no objections raised.

289 existing surveillance patients and their GPs were written to and asked to complete a questionnaire. 73 patients and 2 GPs responded.

The summary of results is included at the end of this report. Overall the feedback has been positive. The main area of concern relates to car parking on the RUH site.</td></tr>
</table>

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?	N/A as service will transfer to the RUH

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.	Gender- The Endoscopy service is delivered in a way that ensures equal access and is appropriate to the needs of the particular group of patients requiring this service, rather than one size fits all	The service will be universally applied to all B&NES residents and it is not expected to have an impact relating to gender
3.2	**Pregnancy and maternity**		The service will be universally applied to all B&NES residents and it is not expected to have an impact relating to .pregnancy and maternity

3.3	**Transgender –** – identify the impact/potential impact of the policy on transgender people		The service will be universally applied to all B&NES residents and it is not expected to have an impact relating to transgender.
3.4	**Disability** - identify the impact/potential impact of the policy on disabled people (ensure consideration both physical and mental impairments)	Disability There is access to RNHRD and RUH for disabled people.	The plan will be universally applied to all B&NES residents and it is not expected to have an adverse impact relating to disability
3.5	**Age** – identify the impact/potential impact of the policy on different age groups	RUH have a wider range of patients' services available for children. The RNHRD does not perform endoscopies for children. The RUH have paediatric skilled clinicians.	The service will be universally applied to all B&NES residents and it is not expected to have an adverse impact relating to age.
3.6	**Race** – identify the impact/potential impact on different black and minority ethnic groups	The Endoscopy service is delivered in a way that ensures equal access and is appropriate to the needs of the particular group of patients requiring this service, rather than one size fits all.	The service will be universally applied to all B&NES residents and it is not expected to have an adverse impact relating to .race
3.6	**Sexual orientation -** identify the impact/potential impact of the policy on lesbians, gay, bisexual & heterosexual people	The Endoscopy service is delivered in a way that ensures equal access and is appropriate to the needs of the particular group of patients requiring this service, rather than one size fits all.	The service will be universally applied to all B&NES residents and it is not expected to have an impact relating to sexual orientation
3.7	**Marriage and civil partnership –** does the policy/strategy treat married and civil partnered people equally?	The Endoscopy service is delivered in a way that ensures equal access and is appropriate to the needs of the particular group of patients requiring this service, rather than one size fits all.	The service will be universally applied to all B&NES residents and it is not expected to have an impact relating to . marriage and civil partnership
3.8	**Religion/belief** – identify the impact/potential	The Endoscopy service is delivered	The service will be universally

	impact of the policy on people of different religious/faith groups and also upon those with no religion.	in a way that ensures equal access and is appropriate to the needs of the particular group of patients requiring this service, rather than one size fits all.	applied to all B&NES residents and it is not expected to have an impact relating to .religion/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	The Endoscopy service is delivered in a way that ensures equal access and is appropriate to the needs of the particular group of patients requiring this service, rather than one size fits all.	The service will be universally applied to all B&NES residents and it is not expected to have an impact relating to the Socio-economically disadvantaged.
3.10	**Rural communities** – identify the impact / potential impact on people living in rural communities	RUH has parking, the RNHRD does not have this facility, but people can park in the public parking facilities. There are public services and bus stops that run to and stops within the RUH.	The service is not expected to have an impact on access to travel arrangements. Parking may be a factor.

Title	**Questionnaire for Feedback on Proposed Changes to the RNHRD Endoscopy Services**
Date	**05.01.2015**

Number of patients sent questionnaire	289
Number of GPs sent questionnaire	54 surgeries with existing patients 21 surgeries with patient on referral/ waiting list
Total number of respondents to 06.01.2015	75
Number of patient responses received	73
Number of GP responses received	2

Patient Equality Data:

Age	Gender	Sexuality	Disability	Type Disability	Religion	Language	Ethnic Group
50-59 = 4 60-69 = 18 70-79 = 19 80-89 = 6 Not stated = 26	Female = 17 Male = 42 Not stated =14	Bisexual = 3 Hetrosexual = 56 Not stated = 14	Yes = 7 No or Not stated = 66	4 physical 3 sensory	Christianity = 45 None = 12 Not stated = 17	English = 57 N/A = 10 Not stated = 6	White British = 58 White Other = 1 Not stated = 14

Trend analysis regarding patients' views of proposed changes:

Trend in comments:	Positive	Negative	Neutral
Opinion based on experiences of RNHRD	27	0	0
Opinion based on experiences of RUH	5	3	0
Opinion based on reputation of RUH	2	10	1
Opinion based on change of location/ parking	5	4	5
Difference in size of RUH/ RNHRD	3	6	0

Trend analysis regarding GPs' views of proposed changes:

Trend in comments:	Positive	Negative	Neutral
Opinion based on experiences of RNHRD	1	0	0
Opinion based on experiences of RUH	0	0	0
Opinion based on reputation of RUH	0	0	0
Opinion based on change of location/ parking	0	1	0
Difference in size of RUH/ RNHRD	1	0	0

NHS
Bath and North East Somerset
Clinical Commissioning Group

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Bath and North East Somerset Clinical Commissioning Group

Combined Tool:
Quality Impact Assessment Tool
Privacy Impact Assessment Tool

Please refer to the combined guidance document for any assistance in completing this

Title of service or policy	Endoscopy Service
Name of directorate and service	Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RNHRD)
Name and role of officers completing the Impact Assessments	Amanda Pacey- Head of Nursing and Operational General Manager (RNHRD) Dawn Clarke- Director of Nursing and Quality- BaNES CCG
Date of assessment	December 2014

The Quality Impact Assessment Tool
This involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Privacy Impact Assessment
Privacy impact assessments (PIAs) are a tool that you can use to identify and reduce the privacy risks of your projects. A PIA can reduce the risks of harm to individuals through the misuse of their personal information. It can also help you to design more efficient and effective processes for handling personal data

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	289 number of patients attend the Endoscopy service at the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RNHRD) as part of an annual or bi annual surveillance programme As a result of significant and longstanding financial challenges the RNHRD cannot continue in its current form and needs to become part of a larger organisation. The RNHRD Trust Board has outlined a strategic intent to be acquired by the Royal United Hospitals Bath NHS Foundation Trust (RUH). The RNHRD Board agree that this is the best opportunity to ensure the future provision and continuity of the RNHRD's high quality patient services. The RNHRD is proposing to transfer its Endoscopy service to the Royal United Hospitals Bath NHS Foundation Trust (RUH) as a result of the proposed acquisition, with a view to integrate the two services from 1st February 2015.
1.2	Provide brief details of the scope of the policy or service being reviewed, for example: • Is it a new service/policy or review of an existing one? • Is it a national requirement?). • How much room for review is there?	This is an existing service within the RNHRD that is to be transferred and absorbed into the existing RUH in February 2015
1.3	Do the aims of this policy link to or conflict with any other policies of the CCG?	**Links to CCG Five Year Plan.** Patients can be assured that they will continue to have access to an endoscopy service. The proposed transfer will ensure service continuity and that patients will benefit from the added

		assurance of externally accredited standards of care. (Joint Advisory Group (JAG) Accreditation https://www.rcplondon.ac.uk/projects/JAG

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	**1**	MINOR
2	UNLIKELY	**2**	MODERATE / LOW
3	MODERATE / POSSIBLE	**3**	SERIOUS
4	LIKELY	**4**	MAJOR
5	ALMOST CERTAIN	**5**	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found at appendix 1.

LIKELIHOOD	IMPACT 1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 6 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Answer positive/negative (P/N) in each area. If N score the impact, likelihood and total in the appropriate box. If score > 8 insert Y for full assessment

Area of Quality	Impact question	P/N	Impact	Likeli-hood	Score	Full Assessment required
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	P	*4*	5	20	No as impact considered positive
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	P	4	5	20	No as impact considered positive
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to	P	4	5	20	No as impact

Area of Quality	Impact question	P/N	Impact	Likeli-hood	Score	Full Assessment required
	prevent harm, including infections?					considered positive
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	P	4	5	20	No as impact considered positive
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	P	3	3	9	No
Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	P	4	5	20	No as impact considered positive
Vacancy impact	Could the proposal impact positively or negatively as a result of staffing posts lost?	P	3	3	9	No as impact considered positive
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing	P	3	3	9	No as impact considered positive

Please describe your rationale for any positive impacts here:
The RUH has an accredited endoscopy service. The staff working within the current RNHRD service will be TUPED across to the RUH so there will be some continuity for patients. The impact of the change to patient care is deemed to be minimal with different travel and car parking arrangements the biggest impact

Privacy Impact Assessment screening questions

These questions are intended to help you decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise. You can expand on your answers as the project develops if you need to.

PIA Screening Questions	Yes	No
Will the project involve the collection of new information about individuals?	Yes	
Will the project compel individuals to provide information about themselves?	Yes	
Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	Yes	
Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		No
Does the project involve you using new technology that might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.		No
Will the project result in you making decisions or taking action against individuals in ways that can have a significant impact on them?		No
Is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For example, health records, criminal records or other information that people would consider to be private.	Yes	
Will the project require you to contact individuals in ways that they may find intrusive?	Yes	

If you have answered yes to any of the questions above please complete the following template, you may find it helpful to refer to the guidance document which sets out the data protection principles

Summarise why the need for a PIA was identified (from screening questions above)	The RNHRD service is to move to the RUH. This will mean that personal information previously only held by the RNHRD will need to be shared with the RUH.
Describe the information flows:	289 patients will be affected. The IT systems are not integrated at

<table>
<tr><td>You should describe the collection, use and deletion of personal data here and it may also be useful to refer to a flow diagram or another way of explaining data flows. You should also say how many individuals are likely to be affected by the project</td><td>present between the RNHRD and the RUH. It is being explored if there can be process to transfer record by IT.If not, it will be completed manually. The patients who are currently RHNRD patients will have the notes photocopied and transferred to the RUH. The patient's transferring who do not access other services at the RNHRD can be transferred. A checklist back up system will be in place to identify any gaps.</td></tr>
<tr><td>Consultation requirements:
Explain what practical steps you will take to ensure that you identify and address privacy risks. Who should be consulted internally and externally? How will you carry out the consultation? You should link this to the relevant stages of your project management process.

You can use consultation at any stage of the PIA process</td><td>All patients have been written to personally about the change and have had an opportunity to respond. The patients GPS have also been advised of the proposed change</td></tr>
<tr><td>Identify the privacy and related risks:
Identify the key privacy risks and the associated compliance and corporate risks. Larger-scale PIAs might record this information on a more formal risk register.</td><td><table><tr><th>Privacy issue</th><th>Risk to individuals</th><th>Compliance risk</th><th>Associated organisation / corporate risk</th></tr><tr><td>None</td><td>None</td><td>JAG accreditation if transfer of endoscopy services does not occur</td><td>None</td></tr></table></td></tr>
</table>

<table>
<tr><td>Identify privacy solutions:
Describe the actions you could take to reduce the risks, and any future steps which would be necessary (eg the production of new guidance or future security testing for systems).</td><td><table>
<tr><th>Risk</th><th>Solution(s)</th><th>Result: is the risk eliminated, reduced, or accepted?</th><th>Evaluation: is the final impact on individuals after implementing each solution a justified, compliant and proportionate response to the aims of the project?</th></tr>
<tr><td></td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Sign off and record the PIA outcomes:
Who has approved the privacy risks involved in the project? What solutions need to be implemented?</td><td><table>
<tr><th>Risk</th><th>Approved solution</th><th>Approved by</th></tr>
<tr><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Integrate the PIA outcomes back into the project plan:
Who is responsible for integrating the PIA outcomes back into the project plan and updating any project management paperwork? Who is responsible for implementing the solutions that have been approved? Who is the contact for any privacy concerns that may arise in the future?</td><td></td></tr>
</table>

Quality Impact Assessment and Privacy Impact assessment Improvement Plan

Please list actions that you plan to take as a result of this combined assessment. 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
No issues have as yet been identified				

Sign off and publishing
Once you have completed this form, it needs to be 'approved' by your Lead Director or their nominated officer. Keep a copy for your own records.

Signed off by: Dawn Clarke, Director of Nursing and Quality- BaNES CCG (Executive Director or nominated senior officer)

Date: 5th Jan 2015

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Bath & North East Somerset Council		
MEETING	**Wellbeing Policy Development & Scrutiny Panel**	
MEETING DATE	**16th January 2015**	
TITLE:	**Update on Health and Wellbeing Board priority: "Increase the resilience of people and communities including action on loneliness"**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix One: Further information on local projects.		

1 THE ISSUE

1.1 This reports updates the Panel on work being undertaken to deliver the Health and Wellbeing Board's priority to increase the resilience of people and communities, including action on loneliness

2 RECOMMENDATION

2.1 That the Panel note the work being undertaken by the Board in delivering this priority

2.2 That the Panel identify any specific opportunities for promoting this priority through partnership working and engaging with local communities

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 None arising from this report. There is the potential for agencies to work more closely together to align commissioning budgets to deliver outcomes relating to this issue.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 Relevant considerations include equalities, human rights and public health. The reports aims to deliver the Joint Health and Wellbeing Strategy which is a statutory document.

5 THE REPORT

5.1 Bath and North East Somerset's Health and Wellbeing Strategy sets out the Board's priority to "increase the resilience of people and communities including action on loneliness". This reflects national research which suggests that loneliness can have significant impacts on key health and care outcomes. In addition, demographic and social changes which can contribute to loneliness – such as people living further away from relatives than previously- will place increasing pressure on informal care. The IPPR estimates that by 2030 there will be more than 2 million people aged over 65 with no child living nearby to give care if needed. It is estimated that there will be an additional 3000 residents aged over 75 living in our area by 2021,

5.2 There are many strengths locally in relation to this theme. These include:

- Our locally-commissioned services such as Active Ageing and the Independent Living Service
- The work of voluntary and community organisations such as Age Concern, which supports befriending schemes and a wide range of projects which aim to address the needs of older people
- Our Village Agents scheme, which operates in 20 parishes
- A wide range of local community initiatives including
    - The Hub in a Pub at Chew Stoke, providing services and support to older people living in the Chew Valley. Hub in the Pub is a joint initiative between The Stoke Inn, Age UK B&NES, Bath & North East Somerset Council, and City of Bath College Community Learning Team. Amongst the many activities taking place at the Hub is the "Gadget Busters" IT scheme
    - Keynsham Older People's Group, a monthly group of older people which meets at Community@67, now in its 3rd year.
    - The Food for Life Project which sees older volunteers passing on practical growing and cooking skills to pupils at Chew Valley School. The project will support intergenerational activities in the school

5.3 Appendix One contains further information on a number of relevant local schemes and projects. The Campaign to End Loneliness has awarded Bath & North East Somerset its "Gold" standard for our Joint Health and Wellbeing Strategy, one of only 11 in the country. A key initial focus of this priority has therefore been on sharing information, understanding current provision better, identifying gaps and securing better co-ordination.

5.4 The Health and Wellbeing Board received a report on this priority at its July meeting. The Board noted that the Campaign to End Loneliness have identified specific risk factors for social isolation in older age including bereavement, disability and mobility. In addition, our own Joint Strategic Needs Assessment identifies a number of factors as potentially leading to social isolation which are not related to age.

5.5 The Board also received an update from a Health and Wellbeing Network session on this topic which brought together a wide range of partners and organisations to share their knowledge of the impact of loneliness and isolation on health and to identify factors can contribute to people becoming lonely and isolated. The Board also noted research which concluded that it is important to distinguish between "isolation" and perceptions of "loneliness" and involvement in social networks. The notes of the Health and Wellbeing Network event can be found here.

5.6 The Board also stressed the importance of not seeing loneliness simply as an issue for older people, and in not reinforcing negative perceptions. It also agreed that key Council strategies such as Advice and Information strategy, Transport Strategy and Leisure Strategy were central to delivering this priority. It agreed to establish a working group on this issue comprising representatives from partner agencies and the voluntary and community sector. This group is focusing on sharing information and is exploring practical "on the ground" improvements. "on the ground", including

- Further developing the current "volunteer car" service in rural areas
- Supporting more initiatives which are shaped positively by what local people have said they would like to be involved with. For example, Age Concern are designing new projects which respond to the needs of older men, as they are more likely to experience social isolation and loneliness, and are reluctant to report health issues
- Working with Community Pharmacies as convenient and knowledgeable local points of contact. This winter Age Concern is ensuring local pharmacists receive posters/flyers on its Winter Warmth service and a stock of *Winter Wrapped Up Leaflets*.
- Developing a "first contact form" which would be standard across the area and could be used by all public services

5.7 In addition, the following are expected also to shape how this priority is progressed:

(1) The results of local survey research on perceptions of loneliness which is currently being undertaken. This uses the internationally-recognised "Duke Scale" and will be used to ensure effective targeting of available resources.

(2) The Public Service's Board's "Connecting Communities" programme. The recently established Forums in the Chew Valley, Somer Valley and Keynsham areas provide a basis for engagement at local level with communities on this issue. The Forums involve partners including the Council, Police, CCG and parish councils and are designed to help identify local priorities and shape service delivery to local needs.

6 RATIONALE

6.1 The recommendations are based on the Board's role in delivering its priority as agreed in the Joint Health and Wellbeing Strategy.

7 OTHER OPTIONS CONSIDERED

7.1 None

8 CONSULTATION

8.1 Strategic Director: People and Communities, Section 151 Officer, Monitoring Officer

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	*Andy Thomas, andy_thomas@bathnes.gov.uk 01225 394322*
Background papers	*Report to Health and Wellbeing Board, 16th July 2014*
Please contact the report author if you need to access this report in an alternative format	

Appendix One- Further information on local projects

- **Age UK Bath and North East Somerset** provides a wide range of services to support older people to remain active, healthy and independent. Services include information and advice (including at the Council's one-stop shop), day services and lunch clubs. Each year, Age Concern screen and match 70 volunteer home-visitors with older people living alone, usually without relatives nearby, to combat loneliness and to promote independent living. **Day centres** at Bath, Keynsham and Midsomer Norton, provide fully accessible transport and intensive support to 130 older people each week, especially for people who find it difficult to get out. The **Culture Club** meets monthly with a variety of speakers.

- Our **Village Agents** provide direct help and support to people across 20 parishes in Bath and North East Somerset. The Agents undertake home visits, and signpost key services including support for health, transport, finance, police and fire services as well as social networks. 12 Village Agent "Roadshows" have been held so far held at local village halls and have covered subjects such as "healthy happy feet" and falls prevention. The Norton Malreward Roadshow saw a "myth busting" quiz to publicise the many free services available.

- Sirona **Community Links** facilitates social support groups, including sport, arts and horticulture across Bath & North East Somerset

- Sirona's **Active Ageing Service** visits older people in their homes and provides a support service to those who are aged 80-84 The team aims to enable older people to maintain independence and to promote dignity and quality of life in their own homes by offering health advice. The team consists of Health Visitors and Health Visitor Support Workers who are based in the community.

- Curo's **Independent Living Service** is dedicated to helping older people to live at home, independently, with support for well-being. The service offers security, peace of mind and regular contact, as well as extra help with issues such as arranging repairs, aids and adaptations to individual's homes if needed. There is also the offer of an alarm linked to a 24 hour call centre. Those eligible to receive the ILS are older and vulnerable people who have support needs, and who are unlikely to sustain their independence without support.

- The latest Bath & North East Somerset's **Community Challenge** days saw over 250 volunteers from partner organisations (including 7 local employers) take part in activities designed to bring communities together. These ranged from garden maintenance at St Martin's Hospital to a Quiz Session at the Leonard Cheshire Home in Timsbury.

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Bath & North East Somerset Council		
MEETING/ DECISION MAKER:	**Wellbeing Policy Development & Scrutiny Panel**	
MEETING/ DECISION DATE:	**16 January 2015**	E
TITLE:	**NHS Health Check Programme Update**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Equality Impact Assessment / Equality Analysis		

1 THE ISSUE

1.1 The NHS Health Check programme is a mandatory universal risk assessment and management programme with the aim of reducing heart disease, stroke, diabetes, kidney disease and certain types of dementia. It aims to do this by increasing uptake of primary prevention interventions including weight management, smoking cessation, physical activity, statins, anti-hypertensives, and improved management of impaired glucose intolerance. This report aims to update the Wellbeing PDS Panel on the progress of delivery of the NHS Health Check programme 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 Local authorities now have a legal duty to make arrangements:

- for each eligible person aged 40-74 to be offered a NHS Health Check once in every five years and for each person to be recalled every five years if they remain eligible
- for the risk assessment to include specific tests and measurements
- to ensure the person having their health check is told their cardiovascular risk score, and other results are communicated to them

- for specific information (such as BMI, blood pressure etc.) and data to be recorded and, where the risk assessment is conducted outside the person's GP practice, for that information to be forwarded to the person's GP

3.2 In B&NES the programme is commissioned by the Public Health team and delivered through all 27 GP surgeries locally. Programme delivery is overseen by a Steering Group with representation from a GP (retired), practice managers and the public health team.

3.3 The NHS Health Check programme is funded from the Public Health Grant which is currently ring-fenced until 2016. From April 2014 GP surgeries in B&NES are paid £21.50 or £23 (when using point of care testing for cholesterol) for every health check completed. This price is in line with national guidance and is similar to other local authorities in the South West. The Public Health contract with local GP surgeries to deliver NHS Health Checks runs from April 2014 – March 2017.

3.4 Cost to deliver the programme during 13/14 was £141,185, against a budget of £199,974, to achieve performance where 51.1% of those invited for a Health Check received one.

3.5 Economic modelling suggests that the NHS Health Check programme is clinically and cost effective[1]. However, this assumes an uptake of 75% therefore the Public Health England aspiration is for all the eligible population to have been offered a health check by 2017 and for the take up to be 75% by 2017. Local authorities are required to seek continuous improvement in the percentage of the eligible population receiving their Health Check in order to improve reach, impact and address inequalities.

3.6 The cost of the programme will rise year on year if improvements in take up are realised. Provision has been made in the ring fenced public health budget for a 5% increase in take up year on year until March 2016. Targeted approaches to increasing take up are being trialled during 14/15 and the costs of these approaches will be assessed in relation to their impact on performance.

3.7 The budget for 2014/15 is £200k, which includes the cost of the targeted approach. This will increase to £211k in 2015/16.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 The Public Health department is responsible for monitoring and reporting on indicators relating to the NHS Health Check which are contained within the Public Health Outcomes Framework. The actions outlined in this report support progress towards these outcomes.

5 THE REPORT

5.1 The NHS Health Check programme is a population wide, primary prevention programme using a systematic approach to identify asymptomatic people aged between 40 – 74 years of age who are then offered a range of tests of risk factors in order to estimate their risk of Cardiovascular Disease (CVD) and deliver interventions to prevent disease occurring. Face to face consultations

[1] Department of Health (2008), *Economic Modelling for Vascular Checks: A technical consultation on the work undertaken to establish the clinical and cost effectiveness evidence base for the Department of Health's policy of vascular checks*, London: Department of Health, available from: http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/department_of_health_publications/

include measurements of blood pressure, cholesterol, body mass index (BMI) and where necessary diabetes and kidney disease. Information is recorded on family history of CVD, ethnicity, smoking, alcohol consumption and physical activity. The results of these investigations are used to estimate CVD risk over the next 10 years. All individuals are offered lifestyle advice and those identified as high risk of CVD will be offered specific interventions to reduce or manage this risk. A risk assessment for dementia awareness is also included for everyone aged 65 – 74. The risk factors for developing vascular dementia (which accounts for 20 – 30% of all dementias) are the same as those for CVD.

5.2 The cardiovascular (CVD) family of diseases includes heart attack, stroke and peripheral vascular disease. These diseases share a common set of risk factors including poor diet, smoking, lack of exercise, being overweight, high blood pressure and high cholesterol. Chronic Kidney disease and diabetes are also included within the CVD family as they have similar risk factors and also increase your risk of cardiovascular disease.

5.3 Circulatory diseases, which include heart disease and strokes, were the second most common cause of death in England and Wales accounting for 28% of all deaths during 2012. In terms of premature deaths – those under 75 years of age – circulatory disease accounts for a quarter of all premature deaths in England. Nationally, more than twice as many people from the poorest backgrounds die of circulatory disease than those from the most affluent backgrounds.

5.4 There were 1,576 deaths from circulatory disease (e.g heart disease and stroke) in Bath and North East Somerset between 2008 and 2010, making these the leading cause of death locally, ahead of cancers (1,341), respiratory diseases (conditions affecting the lungs, 575) and digestive diseases (bowels, liver, kidney, stomach, 268). In terms of years of life lost under the age of 75, ischaemic heart disease is the leading cause of premature death in B&NES.

5.5 Who is eligible for a NHS Health Check?

The NHS Health Check is offered to eligible people aged 40 – 74, once every five years. The health check is not appropriate for people who have already been diagnosed with the following:

- Coronary Heart Disease
- Stroke/Transient Ischaemic Attack (TIA)
- Diabetes
- Chronic Kidney Disease
- Hypertension
- Atrial Fibrillation
- Hypercholesterolaemia
- Heart failure
- Peripheral Arterial Disease (PAD)

Also if someone is taking statins then they are not eligible for the Health Check. The above represents between 26 -30% of 40- 74yr olds in B&NES.

6 RATIONALE

6.1 The total population of Bath and North East Somerset is approximately 180,000 and of these approximately 81,000 are in the 40 – 74 age group. The nationally estimated population for NHS Health checks minus those who are ineligible in B&NES is 51,621[2]. Those eligible are offered a Health Check once every 5 years, so around 10,400 people will be eligible and invited for their check every year. However as B&NES has a relatively healthy population, with less people living with long term conditions on disease registers, our eligible population is slightly higher than national estimates and results in approximately 12,000 people being invited every year.

6.2 National estimates of the impact of the programme predict the following reduction in morbidity and mortality annually:

- 1,600 heart attacks and strokes prevented,
- 650 premature deaths prevented,
- 4000 new cases of diabetes prevented and
- 20,000 cases of chronic kidney disease and diabetes detected earlier.

6.3 The local estimated impact[3] for each of the first five years of the programme in B&NES at 55% take-up is:

- 342 additional people will complete weight loss programme
- 198 additional people will be taking statins
- 88 additional people will be compliant with an Impaired Glucose Regulation lifestyle
- 48 additional people will be diagnosed with diabetes
- 147 additional people with be taking anti-hypertensive drugs
- 122 additional people will be diagnosed with chronic kidney disease
- 88 additional people will increase physical activity
- 6 additional people will quit smoking[4]

6.4 We are currently working with our GP surgeries to support them to provide data on the outcomes of the NHS Health Check for 14/15. This information will help us to more accurately assess the impact of the programme in terms of identifying people at risk of cardiovascular disease and take up of risk reduction interventions and programmes (including medication and lifestyle services).

6.5 Between July 2011 and September 2014, 44,578 people in Bath and North East Somerset were offered a NHS Health Check and 20,080 received a Check. During 13/14 the take up of NHS Health Checks in B&NES was 51.1%, an improvement on 12/13 take up of 45.6% and above the national average of 48%.

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[2] The eligible population is defined as all adults in England, aged 40-74, who are not currently being treated or monitored for a cardiovascular condition, such as heart disease or diabetes, between 2013 and 2018. For the majority of areas the eligible population for each area is based on mid-year population estimates for the latest year minus a 30% adjustment.

[3] NHS Health Check Ready Reckoner http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources_and_training_development_tools/ready_reckoner_tools/

[4] The low number of people quitting smoking is due to the low compliance rate with smoking cessation interventions (5%).

6.6 From April 1st 2013 Public Health England has required local authorities to submit quarterly data on the number of people offered a NHS Health Check and the number of people who received a NHS Health Check. This information is published on the PHE Healthier Lives website: http://healthierlives.phe.org.uk/topic/nhs-health-check

6.7 Performance is represented as five year cumulative data from April 2013 – March 2018. B&NES performance ranks above national average for percentage of the eligible population offered a health check and percentage of the eligible population receiving a health check. Take up to date (April 2013 – Sep 2014) is currently 45.6% which is below national average (47.7%) however year end data is a more accurate reflection of overall performance so this mid-year data should be interpreted with caution until the full year 14/15 data is available.

6.8 During 13/14 there was significant variation in take up of the NHS Health Check across GP surgeries in B&NES, ranging from 29% - 79%. In response to this additional support has been given during 14/15 to enable GP surgeries to undertake self-assessments against national programme standards to inform action plans for improvement. This has already resulted in some practices changing how they manage their programme and we would expect this to have a positive impact on their 14/15 performance.

6.9 Qualitative research[5] on what affects people's decisions to take up the offer of health check found the following key themes reported:

- Lack of awareness of the health check programme
- Beliefs about susceptibility to Cardiovascular Disease
- Beliefs about civic responsibility
- Issues concerning access to appointments
- Beliefs about the consequences of having a check

6.10 One of the criticisms of the NHS Health Check is that it has the potential to increase health inequalities if only the 'worried well' attend and those at high risk of cardiovascular disease fail to engage therefore it is important to understand who is taking up the offer of the health check

6.11 In April 2014, 7 GP practices participated in a small scale research project in order to better understand the profile of attenders and non-attenders in B&NES. Using data from 3,622 people invited for a Health Check during 12/13 we found that the following groups of people are less likely to take up their offer of a health check:

- Men
- Younger people (40 – 50 yrs)
- Smokers
- Those living in relatively more deprived areas

[5] C. Burgess et al (22 April 2014) Influences on individuals' decisions to take up the offer of a health check: a qualitative study Health Expectations: John Wiley and Sons 2014

6.12 Public Health England advice on increasing take up of the NHS Health Checks includes increasing marketing of the programme, ensuring that the offer of a NHS Health Check is as accessible as possible especially to people of working age and that Checks are offered in a variety of community settings to reach out to those less likely to attend a GP surgery.

6.13 During 14/15 we are piloting three new approaches to increasing take up from men of working age, those in more deprived areas and younger people. The following practices are testing these community outreach approaches:

- St Michaels Surgery, Twerton – Telephone invitation/outreach
- Grosvenor Surgery and Larkhall Pharmacy – Delivering health checks in the local pharmacy
- Somerton Surgery, MSN – Delivery in local workplaces (Integrity Print, Westfield Trading Estate)

These approaches will be evaluated to see what impact they have on increasing take up amongst these groups.

7 OTHER OPTIONS CONSIDERED

7.1 None

8 CONSULTATION

8.1 As this is an update report formal consultation is not required however the following have been consulted on the contents of this report. Members of the B&NES NHS Health Check Steering Group, Director of Public Health, Strategic Director People and Communities, Lead Cllr for Wellbeing.

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* *Cathy_mcmahon@bathnes.gov.uk*
Background papers	*None.*
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Equality Impact Assessment / Equality Analysis

Title of service or policy	NHS Health Checks Programme
Name of directorate and service	Public Health
Name and role of officers completing the EIA	Cathy McMahon, Public Health Development and Commissioning Manager
Date of assessment	22 December 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 NHS Health Check programme is a universal risk assessment and management programme with the aim of reducing heart disease, stroke, diabetes, kidney disease and certain types of dementia. It aims to do this by increasing uptake of primary prevention interventions including weight management, smoking cessation, physical activity, statins, anti-hypertensives, and improved management of impaired glucose intolerance. In B&NES the programme is commissioned by the Public Health team and delivered through all 27 GP surgeries locally.
1.2	Provide brief details of the scope of the policy or service being reviewed, for example: • Is it a new service/policy or review of an existing one? • Is it a national requirement?). • How much room for review is there?	The NHS Health Checks Programme has been running in B&NES since 2011 and is a mandated Public Health Programme. There is clear guidance, ambitions and standards for delivery nationally however there is scope for local interpretation of the ambition.
1.3	Do the aims of this policy link to or conflict with any other policies of the Council?	The Programme contributes to a range of public health outcomes and

		supports the delivery of the following strategies: B&NES Health and Wellbeing Board Strategy (2013) The Board aims to: • Reduce health inequalities and improve health and wellbeing in Bath and North East Somerset Theme area: • Helping people to stay healthy (prevention) • B&NES CCG 5 year Strategic Plan – Prevention and self-care priorities B&NES Tobacco Control Strategy B&NES Fit for Life Strategy B&NES Healthy Weight Strategy

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 the NHS Health Check programme
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?	In April 2014, 7 GP practices participated in a small scale research project to look at who is more or less likely to take up their offer of a NHS Health Check in B&NES. Using data from 3,622 people invited for a Health Check during 12/13 we found that the following groups of people are less likely to take up their offer of a health check: • Men • Younger people (40 – 50 yrs) • Smokers • Those living in relatively more deprived areas
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?	GP surgeries are not collecting specific patient feedback regarding the NHS Health Checks or following up with non-attenders. Published research suggests a range of reasons: • Lack of awareness of the health check programme

		• Beliefs about susceptibility to Cardiovascular Disease • Beliefs about civic responsibility • Issues concerning access to appointments • Beliefs about the consequences of having a check
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	All practices have been asked to complete a self-assessment against the National Programme Standards to support them to improve both quality and performance during 14/15.
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?	Ensure that specific strategies are used to engage effectively with minority groups and vulnerable clients.

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. (Are there any issues regarding pregnancy and maternity?)	We are currently piloting delivery of the Checks in a male dominated business on a local trading estate to see if this will increase access for men.	Men are less likely than women to attend a NHS Health Check.

		New resources have been produced by PHE to help with marketing of the programme to men in particular and ethnic minority groups	
3.2	**Transgender –** – identify the impact/potential impact of the policy on transgender people	All eligible population are invited for a Health Check regardless of race, gender, ethnicity etc	
3.3	**Disability** - identify the impact/potential impact of the policy on disabled people (ensure consideration of a range of impairments including both physical and mental impairments)		People with learning or physical disabilities are offered a annual health check via their GP surgery however this does not cover all aspects of the NHS Health Check so there is a possibility that they could miss out / deselect due to misunderstanding of the offer.
3.4	**Age** – identify the impact/potential impact of the policy on different age groups	Everyone aged 40 – 74 who does not have a related pre-existing condition is invited for a NHS Health Check. New resources have been produced by PHE to help with the marketing of the programme to younger people. We are piloting delivery of the NHS Health Checks in workplaces in Midsomer Norton. This will support those of working age in the area to access the service during working hours.	Younger people are less likely to attend their NHS Health Check.
3.5	**Race** – identify the impact/potential impact on different black and minority ethnic groups	Ethnicity is recorded as part of the NHS Health Check programme and used to assess CVD risk Information from GP surgeries on take	Indian, Pakistani, Bangladeshi, Other Asian & Chinese, have a lower threshold for diabetes risk.

		up will include a breakdown by ethnic group	
3.6	**Sexual orientation -** identify the impact/potential impact of the policy on lesbians, gay, bisexual & heterosexual people	Everyone aged 40 – 74 who does not have a related pre-existing condition is invited for a NHS Health Check.	
3.7	**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 programme will not have any negative impact on people of different religious/faith groups as it will have a positive impact on adults regardless of religion or belief.
3.8	**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	We are working with the GP surgery in Twerton to proactively invite people for the NHS Health Check by telephone. This more personalised approach has had some success in improving uptake in deprived areas of Bristol.	Targeting routine and manual workers with support services will help to reduce the healt h inequalities experienced disproportionately by this group as they are more likely to have a higher risk of CVD due to a range of socioeconomic and lifestyle factors.
3.9	**Rural communities** – identify the impact / potential impact on people living in rural communities	We are piloting delivery of the NHS Health Checks in workplaces in midsomer Norton. This will support those of working age in the area to access the service during working hours.	.

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
Only 51.1% of people who are offered a check currently take up the offer. A range of inequalities issues have been identified regarding delivery of the programme. These include: Lower take up rates in deprived areas Men less likely to attend Younger people less likely to attend Smokers less likely to attend	Piloting outreach approaches in workplaces, pharmacy and deprived communities to evaluate the impact on uptake Improving data collection on impact of the programme from GP surgeries	Evaluation of uptake in targeted areas GP Practice annual reports	Cathy McMahon Cathy McMahon	April 2015 June 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 (Director of Public Health)
Date: 23/12/2014

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Bath & North East Somerset Council		
MEETING:	Wellbeing Policy Development and Scrutiny Panel	
MEETING DATE:	January 2015	**AGENDA ITEM NUMBER**
TITLE:	**Specialist Mental Health Services – inpatient redesign impact assessment and update**	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix 1: Impact Assessment (with embedded documents) Appendix 2: Strategic Outline Business Case (with embedded document)		

1 THE ISSUE

1.1 This paper presents the result of stakeholder and staff engagement and impact assessments on transferring Ward 4 dementia inpatient services from St Martin's Hospital to the Royal United Hospital into a new build specialist mental health unit.

1.2 The report also includes a draft strategic outline case to be presented to the Clinical Commissioning Group and AWP Executives if the Wellbeing Policy Development and Scrutiny panel agree that all local engagement is adequate to support continued proposal development.

2 RECOMMENDATION

The Wellbeing Policy Development and Scrutiny Panel is asked <u>to note</u>:

2.1 The issues as outlined in the impact assessment documentation and embedded documents.

2.2 The overwhelmingly positive support for the move of Ward 4 - as described above - by stakeholders, staff and Healthwatch.

The Wellbeing Policy Development and Scrutiny Panel is asked <u>to agree that</u>:

2.3 All local engagement, assessment of impact and support is adequate to enable continued proposal development for a new build mental health and dementia unit on the RUH site.

3 FINANCIAL IMPLICATIONS

The longer term financial revenue (CCG) and capital (AWP) implications of improving specialist acute mental health in-patient facilities are quantified and

assessed as part of the attached *draft* Strategic Outline Case to be presented to the CCG/LA Joint Commissioning Committee and discussed. This outline strategic case will then be further worked up into a business case following executive involvement and feedback.

4 THE REPORT

4.1 Specialist Acute In-Patient Mental Health services

As described in the July 2014 Mental Health update paper to the panel urgent consideration of the future of in-patient services was required in B&NES in order to address quality deficits in the local mental health and dementia ward environments as well as the effect of demographic pressure.

The quality concerns were described by patients, staff and CQC and resulted in a CQC warning notice being issued to Sycamore Ward and concerns expressed about the suitability of Ward 4 for long term care. Whilst remedial work has taken place which has resulted in the warning notices being lifted and CQC being satisfied with the quality of care being provided, they have still noted that pace is needed to address the environmental limitations of our in-patient facilities in order to ensure high quality environments for future services.

4.1.1 Review of longer term acute mental health in-patient provision

As previously described commissioners decided to engage with the local community for their views on an option of establishing a mental health unit that combined specialist acute mental health and dementia assessment and treatment wards. Our aim was to "future proof" capacity and provision to ensure we deliver high quality, skilled in-patient care to both our functionally ill and dementia patients.

We widened our view to consider whether it was physically possible to co-locate the dementia beds and some community services into one building and what capacity may be needed to ensure this facility could support future demand.

The draft Strategic Outline Case at Appendix 2 describes these options and current thinking.

4.1.2 Local community engagement and impact assessment

Before moving forward with any proposals in detail commissioners and AWP have spent from April until December 2014 working with the local community and clinicians to shape our thinking in order to be sure that any decisions taken were in line with clinical and stakeholder thinking. This has particularly concerned the move of Ward 4 from St Martin's onto the RUH site into a specialist mental health unit as this is a geographical shift of service.

Engagement has been with the following:

- Mental Health Project Board (29/04/14)
- B&NES CCG senior leadership team (29/05/14).
- Dementia Care pathway Group (26/06/14)
- Mental Health and Wellbeing Forum (01/07/14)
- Your Health, Your Voice (04/09/14)

- Healthwatch public meeting (11/11/14)
- Health watch Survey (December 2014)

The results of the engagement can be seen in the embedded presentation in the Impact Assessment paperwork at Appendix 1.

4.1.3 Impact assessment

The full impact assessment is found at Appendix 1.

Impact assessment meetings were held to discuss the move of Ward 4 from St Martins Hospital to the RUH site. Three meetings were held in December.

- A stakeholders meeting was held on 10th December with eight representatives present including service user and carers, Health Watch, Age Concern and members of the Health and Wellbeing Forum.
- A second meeting was held on 12th December which was attended by eight members of staff from the specialist mental health community teams.
- A third meeting was held on 15th December which was purely for the staff of Ward 4.

Benefits of the proposed service changes	- Improved inter-team professional working both within AWP and across into the RUH. - Improved quality of care for older adults with dementia. - Improved in-patient environments for delivery of care to all mental health and dementia patients. - Increased access to diagnostics in the RUH. - Platform for realising "parity of esteem" national agenda. - Potential to increase provision e.g. S136 suite and assessment unit if space allows.
Any disbenefits, including how you think these could be managed	- Safe parking for staff, patients and carers is a potential cause for anxiety. **Management:** Discussions needed with RUH and transport providers to increase provision. Specific parking for new unit to be provided.
Any issues for patients/carers/families in accessing the new service particularly if a change of location has been suggested	- As above: car parking is an issue on the new site. There is an RUH bus service which is very helpful but maybe consideration could be given to increasing the number of stops around the hospital site depending on the location of the unit.
How do you think the proposed changes will affect the quality of the service	- Improved medical care for inpatients as long as medical liaison and communication increases between RUH and AWP teams. - Easier and more timely access to

	both AWP and RUH services. - Extra support and response across all services.
Impact of the proposed changes on health inequalities	- The greatly improved environment for Older Peoples service will be an enhancement of the service. - Provision of a new environment for frail/vulnerable service users will improve access. - People of all protected characteristics already attend RUH for acute services so joint site may reduce hesitation to use services. - Assessment facility for ante-natal care will be beneficial
If you are a representative of an organisation, such as Healthwatch, please indicate how you have drawn on the views of others from your group	- Healthwatch public meeting held and online survey completed (see attachments). - Healthwatch representatives have also been present /copied into all other stakeholder communications.
Who have you engaged with in drawing together these views?	- See body of the paper and attachments for ongoing engagement. For impact assessment: • Bipolar Group • New Hope – service user group • The Care Forum • Healthwatch • Age UK • Keep Safe Keep Sane - Carers • Staff – AWP • Staff – Ward 4 • Equality and diversity officer - AWP
When was this consultation made?	From July-December 2014
Involvement of 'protected' equality groups	As above and equalities representative from AWP
Summarise the outcomes of stakeholder involvement carried out to date	See main body of report and embedded documents
Any other comments	Ongoing equalities impact assessment will be carried out a part of the implementation of the build.

Impacts at a glance

Impacts	***NHS View***	***Patient/carer/public representatives' view***
Impact on patients	🟢🟢🟢🟢🟢🟢🟢🟢	🟢🟢🟢🟢🟢🟢🟢🟢
Impact on carers	🟢🟢🟢🟢🟢🟢🟢🟠	🟢🟢🟢🟢🟢🟢🟢🟠
Impact on health inequalities	🟢🟢🟢🟢🟢🟢🟢🟢	🟢🟢🟢🟢🟢🟢🟢🟢

Impact on local health community	● ● ● ● ● ● ● ●	● ● ● ● ● ● ● ●

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

4.1.4 Impact assessment results

The impact assessment indicate that there is a high level of support for the move of Ward 4 and the provision of a single specialist unit on the RUH site. This echoed all the engagement with local people.

5 RISK MANAGEMENT

5.1 Risks associated with in-patient service redesign are being managed as part of the AWP risk management processes - Sycamore Ward is on the AWP risk register.

6 EQUALITIES

6.1 Equality impact assessments relating to the options for in-patient redesign were included as part of the engagement and impact assessment processes. Full equalities impact assessments will be completed by AWP as part of the implementation processes.

7 CONSULTATION

7.1 All mental health community service developments are taking place in conjunction with the Mental Health Wellbeing Forum, service users and carers.

7.3 Engagement has taken place with HealthWatch, Your Health, Your Voice (CCG participation group) stakeholders, clinicians, staff, service users and carers in line with public duty requirements to involve the community under Section S244 of the NHS Act 2006 (as amended).

7 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Human Resources; Health & Safety; Impact on Staff

8 ADVICE SOUGHT

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

Contact person	Andrea Morland, Senior Commissioning Manager, Mental Health and Substance Misuse Commissioning 01225 831513
Background	*Equity & Excellence: Liberating the NHS (DH 2010)*, sets out ambitions to make primary care the nexus of health care planning, commissioning and delivery, with acute/secondary care services restricted for those with

papers	the most severe conditions. Care close to home is emphasised, as is a focus on clinical outcomes and the patient experience. *The Transforming Community Services (DH 2010)* program states that Community services are changing to provide better health outcomes for patients, families and communities and to become more efficient; by providing modern, personalised, and responsive care of a consistently high quality that is accessible to all. *Bath and North East Somerset Joint Mental Health Commissioning Strategy 2008-2012 (currently under review for 2013-18)*
Please contact the report author if you need to access this report in an alternative format	

Appendix 2.

REPORT TO WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL
Bath and North East Somerset COUNCIL

PROPOSED CHANGES TO:
Acute Mental Health and Dementia Inpatient Services Provision

DECISIONS REQUESTED
The Wellbeing PD&S Panel is requested to note the engagement and impact assessment responses that positively support a move of AWP's Dementia unit at St Martin's Hospital onto the RUH site as part of a new build for mental health in-patient services.

Prepared by:
Andrea Morland, Senior Commissioning Manager Mental Health & Substance Misuse
Dr Bill Bruce-Jones, Clinical Director Avon & Wiltshire Mental health Partnership Trust
Liz Richards, Managing Director Avon & Wiltshire Mental Health Partnership Trust

Date: December 22nd 2014
PART ONE – Description of proposed service changes

1. The current service

The current commissioned inpatient service provision is made up of:

- *23 acute mental health beds (Sycamore Ward on Hillview Lodge) including 3 for Later Life clients*
- *1.6 Psychiatric Intensive Care Unit beds (PICU) based in specialist units - Callington Road, Brislington is the main site for B&NES clients.*
- *12 organic mental health beds (dementia) are accommodated within Ward 4, on the St Martin's Hospital site in Bath.*
- *5 Rehabilitation beds at Whittucks Road, Hanham.*

2. What are the proposed service changes

The proposals put forward are for the improvement of the acute mental health and dementia inpatient bed provision for Bath and North East Somerset (B&NES). Working in conjunction with the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), our specialist mental health services provider, we are considering mental health and dementia in-patient services at the same time because it is important that we make sure that we are using our existing resources of staff, money and buildings more efficiently and to the best advantage of the people who most need them – now and in the future.

AWP, B&NES CCG and B&NES Social Service staff share service delivery and sites in B&NES and we want to continue to develop this shared model as well as working more closely with primary care, increasing the access to urgent care and integrating with mainstream services where possible. Our overarching aim in commissioning services is that people experiencing mental health problems get all their assessed mental and physical health and social care needs met through integrated and understandable services.

2.1 Options for Service Delivery

In light of the above and discussions between B&NES CCG and AWP, several ways forward were suggested for acute and dementia inpatient services in B&NES. These included:

1. Leave services as they are
2. Do refurbishment works to Sycamore Ward only
3. Redevelop all of the existing Hillview Lodge building for adults with mental health problems only
4. Redevelopment and co-location of dementia beds into Hillview Lodge with the mental health beds
5. Decant, demolish and rebuild on Hillview Lodge footprint
6. New build on the Royal United Hospital (RUH) site, where we can co-locate the dementia services of Ward 4 with the mental health services currently offered on Sycamore Ward, Hillview Lodge.
7. New build in a new location for both services

On sharing these options with the CCG Operational Leadership Team and GPs, the Mental Health and Wellbeing Forum and the Dementia Care Pathway Group members, initial thoughts are that the most favourable options for further more detailed consideration would be to co-locate mental health services with dementia service on the same site at RUH, as it would cause the least disruption to service users, their carers and families. It would deliver a purpose built design that supports an ageless service across acute and dementia care on a single site. Being on the RUH site would also be beneficial in terms of linking mental health services with

physical health services, affording the chance to forge multi-disciplinary teams across NHS service lines.
In addition both services on a new site could also be reviewed and I have included in this briefing the option of just developing an acute mental health facility without dementia for further consideration.

Option 1 - Redevelopment and co-location of dementia beds into Hillview Lodge

Following the scoping exercise, Hillview Lodge could accommodate 23 acute inpatient beds and 4 frail vulnerable beds aligned with 12 dementia beds. This would be a modular design that groups beds in clusters to enable flexible use of space based on clinical need.

Benefits

- Reduce the feeling of isolation by co-locating wards in a single environment.
- Retains close working with acute services on the RUH site, with a reduction in time spent transferring dementia patients for scans to RUH from current site.
- Integration of inpatient services will support flexible working due to improved proximity of wards.
- Improved central front entrance to clinical areas
- Based on the RUH site would retain the benefits of being part of the wider health community linking mental health with physical health.
- Community and potential other in-patient teams on the same site would enable an effective inpatient pathway without the need for transfer from one site to another.

Issues

- The extensive refurbishment of the site will require an interim decant of the current acute ward
- Initial scoping suggests 23 acute beds could be accommodated on the current site. Initial scoping suggests 24 acute beds would be the ideal requirement based on current activity.
- All bedrooms will have external windows but some bedrooms will overlook gardens based on initial scoping. Further work will be required to address privacy issues as part of the detailed planning.
- There may be some resistance from the local community, family and carers to a proposal that aligns dementia care directly with acute mental health and away from the community model associated with St Martin's. This will need to be balanced against the benefits of alignment with an acute physical health setting and an assurance that the internal environment will retain the benefits of the current environment whilst improving patient and carer experience in other areas of care.

Option 2 - New build - general

- A new build would provide a number of options for AWP to consider:

- A co-location of the acute and dementia beds on an alternative plot on the

RUH site in line with option 1 of this paper.

- A co-location of acute and dementia beds (in line with option 1) and the inclusion of a range of community services currently delivered from Bath NHS House, preferably on an alternative RUH site.
- An extensive build that includes a range of AWP services (Section 136 suite for people detained by the police) with additional services from other providers (e.g. Oxford Health, The Priory).

Option 2.1 - New Build RUH Site

This option will deliver a purpose built design that supports an ageless service across acute and dementia care on a single site. This option will require more detailed business planning and evaluation of available sites and feasibility to meet the service delivery model. Consideration will need to be given to timescales for delivery but it is AWP's intention that whatever works takes place will be completed by Summer 2016.

The option of a different plot on the RUH site has been discussed. This would need to fit with the wider estate strategy for the RUH. The initial response from the trust suggests that the RUH are interested in a land swap and offering AWP an alternative site for development. The site options are currently under discussion for viability.

Benefits

- A new build would offer more flexibility for space that could accommodate more acute beds in response to demographic changes.
- It would provide an option to consider a wider range services within a purpose built environment that other commissioners may also want to use e.g Section 136 suite for people detained by the police.
- Community teams on the same site would enable an effective inpatient pathway without the need for transfer from one site to another.
- The development of a larger site would provide a business opportunity to work in partnership with another provider or as a lease of facilities from current/ future AWP estate.
- A new build option on the RUH site will not require an interim decant in order to undertake the work (subject to RUH approval).
- A new build on the RUH site would retain the benefits from being part of the wider health community linking mental health with physical health and the improvements for dementia care reducing time spent transferring from one site to another.

Issues

- A new build option would be subject a detailed business case, agreement on optimal site and may be subject to planning permission.

Option 2.2 - New Build- New Site

A new build site off the grounds of the RUH would require further scoping in

relation to geographical location, accessibility and feasibility with planners.

The agreement of a suitable site in B&NES, design and planning permission implications will need to be considered which may add to the timescales for delivery depending on the preferred site.

Benefits

- A new build would offer more flexibility for space as above. It would provide an option to consider a wider range services within a purpose built environment.
- Community teams on the same site would enable an effective inpatient pathway without the need for transfer from one site to another.
- The development of a larger site would provide a business opportunity to work in partnership with another provider or as a lease of facilities from current/ future AWP estate.
- A new build option will not necessarily require an interim decant in order to undertake the work.

Issues

- A new build option would be subject a detailed business case, agreement on optimal site and be subject to planning permission which may impact on project timescales.
- A new build away from the RUH would have implications for clinical pathways with wider mental health and physical health communities, e.g. links to Psychiatric Liaison within the Emergency Department with Intensive Team and Section 136. Transferring patients for scans as part of the dementia pathway.

Option 3 - Redevelopment of Hillview Lodge for acute care only and redevelop dementia in-patient beds separately

This site could be redeveloped to support delivery of acute mental health services only. Dementia services would stay on Ward 4 in the short term. Consideration will need to be given to the longer term alternative re-provision of this site with the option of working with social care providers on a joint venture to co-locate acute dementia inpatient services with residential dementia beds as part of a community model.

This option would still need to include accommodation for some of the community teams and could include some other more specialist in-patient facilities such as the Section 136 Assessment Suite for people detained by the police and others provided in partnership with other providers.

Benefits

- Acute inpatient care would enable shared facilities on a single site for adolescent and adult care.
- This option would allow the Trust to consider income generation for inpatient services in the short term and longer term strategic options for delivery if services subject to tender in the future.

- The design would enable a separate entrance and dedicated local provision of Section 136 suite reducing the associated travel to the current facility in Bristol
- Community teams on the same site would enable an effective inpatient pathway without the need for transfer from one site to another.
- The design would enable a separate entrance and dedicated local provision of Section 136 suite reducing the associated travel to the current facility in Bristol
- Based on the RUH site would retain the benefits of being part of the wider health community linking mental health with physical health.

Issues

- The current issue of staff isolation, patient transfers to the RUH from Ward 4 for scans will not be resolved. Consideration will need to be given to the changing demographics and the longer term impact on the delivery of dementia services within the current ward environment.
- The extensive refurbishment of the site will require an interim decant of the current acute ward (23 beds).
- There is a risk that once a detailed scoping and design exercise is complete the space available does not meet the needs of other provider.

3. Why are these changes being proposed?

Currently, provision of adult acute mental health inpatient beds for B&NES is accommodated on Sycamore Ward, within the Hillview Lodge building on the Royal United Hospital site in Bath. There are 23 beds providing inpatient services for people whose health needs require specialist mental health investigation, assessment and intervention. Some of these patients will recover and not need another in-patient admission and some may go on to receive treatment over the course of their lifetime in either hospital or residential or supported housing schemes.

A report from the CQC in June 2014, following a visit to the ward in December 2013, confirmed issues with the accommodation which had already been the subject of discussion within the Trust and with the Commissioners. The issues confirmed that the accommodation is no longer functionally suitable for their purpose, impacting on patient care and staff welfare especially in regard to:

- Privacy and dignity
- Facilities, condition and maintenance.

AWP felt that in response to the informal feedback from CQC they needed to take action on Sycamore Ward and this resulted, in June and July 2014, in:

- A reduction of beds on Sycamore ward at Hillview Lodge, with local provision reducing from 23 to 15 beds.
- An agreement to take B&NES clients only into the beds
- A decision to prioritise older adults to go into more suitable facilities in Callington Road, Brislington or other neighbouring units depending on locality of client and transport etc
- Removal of “swing beds” used as male or female beds depending on demand
- Buildings work to address line of sight issues
- Investigation of door sensors in relation to ligature concerns.

The longer term unsuitability of the ward is not in doubt. It is clear that action has to be taken in addition to these remedial steps, it is the urgency with which we need to gain agreement about the way forward that is now pressing.

Currently, provision of inpatient assessment for service users with organic mental health problems (dementia) within B&NES is accommodated within Ward 4, on the St Martin's Hospital site in Bath. 12 beds are currently available. CQC also visited Ward 4, and again expressed concerns about the suitability of the environment for the safe care of people with dementia especially in relation to same sex accommodation and anti-ligature facilities.

The commissioners and staff are also concerned about the environmental limitations on the ward as it was not purpose-built for the assessment and treatment of people with severe dementia and makes some delivery of care challenging. In addition, the design for an inpatient dementia ward should include the following which is not possible in their entirety on Ward 4:

- Aids to support orientation including visual stimulation.
- Ability to have personalised bed area with familiar objects such as pictures, images and photos.
- Effective lighting (often of higher intensity than general ward areas) this should include lighting that is free of shadows and glare.
- Space that supports activity and stimulation; considering how communal areas can be designed that enable relatives and carers to be involved in care and activities. Evidence suggests that people with dementia often eat better in areas that reflect a dining room or cafe.
- Discreet, calming space away from busy communal areas that can be flexibly utilised.
- Doors are a key. Way finding doors for patients will have clear contrast to the walls whilst staff only doors should be the same colour as the walls.

These are not new concerns and it is worth noting at this point that in 2008 when we reduced the number of dementia beds at St Martin's Hospital from 40-20 and invested in community services it was recognised by all stakeholders that in the longer term the dementia beds would be better suited to being on the RUH site and that this should be considered as part of a wider improvement in all mental health in-patient facilities when the opportunity arose.

4. Rationale

4.1 Current Bed Activity Evaluation

An evaluation took place in the national context wherein pressure on adult acute beds in mental health services has been increasing in recent years (in some places, increasing sharply) and where the balance of alternatives to admission, step-down services, NHS and overspill beds is coming under increasing scrutiny.

It is important to remember that we do not just buy beds *in B&NES* we buy bed availability for people in B&NES who need a bed to the value of 23 beds across *all* of AWP's bed base. We hope that as much of this activity happens in B&NES as possible but in reality sometimes people want to be nearer relatives (in Bristol for example) or there are peaks in demand at certain times so people need to be admitted into another AWP bed. So a bed is available for 365 days a year (bed days). 23 bed days is 23 x 365 = 8,395

i) Acute mental health beds – For illustration - during the period April to December 2013 (9 months), the 23 beds available within Sycamore, would have provided 6325 bed "days" of which occupancy by B&NES CCG was 5886 (93%). The total number of bed days occupied however was 6279, as 393 bed days were taken up by OOA patients from Bristol, South Glos, N Somerset, Wilts and Swindon, resulting in a 99% occupancy on Sycamore Ward.

During this same period the following occupancy of beds by B&NES CCG service users took place *outside* of the B&NES area (i.e. in other AWP facilities in Wiltshire, Bristol, South Gloucestershire, Swindon or North Somerset):

Adult Acute	BaNES occupation - Bed days
Lime	45
Oakwood	25
Silver	1
Imber	68
Beechlydene	261
Applewood	22
Juniper	247
Totals	669

Therefore, from the above B&NES CCG actually used 6,555 bed days during the 9 months which was more than we had "bought" at 6296. This carried on to us needing 8760 bed days across the year: 23 bed days worth of activity would have come to 8395.

We were therefore short of 1 bed day worth of activity in 2013 due to demand (which we paid for above the contract).

ii)Dementia assessment beds*:* Using the same time period, the 12 beds available within Ward 4 would have provided 3300 bed days of which occupancy by BaNES CCG was 2222 (67.33%), However during this period, the number of bed days occupied was 2939, as 717 bed days were taken up by OOA patients from Bristol, South Glos, N Somerset, Wilts and Swindon, resulting in a 89% occupancy.

During this time, however, the following occupancy of beds by B&NES CCG service users took place outside of the B&NES area:

B&NES Occupancy of other CCG area beds (B&NES AWP OOA)

'LL' Bed days	B&NES occupation – bed days
Aspen	287
Laurel	41
Cove	121
Dune	12
Amblescroft N	183
Amblescroft S	115
Liddington	33
Hodson	103
	895

Of the total 3300 Dementia (ward 4) bed days available for B&NES, 2222 were occupied by BaNES CCG patients, with B&NES patients occupying 895 beds OOA, making a total of 3117 bed days required during the 9 months for B&NES patients. As Ward 4 capacity over this time was 3300 bed days, to have provided for the full demand would have decreased bed day requirement by 183. **However by the end of the year we had used 4353 bed days, or the equivalent of 12 beds so on target.**

4.2) Delayed transfers of care

People are experiencing delays in being discharged from our dementia treatment beds when their next care requirement is for a specialist dementia nursing home. There is currently not enough provision to meet demand in other areas and so people are coin goer the border into B&NES beds. Whilst the Council (and other neighbouring Councils) is working on this to try and increase the numbers of nursing homes providers who want to provide care in the area it does have an impact on the NHS beds.

4.3) Modelling future services in relation to demographics

This is an inexact science. However, we have done some scenario "mapping" - projecting forward for the next ten years and draft estimates are that whilst we have just about the right level of provision at the moment (although we are already experiencing some pressures for beds as demonstrated above) - we may need to increase the number of available beds as well as continue to re-design the community services.

4.4) Financial investment to support change

There is no agenda to decrease the levels of investment in buying beds for the population. At the very least the current amount of money available for the provision of care is in place and a costing expertise will take place to ascertain whether any further investment is needed or re-investment from other changes is required. AWP are currently investigating ways of providing the capital for the build.

We therefore know that:

- We have to provide new facilities for the mental health in-patient wards
- We have a recommendation from previous dementia service redesigns to site

the dementia in-patient assessment wards onto the RUH site when longer term solutions are being investigated
- The current number of beds we have available under contract is just about OK for now but is beginning to come under pressure
- Delays in being discharged from the dementia assessment ward is beginning to be witnessed for dementia patients due to a lack of nursing home beds
- Nationally there is pressure on mental health beds that is beginning to come under scrutiny.
- There is commitment to financial stability (CCG) and investigating capital investment (AWP).

5. Summary of involvement outcomes

Our vision in B&NES is to develop and deliver best value, accessible and effective high quality services and networks that support carers and enable people who experience mental health problems to recover and lead self-directed, personally satisfying, physically safe and socially meaningful lives as valued members of our local communities.

5.1 Listening to local stakeholders

There has been a long conversation with local people about the development of mental health and older people's services over many years through Planning Fairs, NHS public consultations, voluntary sector network meetings, stakeholder events and public questionnaires. Building on this evolving view the intentions of the local B&NES Mental Health and Wellbeing Forum (previously the Mental Health Provider Forum) – a dynamic collaborative forum of service users, carers, service providers and commissioners shaping and delivering local services – are that we work together in B&NES to:

- Build a wellbeing community
- Demonstrate an ongoing commitment to co-production and joint service delivery
- Further raise the service user and carer voice in order to advocate for what works and contribute to evidence based practice
- Increase peer-led initiatives through, for example, more peer workers and networks in order to develop communities of support
- Focus on people's resilience and their strengths rather than disability – giving people tools that enable them to better keep themselves well
- Involve carers and the family
- Promote recovery through high quality information, education, early intervention and long term support.

5.2 Learning from service users and carers

The peer research produced report – **Bridging the Gap** - examines what helps and what hinders people affected by mental health issues when accessing groups and support which would improve their overall wellbeing. This work with local service users emphasised the importance of:

- Improving wellbeing
- Making connections between people
- Ensuring good care is provided from statutory services
- Motivation with an emphasis on "doing" to improve motivation
- Ensuring ease of access to services
- Being able to find out about services and activities

5.3 Stakeholder engagement in shaping our plans for in-patient beds

Before coming to our final proposal the CCG and AWP carried out considerable engagement with local stakeholder groups. It was this engagement that led us to our options as well as indicated that we needed to ensure we did an impact assessment on the move of Ward 4 to the RUH site as part of a specialist in-patient unit. This included work with:

- Local clinicians – GPs and AWP clinicians
- Dementia Care Pathway Group
- Mental Health and Wellbeing Forum
- Your Health, Your Voice – health participation Group
- Healthwatch public meeting
- Health watch online survey.

We also outlined the pertinent issues in a paper to the Wellbeing Policy development and Scrutiny panel in July 2014

6. Timescales

Detailed project planning will begin within AWP to implement this project once approval has been gained form the Wellbeing Policy Development and Scrutiny panel. It is hoped that the new unit will be completed by the summer of 2016 – planning allowing.

7. Additional information

None.

8. Equality Impact Assessment

Detailed equality impact assessments will be completed during the implementation of the project by AWP. However as part of the impact assessment process equality impacts were considered.

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

No in regard to substantial variation.
B&NES CCG views the move of Ward 4 from St Martin's into the RUH on a shared site with the other specialist mental health services to be the only aspect of the move that is a variation in service as there are no other changes that substantially alter the current arrangements and it was this that we worked with stakeholders and staff on in the impact assessment meetings.
The outcome of all these meetings was a positive recommendation for the proposed move to proceed – please see impacts.

10. Next Steps

All work will take place in the context of the Strategic Outline case prepared by AWP and the CCG.

11. Recommendations

That the panel note the positive endorsement from stakeholders, public and staff to move Ward 4 onto the RUH site and place it in a newly built specialist unit alongside acute mental health and general services.

12. Appendices

Attached to the impact assessment are:

- The briefing paper for engagement and the impact assessment.

MHD Inpatient
Briefing Note final.do

- Presentations outlining the results of engagement.

Presentation.ppt

- The Healthwatch survey comments.

MH Services
Redesign Survey rep

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

Impact assessment meetings were held to discuss the move of Ward 4 from St Martins Hospital to the RUH site. Three meetings were held in December.

- A stakeholders meeting was held on 10th December with eight representatives present including Health Watch, Age Concern and members of the Health and Wellbeing Forum.
- A second meeting was held on 12th December which was attended by eight members of staff from the community teams.
- A third meeting was held on 15th December which was purely for the staff of Ward 4.

Benefits of the proposed service changes	Improved inter-team professional working both within AWP and across into the RUH. Improved quality of care for older adults with dementia. Improved in-patient environments for delivery of care to all mental health and dementia patients. Increased access to diagnostics in the RUH. Platform for realising "parity of esteem" national agenda. Potential to increase provision e.g. S136 suite and assessment unit if space allows.
Any disbenefits, including how you think these could be managed	Safe parking for staff, patients and carers is a potential cause for anxiety. **Management:** Discussions needed with RUH and transport providers to increase provision. Specific parking for new unit to be provided.
Any issues for patients/carers/families in accessing the new service particularly if a change of location has been suggested	As above: car parking is an issue on the new site. There is an RUH bus service which is very helpful but maybe consideration could be given to increasing the number of stops around the hospital site depending on the location of the unit.
How do you think the proposed changes will affect the quality of the service	Improved medical care for inpatients as long as medical liaison and communication increases between RUH and AWP teams. Easier and more timely access to both AWP and RUH services. Extra support and response across all services.
Impact of the proposed changes on health inequalities	The greatly improved environment for Older Peoples service will be an enhancement of the service. Provision of a new environment for frail/vulnerable service users will

	improve access. People of all protected characteristics already attend RUH for acute services so joint site may reduce hesitation to use services.
If you are a representative of an organisation, such as Healthwatch, please indicate how you have drawn on the views of others from your group	Healthwatch public meeting held and online survey completed (see attachments). Healthwatch representatives have also been present /copied into all other stakeholder communications.
Who have you engaged with in drawing together these views?	See body of the paper and attachments for ongoing engagement. For impact assessment: • Bipolar Group • New Hope – service user group • The Care Forum • Healthwatch • Age UK • Keep Safe Keep Sane - Carers • Staff – AWP • Staff – Ward 4 • Equality and diversity officer - AWP
When was this consultation made?	From July-December 2014
Involvement of 'protected' equality groups	As above and equalities representative from AWP
Summarise the outcomes of stakeholder involvement carried out to date	See main body of report and embedded documents
Any other comments	Ongoing equalities impact assessment will be carried out a part of the implementation of the build.

PART THREE – Impacts at a glance

Impacts	***NHS View***	***Patient/carer/public representatives' view***
Impact on patients	🟢🟢🟢🟢🟢🟢🟢🟢	🟢🟢🟢🟢🟢🟢🟢🟢
Impact on carers	🟢🟢🟢🟢🟢🟢🟢🟠	🟢🟢🟢🟢🟢🟢🟢🟠
Impact on health inequalities	🟢🟢🟢🟢🟢🟢🟢🟢	🟢🟢🟢🟢🟢🟢🟢🟢
Impact on local health community	🟢🟢🟢🟢🟢🟢🟢🟢	🟢🟢🟢🟢🟢🟢🟢🟢

🔴 = significant negative impact
🟠 = negative impact for some
🟢 = positive impact

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Strategic Outline Case

B&NES community and inpatient re-provision

2014 to 2016

Avon and Wiltshire Mental Health Partnership NHS Trust	
Project Name:	**B&NES Community & Inpatient re-provision**
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TABLE OF CONTENTS

1. Executive Summary 5
2. Introduction and background 6
2.1. Purpose and scope of this business case paper. 6
2.2. General outline of proposed options 6
3. Strategic Context 7
3.1. History of inpatient services in B&NES 7
3.2. Recent Care Quality Commission recommendations 7
3.3. Mental Health Strategies 7
3.4. Emerging Plans for re-provision and general re-design of services. 8
3.5. Site opportunity to re-design services 8
4. Health Service Need and Service Vision 9
4.1. Existing services provided by AWP 9
4.2. Overall approach and vision 9
4.3. Current demand 9
4.4. Future demand and demography 10
4.5. Existing services at Ward 4 10
4.6. New possibilities for Older People's services 10
4.7. Effect of the proposed changes on other AWP areas 11
4.8. 36 bed or 45 bed unit? 11
5. Option 1 – No change at Hillview Lodge and Ward 4 St Martins 11
5.1. Option 1 in outline 11
5.2. Option 1 advantages 11
5.3. Option 1 disadvantages 12
6. Option 2a – Remodel existing buildings at Hillview (three 12 bed wards) 12
6.1. Option 2a in outline 12
6.2. Option 2a advantages 12
6.3. Option 2a disadvantages 12
7. Option 2b – Rebuild new on existing Hillview site (three 15 bed wards) 13
7.1. Option 2b in outline 13
7.2. Option 2b advantages 13

7.3. Option 2b disadvantages 13
8. Option 3 – Develop a new footprint on another RUH site with three 15 bed wards 14
8.1. Option 3 in outline 14
8.2. Option 3 advantages 14
8.3. Option 3 disadvantages 14
9. Selection of Preferred Option 15
10. Decant Plan 16
11. Vacated Site options 16
12. Listed Building Options 16
13. Financial Appraisal and affordability of Options 16
13.1. Existing financial envelopes 16
13.2. Cost of Capital and Funding Rate of Return 17
13.3. Acquisition of Land 17
13.4. Building costs – Option 2a (three 12 bed wards using Hillview buildings) 17
13.5. New Build costs – hypothetical three 12 bed wards 18
13.6. Building costs –Options 2b and 3 (three 15 bed wards and second storey) 18
13.7. Revenue costs – Option 2a (Develop Hillview site in existing buildings) 19
13.8. Revenue costs – For a 36 bed unit of three wards 19
13.9. Revenue costs – Options 2b and 3 (three 15 bed wards) 20
13.10. Safer staffing – Options 2b, 3 (three 15 bed wards) 20
13.11. Double running and transitional costs 21
14. The Commercial Factors 21
15. Workforce Implications 21
16. Project Management Arrangements 22
17. Timings 22
18. Commissioner, service users and carers involvement. 22
18.1. Joint Business Cases 22
18.2. Commissioning intentions. 22
18.3. Commissioning arrangements. 23
18.4. Service users and carers. 23
19. Risk 24
19.1. Buildings footprint risk 24

19.2. Affordability risks 24
20. Governance 24
20.1. Overall governance 24
20.2. Leadership and responsibilities 24
21. Impact Assessment 24
22. Recommendations 25
23. Appendices 25
23.1. Appendix 1 –Mental Health Strategies Report 25
23.2. Appendix 2 – Impact Assessment 25

1. Executive Summary

An opportunity has arisen to work with the RUH and to re-provide the existing Hillview Lodge services, and the Ward 4 St Martin's services into a new build within the RUH boundary. This follows feedback from CQC (warning notice for Hillview Lodge and concerns for Ward 4)) and acknowledgment from senior managers that the environments on both wards are not suitable for the delivery of high quality care into the future.

The preferred option for the redevelopment of inpatient services in the B&NES locality as described above is for a new build on an RUH site. This conclusion is reached following engagement with local stakeholders and staff from July-December 2014, including the completion of impact assessments in December 2014. The results of the impact assessments and engagement are being presented to the Wellbeing Policy Development and Scrutiny Panel on January 16th 2015 following previous outline of the issues to the same panel in July 2014. If the panel agree that we have engaged widely enough and that the proposal is supported by local stakeholders and staff we will be in a position to actively pursue the options outlined in this outline case.

In addition to combining the ward facilities in one unit there has also been a request for the new site to include a section 136 place of safety/assessment suite, a seclusion suite, offices and community staff accommodation on the second floor.

It is estimated that a new build on this site would costs around £14.025m.

The table below sets out the relative costs of the different options. The first column shows the existing envelope. The second the refurbishment option with similar number of beds. The third columns show a new build with 36 beds. The fourth shows a new build with 45 beds. The fifth column shows the 45 bed new build with safer staffing costs.

	Existing 35 beds		3 wards of 12 beds - refurbishment		3 wards of 12 beds - new build		3 wards of 15 beds - new build		45 beds safer staffing	
	WTE	Total £'000	WTE	Total £'000			WTE	Total £'000	WTE	Total £'000
Direct staff pay & non-pay	55.79	2,527	71.68	2,602	71.68	2,602	84.33	2,832	95.88	3,290
Indirect non pay		2,725		2,540		2,540		2,662		2,662
Cost of capital existing		254		254		254		254		254
Cost of capital additional				222		684		859		859
Total costs		**5,506**		**5,618**		**6,080**		**6,607**		**7,064**
				112		**574**		**1,101**		**1,558**

This paper outlines all current options for consideration. It is requested that the Clinical Commissioning group and AWP consider the contents of this outline case in order to shape the future build and service options.

2. Introduction and background

2.1. Purpose and scope of this business case paper.

The purpose of this Strategic Outline Case (SOC) is to outline the options for inpatient redesign and make recommendations for Mental Health in B&NES currently being run by Avon and Wiltshire Mental Health Partnership NHS Trust. This SOC will look specifically at the re-provision of adult inpatient services at Hillview Lodge, the re-location of community services currently being provided out of Hillview Lodge, the re-provision of older people's dementia inpatient services based at Ward 4 St Martin's and the development of partnerships with other community based providers.

2.2. General outline of proposed options

These proposals outline four options for consideration:

- ***Option 1*** – No change to Hillview Lodge and St Martins Ward 4, continue to re-design community services.

- ***Option 2a*** – To incorporate an acute adult ward, a ward for frail and vulnerable adults, a ward for dementia assessment and treatment, a section 136, a seclusion suite, some community and administrative space on the existing Hillview site using the existing buildings ***– total 36 or 45 beds***.

- ***Option 2b*** – To incorporate an acute adult ward, a ward for frail and vulnerable adults, a ward for dementia assessment and treatment, a section 136, a seclusion suite, some community and administrative space on the existing Hillview site but building completely new. ***– total 45 beds***.

- ***Option 3*** –Develop a new hospital on another RUH site to incorporate an acute adult ward, a ward for frail and vulnerable adults and a ward for dementia assessment and treatment, section 136, seclusion suite, some community and administrative space. This will be considered for ***three wards of 45 beds***.

Following stakeholder, staff and CQC engagement in addition to the impact assessments completed in December the commissioner advises that this paper focus on options 2a-3.

This paper will also not go into great detail on the development of community services as these are moving forward independently and are not dependent on the changes in inpatient services, although any new inpatient units should be complimentary. Development of community services are described in the B&NES Crisis concordat action plan and annual commissioning intentions.

3. Strategic Context

3.1. History of inpatient services in B&NES

Hillview Lodge was built housing two inpatient wards, Cedar and Sycamore, and a PICU/HDU at Balmoral. Later when Balmoral was closed the Cherries was made into a High Dependency Unit (HDU). Offices for community staff were also made. At St Martins there were originally three wards for older people. As Mental Health services have developed nationally and locally since then, the emphasis has been on limiting inpatient care and developing targeted community teams, such as early intervention and crisis services. This has meant that the numbers of inpatient beds have been reduced. First to go was Balmoral, Cedar and two of the St Martin's wards, leaving by the start of 2010/11 the Cherries with 7 beds, Sycamore with 23 beds and Ward 4 St Martin's with 12 beds.

In addition to services situated in B&NES, B&NES CCG had commissioned a number of male and female PICU beds. In 2008/09 a rebasing of the PICU beds was done, but it was a period when for that year B&NES PICU activity was particularly low. When the re-basing was done it left B&NES with 1.0 male and 0.6 female PICU beds. A more thorough analysis of trends over a number of years has determined that the more realistic usage was 2.0 male and 1.0 female beds.

In 2011, it was decided to close the Cherries high dependency unit, as this model of care was not recognised nationally, and to rely on the standard inpatient and PICU services. This reduced the bed base to 23 adult at Hillview and 12 dementia beds at St Martin's (total 35).

3.2. Recent Care Quality Commission recommendations

Given the new models of care being implemented across all localities and in particular the emphasis on recovery and movement of patients more quickly into appropriate community settings, it has been of concern to AWP managers and the CCG that the layout and general standard of the remaining Sycamore services were not up to the desired level. This was brought home to the Trust in a recent CQC inspection in August 2014, which picked up on environmental issues at Sycamore ward. At the same time CQC also highlighted concerns regarding Ward 4 as this is not a specialist dementia environment. Whilst these are varied the most serious of them concerned anti-ligature facilities and the provision of single sex accommodation. Doing nothing is not an option.

3.3. Mental Health Strategies

B&NES CCG recently commissioned a capacity and flow modelling of community and inpatient services and how the patient flows interact and travel through the care pathways and services. The evaluation was based on what was termed "fails" which were times when there was a demand for one type of service, but not the capacity to

deal with that person in the prescribed timescale. Eight scenarios of service change were modelled and the number of "fails" recalculated. The key recommendations concluded in the paper are shown in the bullet points below, and the report itself is shown in Appendix 1.

- **One**: Make small increases in the bed pool to reduce reliance on overspill. In this case it was suggested that there should be 30 adult beds (current level 23). In the body of the document it suggested that PICU should move from 1.6 to 3.0 beds.

- **Two**: Establish a home treatment service at a level sufficient to manage demand. This would mean going to a 24/7 "ward in the community" model holding a caseload of around 20.

- **Three**: Consider the establishment of a Rapid Response service. This service would handle urgent GP and self-referrals short of acute crisis. This service is interposed between the existing primary care liaison and the crisis service.

- **Four**: Negotiate a new understanding across the health economy for the care of people in cluster 1-3 and 11. This recommendation follows on from the expansions of the services mentioned above. These clusters are less acute and can be managed outside the acute settings either as GP based services or in third sector providers.

3.4. Emerging Plans for re-provision and general re-design of services.

The need to re-provide inpatient services in B&NES has been realised for some time. In November 2013 AWP agreed at the Investment and Planning Group to re-provide services both from St Martins and from Hillview. Options were explored.

3.5. Site opportunity to re-design services

The site on which Hillview Lodge stands is owned by AWP and the RUH provide some of the services. In their recent space and buildings review and development, it has become clear that there is some space near to the existing AWP services which can be redeveloped and built on. The RUH estate plans have provided the momentum for change whether or not a new site is used.

4. Health Service Need and Service Vision

4.1. *Existing services provided by AWP*

The table below sets out the resource mapped services which are represented by the AWP B&NES quantum in 2013/14. The costs are attributed to B&NES based on the usage of the teams. It should be noted that total inpatient usage for B&NES is £8.006m.

For services in 2013/14		Main contract
Community Services		£'000
	Assessment and Recovery	3,564
	Early intervention	433
	Crisis services	1,029
	Complex psychological	451
Dementia Services		874
Employment services		3
Liaison Services		248
Inpatient units in Bristol		755
Inpatient units in B&NES		4,897
Inpatient units located elsewhere		2,354
Specialist services		190
	Balance to contract values	236
	Sub total expenditure	**15,034**
Contract plus CQUIN		13,318
Other income		1,716
	Total contract values 2013/14	**15,034**

4.2. *Overall approach and vision*

The vision for any successful Mental Health service, is for service users and carers to be at the centre of a fully integrated service pathway involving AWP, B&NES social services, B&NES CCG and primary care. Key to this is the access to mainstream services where needed. This will enable people who experience mental health problems to recover and lead self-directed, personally satisfying, physically safe and socially meaningful lives as valued members of our local communities

4.3. *Current demand*

Mental Health Strategies showed that even under present demand there was a strain on the system such that there were significant ”fails” and overspills. This confirms the current experience of having high internal bed occupancy levels and significant numbers

of patients out of area who are acute adult, functional elderly and PICU. Any new facility should have built in the capacity to absorb the overspills and allow for future growth.

4.4. Future demand and demography

It is anticipated that the demand from a dementia point of view will increase in the future. The numbers of elderly functional cases is also anticipated to rise. This supports the approach to provide more beds than the current numbers of 23 plus 12 = 35. Option 2b and 3b advocates the building of three 15 bed wards, a total of 45 beds, and increase of 10 over the existing numbers.

The Office of National Statistics (ONS) projects that the population of B&NES will increase by 12%, to 198,800, by 2026. This increase is expected to mainly be in older age groups; in particular the 80+ population is projected to increase by 40% from 9,900 in 2010 to 13,900 in 2026. It is important to note that the resident population quoted above increases by 16,000 when we include all the people registered with a GP in B&NES requiring health services (whether or not they reside in B&NES county boundary). The GP registered population in 2010 was circa 192,000. We can expect then that demand for services particularly for older adults will increase including the in-patient assessment beds.

4.5. Existing services at Ward 4

In the days when Bath Mental Health Trust were based at St Martin's Hospital, there were three Mental Health wards on site, for organic cases. As new models of care were introduced, the functional service became more community based and now only the Ward 4 dementia inpatient service remains. It has been recognised for some time by AWP and commissioners that the ward does not have the environmental characteristics which professionals would now consider essential. Such as:

- Aids to support orientation including visual stimulation.
- Ability to have personalised bed area with familiar objects such as pictures, images and photos.
- Effective lighting (often of higher intensity than general ward areas) this should include lighting that is free of shadows and glare.
- Space that supports activity and stimulation; considering how communal areas can be designed that enable relatives and carers to be involved in care and activities. Evidence suggests that people with dementia often eat better in areas that reflect a dining room or cafe.
- Discreet, calming space away from busy communal areas that can be flexibly utilised.
- Doors are a key. Way finding doors for patients will have clear contrast to the walls whilst staff only doors should be the same colour as the walls.

4.6. New possibilities for Older People's services

If an expansion of buildings was possible at the RUH site, then there would be a good argument for re-locating the dementia services there so that they can more easily be related to RUH services, be supported by them and have more effective liaison. Co-location with other Mental Health services would also provide economies of scale and a common use of some of the clinical staff across services. It would also be possible for patient flow to be better between adult and older people's services. This approach is strongly supported by stakeholders and staff.

4.7. Effect of the proposed changes on other AWP areas

In the past, it was thought that inpatient services would go on being reduced across the whole of AWP such that it would not be possible for each of the six areas to have their own locality units. B&NES was considered to be one of the areas in which this might apply. More recent thinking has come to the view that not only are there not enough Mental Health beds, but that B&NES does need its own locality units, particularly as it has a large General Hospital in its centre. An increase in beds in B&NES would also help in the medium term to absorb inpatient pressure across the whole in-patient provision from other areas of the Trusts such as South Gloucestershire and Bristol.

4.8. 36 bed or 45 bed unit?

In any redevelopment of the inpatient service, there is a choice between having three 12 bed wards or three 15 bed wards. In the light of the known expected increases in older people's needs over the next ten years both AWP and B&NES CCG/LA commissioner, on the basis of the capacity mapping and projected demographics, recommend that three 15 bed wards are provided. Initially with any new 45 bed unit, staffing can be set at a lower level until the additional beds are needed. It is likely with the extreme pressure being experienced at the moment across AWP that other CCGs will want to utilise the additional beds. The option of a 12 bed refurbishment of Hillview has been included here for completeness however.

5. Option 1 – No change at Hillview Lodge and Ward 4 St Martins

5.1. Option 1 in outline

This option is for the same configuration of inpatient facilities both at Hillview Lodge and Ward 4 St Martins, but to continue to make changes to the community services in line with the MH Strategies recommendations.

5.2. Option 1 advantages

The advantages with this approach are:

- No additional costs or least additional cost for the commissioner.

- Least disruption to existing patients in the inpatient units, whilst work would otherwise have been going on.

5.3. *Option 1 disadvantages*

The disadvantages for this option 1 are:

- The physical state of the buildings and the attendant environmental issues will not be addressed. It is likely that the inpatient unit at Hillview will be the subject again of serious criticism from the CQC. This option does not allow full compliance with more modern models of care.
- Does not allow opportunity to incorporate elderly and dementia patients onto the RUH site and to add a local section 136 suite.
- The necessity to expand and develop services as demand and practices change will not be possible.

6. Option 2a – Remodel existing buildings at Hillview (three 12 bed wards)

6.1. *Option 2a in outline*

Option 2a would consist of re-providing adult, frail elderly and vulnerable adult and dementia services on the Hillview site using the existing building shell and to accommodate administrative and existing community staff. The building would aim to house a seclusion suite and a section 136. This option would require the re-modelling of the existing Hillview unit, by primarily internal refurbishment, but not rebuilding. Planning assumption would be for three 12 bed wards, although 15 bed wards can be considered. Capita have scoped the 12 bed option using the existing buildings.

6.2. *Option 2a advantages*

The advantages of this option are:

- This option would be the least expensive. Capita estimates a cost of £6.5m for refurbishment as against £11.82m for a 36 bed new build.
- The larger ground area of 9,000 square metres as compared to 6,500 to 7,700 square metres on the alternative RUH site, could provide flexibility in the future for an expansion of services.
- Building could be done in stages, thus reducing the disruption to existing services.

6.3. *Option 2a disadvantages*

The disadvantages of this option are as follows.

- Modern forms of care mean that the buildings may never be able to get up to the required standard. They have no en-suite rooms and the layout is limiting. There is no second storey so valuable ground space is taken up.
- Services would have to decant into another property as building work would go on.
- Three 12 beds wards do not future proof the service. Putting 45 beds into the existing buildings will be difficult given the current shape of the buildings. The space will be cramped and it will not be possible to accommodate modern management of the unit.

7. Option 2b – Rebuild new on existing Hillview site (three 15 bed wards)

7.1. Option 2b in outline

Option 2b would consist of building a new 45 bed unit on the existing Hillview site, providing adult, frail elderly and vulnerable adult and dementia services and accommodating the existing administrative and community staff. The building would aim to house a seclusion suite, a section 136 and an observation/assessment suite of 4 places. Part of the building would be second storey. The existing buildings would be demolished.

7.2. Option 2b advantages

The advantages of this option are:

- AWP would not have to buy any additional land. However, this option would cost around £14.025m, which is more expensive than a 36 bed new build option costing £11.820m. The funding for this would come from an NHS Capital Investment Loan or Social Bank.
- The new build would incorporate all the new CQC requirements and be fit for purpose. 45 bed unit future proofs the services for the next ten years.
- The Hillview usable site is around 9,000 square metres which is larger than the RUH alternative site of 6,500 square metres (7,700 square metres if site was expanded) and so will leave room for expansion in the future or additional parking.

7.3. Option 2b disadvantages

The disadvantages of this option are as follows.

- This may require a "de-canting" of clients for the period of the build – whilst every effort will be made by AWP to use Callington Road as it is nearer to us this is not currently agreed (see Section 10).

- The 45 bed unit costs around £14.025m to build as compared to £11.82m for a 36 bed unit and £6.5m for a refurbishment. The additional cost of capital from 36 to 45 beds amounts to £175k per year.

- There will be an additional cost of staffing the 45 bed unit as compared to the 36 bed unit. The staffing difference amounts to £210k per year. Initially it is likely that staffing levels of a new unit would be the same as for a 36 bed unit, only staffing up when there was demand and a corresponding cross charge to other CCGs.

- The number of beds might well be more than is currently used by B&NES and therefore there could be a lack of recovery of income to pay for the additional costs. This would be mitigated by the additional beds being "sold" to other commissioners both inside and outside of the former Avon.

8. Option 3 – Develop a new footprint on another RUH site with three 15 bed wards

8.1. Option 3 in outline

Option 3 would consist of a new build on a site adjacent to the existing Hillview Lodge consisting of at least three 15 bed wards. This building would also house the existing community and administrative teams, a section 136 suite, a seclusion suite and 4 bed observation/assessment ward. This option includes adding a second story to part of the unit.

8.2. Option 3 advantages

The advantages of this option are the same as for a new build on the existing Hillview site, option 2b. In addition:

- The existing services could continue uninterrupted at Hillview Lodge, whilst building is going on, thus avoiding any disruption to patients and community staff.
- A new building position might more easily encourage a new approach to models of care.
- The 45 bed option will future proof the inpatient services

8.3. Option 3 disadvantages

The disadvantages of this option are as the same as for Option 2b for a new build of 45 beds at Hillview, and in addition:

- The area into which a new build would be situated is around 7,700 square metres. In doing this the Trust will be losing a larger area at Hillview of 9,000 square metres usable area. Thus AWP will lose flexibility in the future for any kind of expansion.

- The 45 bed unit costs around £14.025m to build as compared to £11.82m for a 36 bed unit. The additional costs of capital amount to £175k per year.

- There will be an additional cost of staffing the 45 bed unit as compared to the 36 bed unit. The staffing difference amounts to £210k per year. Initially it is likely that staffing levels of a new unit would be the same as for a 36 bed unit, only staffing up when there was demand and a corresponding cross charge to other CCGs

9. Selection of Preferred Option

At this stage given the vision of the Local Delivery Unit (LDU) and B&NES CCG, the preferred options are the ones which provide for a new three 15 bed ward unit, either on the existing Hillview site or on a new nearby RUH site. That is options 2b and 3. When we then look at these two options the one which provides the most flexibility into the future and space is option 2b. Other points are:

- Option 2b and 3 offer the flexibility for growth in the next ten years for inpatient and other services, and the chance to remodel the way care is provided in fit-for-purpose inpatient units of 45 beds.

- A renovation of the existing Hillview buildings in option 2a will not provide the environment which fully complies with CQC requirements and modern models of care.

- Option 2b offers the same building shape as option 3, but the larger area will provide greater flexibility of space than in option 3.

- It is not clear at this point whether or not in choosing to move to a new site on the RUH there will be some financial capital gain by relinquishing Hillview. If there was a significant gain then this might weight the new site build option in its favour. The relative values of the respective land elements are being looked at in January 2015.

10. Decant Plan

The preferred options are for a new build of 45 beds. The option 2b involves a new build on the Hillview site. It is vitally important if this option is chosen that there is a detailed and credible plan for decanting the services for a period of up to a year. Decant options are being considered for the inpatient element at Southmead and Callington Road. The community teams could be housed across Bath NHS House and also possibly in some of the empty RUH buildings close to the existing site.

11. Vacated Site options

For one of the preferred options, option 3, where the existing site is not utilised, there will be a vacated Hillview site. It is really important that no net costs accrue to AWP as a result of the disposal of the vacated site. Discussions are taking place with the RUH on their own options for use of this site. Other options are being explored by AWP for income generation or disposal.

12. Listed Building Options

The proposed new site at the RUH for option 3, also includes a large listed building, called the Manor House. The RUH have not yet decided on what to do with this. AWP is exploring options around this listed building in case it can be used.

13. Financial Appraisal and affordability of Options

This section will deal with the relative costs of the three major options and their affordability.

13.1. Existing financial envelopes

Financial areas that will be included in this appraisal are, the existing financial revenue envelopes for Ward 4 St Martins and Sycamore ward, the financial envelope of Hillview Lodge as a whole with administrative and community staff and the current levels of acute, adult and older people's out of area costs. The table below sets out the existing cost envelope in its various parts, which total £5.506m. Out of area costs at month 5 2014/15 amount to £0.7m, which can be added to this total.

Type of cost centre	WTE	Direct costs £'000	Indirect & estate costs £'000	Cost of capital £'000	Total £'000
Ward 4 St Martins	26.03	891			891
Sycamore ward	29.76	1,402			1,402
Sycamore admin & office costs		12			12
FM - St Martins			8		8
FM - Sycamore			477		477
SLA - St Martins			282		282
SLA - Sycamore			78		78
Ward 4 central costs			611	31	642
Sycamore central costs			1,269	223	1,493
Therapy and Medical staff		222			222
Total financial envelope	**55.79**	**2,527**	**2,725**	**254**	**5,506**

13.2. Cost of Capital and Funding Rate of Return

Because there are uncertain sources of funding at this stage of the business planning process, it has been assumed that the cost of capital from an NHS Capital Investment Loan (CIL) will be 1.88% above the 0.5% base rate for a 15 year pay back option. There are a number of other sources of funds open to the Trust for this project. These are:

- Internal capital funding from AWP cash reserves.
- NHS Loans for "Normal Course of Business" for NHS Trusts.
- NHS Loans or Public Dividend Capital (PDC) for strategic investment.
- Loans provided by B&NES Local Authority and St John's Charity.
- Funding through a social bank such as Triodos where rates are relatively low.
- A combination of two or more of these possibilities.

13.3. Acquisition of Land

For option 3, there will be an acquisition of land between the RUH and AWP. In accordance with NHS procedures this will take the form of a transfer of the net book value of the land. It is expected that there will be some kind of value transfer which will that there will be no net cost to AWP.

13.4. Building costs – Option 2a (three 12 bed wards using Hillview buildings)

Capita have done a piece of work to re-model Hillview Lodge to house three wards of 12 beds each on the existing Hillview Lodge site. Their site area totals 2,598 square metres. This includes offices, activity areas and a section 136 suite. The renovation costs including fittings are estimated as £2,500 per square metre. Total costs are therefore estimated at around £6,500,000.

13.5. New Build costs – hypothetical three 12 bed wards

The building costs of a three 12 bed ward unit with a second storey are shown in the table below together with the assumptions on space. It has been assumed that all the capital will be obtained from non-NHS sources. Advice from NHS organisations and Capita suggest that the area needed for one bed including all circulation and amenity areas is between 60 and 70 square metres. Maximum community and administrative space needed is around 1,000 square metres.

OPTIONS 36 bed unit - space	Number beds	Area per bed	Admin & comm	Total site size
		Sq m	Sq m	Sq m
Option - 3 x 12 bed wards	36	70		2,520
Section 136 suite			200	200
Admin & community space			1,000	1,000
Total space for 36 bed ward				3,720

OPTIONS 36 bed unit - costs	Cost to build	Total Wards	Total Admin & comm	Total
	£	£'000	£'000	£'000
Option - 3 x 12 bed wards, s136	3,500	8,820		8,820
Admin & community space	2,500		3,000	3,000
Total costs for 36 bed new build		8,820	3,000	11,820

13.6. Building costs –Options 2b and 3 (three 15 bed wards and second storey)

The building costs of a three 15 bed ward unit with a second storey are shown in the table below together with the assumptions on space.

OPTIONS 45 beds - Space required	Number beds	Area per bed	Admin & comm	Total site size
		Sq m	Sq m	Sq m
Option - 3 x 15 bed wards	45	70		3,150
Section 136 suite			200	200
Admin & community space			1,000	1,000
Total space for 45 beds				4,350

OPTIONS 45 beds - costs	Cost to build	Total Wards	Total Admin & comm	Total
	£	£'000	£'000	£'000
Option - 3 x 15 bed wards	3,500	11,025		11,025
Admin & community space	2,500		3,000	3,000
Total costs for 45 bed new build		11,025	3,000	14,025

13.7. Revenue costs – Option 2a (Develop Hillview site in existing buildings)

The assumption around the revenue costs of this option is that the costs of ward staff are the same as for the new build with three 12 bed ward unit. The table below sets out the revenue costs, which include the revenue costs of capital. Cost of capital will be less than the new build options. Increase in costs from existing funding envelope is **£112k per year**.

Using Hillview buildings	Adult ward		Functional ward		Dementia ward		Total all wards	
12 bed wards	WTE	Total £'000	WTE	Total £'000	WTE	Total £'000	WTE	Total £'000
Direct staff	22.54	748	26.59	969	22.54	748	71.68	2,465
Direct non-pay		45		46		45		136
Direct accommodation		152		160		152		464
Estates costs		334		334		334		1,002
Apportioned costs		358		358		358		1,073
Cost of capital		159		159		159		476
Total costs		**1,796**		**2,026**		**1,796**		**5,618**

13.8. Revenue costs – For a 36 bed unit of three wards

The main assumption for these options is that levels of nursing staff have been determined from the Nursing Hours per Patient Day staffing model recommended by the NHS. Economies of scale have then been applied for certain specialist staff groups like therapies and doctors. This chart excludes the safer staffing increases. Increase in costs from existing funding envelope is **£574k per year**.

12 bed wards	Adult ward WTE	Adult ward Total £'000	Functional ward WTE	Functional ward Total £'000	Dementia ward WTE	Dementia ward Total £'000	Total all wards WTE	Total all wards Total £'000
Direct staff	22.54	748	26.59	969	22.54	748	71.68	2,465
Direct non-pay		45		46		45		136
Direct accommodation		152		160		152		464
Estates costs		334		334		334		1,002
Apportioned costs		358		358		358		1,073
Cost of capital		313		313		313		938
Total costs		**1,950**		**2,180**		**1,950**		**6,080**

13.9. Revenue costs – Options 2b and 3 (three 15 bed wards)

The main assumption on staffing for this option is that levels of nursing staff have been determined from the Nursing Hours per Patient Day staffing model recommended by the NHS. Economies of scale have then been applied for certain specialist staff groups like therapies and doctors. The model relies upon a unit nurse in charge for late, night and weekend shifts, which cost has been included under the functional ward. Increase in costs from existing funding envelope is **£1.101m per year**.

Excludes safer staffing 15 bed wards	Adult ward WTE	Adult ward Total £'000	Functional ward WTE	Functional ward Total £'000	Dementia ward WTE	Dementia ward Total £'000	Total all wards WTE	Total all wards Total £'000
Direct staff	26.52	818	31.29	1,039	26.52	818	84.33	2,675
Direct non-pay		52		53		52		157
Direct accommodation		196		196		196		587
Estates costs		334		334		334		1,002
Apportioned costs		358		358		358		1,073
Cost of capital		371		371		371		1,113
Total costs		**2,128**		**2,351**		**2,128**		**6,607**

13.10. Safer staffing – Options 2b, 3 (three 15 bed wards)

The staffing level assumption has also been guided by recent information from the CQC. The staffing element change attributed to the safer staffing model in the 45 bed unit is shown in the table below and represents 3.85 WTE staff in each ward costed at £152k, a total increase of £457k. This increase is one band 5 nurse on all week on the early, late and night shifts. Increase in costs from existing funding envelope is **£1.558m per year**.

Includes safer staffing	Adult ward		Functional ward		Dementia ward		Total all wards	
15 bed wards	WTE	Total £'000	WTE	Total £'000	WTE	Total £'000	WTE	Total £'000
Direct staff	30.37	962	35.14	1,183	30.37	962	95.88	3,107
Direct non-pay		61		61		61		183
Direct accommodation		196		196		196		587
Estates costs		334		334		334		1,002
Apportioned costs		358		358		358		1,073
Cost of capital		371		371		371		1,113
Total costs		**2,281**		**2,502**		**2,281**		**7,064**

13.11. Double running and transitional costs

For options 2b and 3, there will be double running costs between the new build and the existing premises. The areas of double running and transitional costs will be:

- De-cant costs from Hillview into the new site under option 3.
- For option 3 residue costs of the empty Hillview Lodge site prior to its disposal.
- For options 2b, there will be significant decant costs whilst building work is going on for from 9 to 12 months.
- For option 2a there will be temporary de-cant costs as parts of the building are renovated.

14. The Commercial Factors

The physical state of the inpatient unit at Sycamore has long been of concern to the local health community. It is important that the local health economy take this opportunity to bring the service up to a proper level which will have a standard, which can compete with anything that is around as best practice at the moment.

15. Workforce Implications

It is anticipated that the inpatient moves into a single site on the RUH, will not affect the recruitment of staff directly. A better standard of working space will indirectly help staff to have more job satisfaction, and this will aid recruitment. The greater number of beds does require more staff overall.

16. Project Management Arrangements

AWP have put into practice a formal project management structure. This consists of a project board chaired by the Chief Executive, Iain Tulley, and made up of AWP senior staff, B&NES CCG senior staff and the RUH director of estates. The project owner and director is Bill Bruce-Jones. The project manager is Dick Beath. The first board took place in early December and these will continue monthly until the project is finished.

17. Timings

There is a target to get the new unit built by the summer of 2016. This is a tight timescale. A timeline will be produced for the January project board. There are a number of key events coming up which can be noted.

- Presentation of the Strategic Outline Case and impact assessment to the B&NES scrutiny committee in January 2015.
- Final detailed options appraisal to the AWP finance and planning committee in January 23rd 2015.
- Short listing of Quantity Surveyors and building project managers for selection in providing detailed costing of new build sketches by the end of January 2015.
- Development of the Outline Business Case for the preferred option from January to February 2015.
- Development of a Full Business Case up to 31st March 2015
- Acquisition of development partners from 1st April 2015

18. Commissioner, service users and carers involvement.

18.1. Joint Business Cases

This paper is a joint Strategic Outline Case and is jointly led by AWP and B&NES CCG.

18.2. Commissioning intentions.

The latest B&NES CCG commissioning intentions highlights key aspirations which support the re-modelling of the services. Key points are:

- In-patient services to be designed in such a way that they help people, who are suffering from an acute mental health episode to feel batter and for the staff to be able to provide the best clinical care.

- Mental Health services generally to be more closely associated with physical acute care so that patients can receive appropriate physical as well as mental health care in a seamless way.

- To provide patient centred care, closer to where they live, thus maximising patient recovery and support and keeping them out of acute hospital settings.

18.3. Commissioning arrangements.

It is the desire of AWP and B&NES CCG to create a more integrated Mental Health service, which works across organisational boundaries. Commissioning arrangements need to be flexible and a collaborative approach by all parties needs to be maintained.

18.4. Service users and carers.

A recent B&NES CCG report has emphasised the important issues for service users and carers as:

- Easy access to relevant information about what services are available

- Services which provide motivation and good support relationships.

There have been a number of consultative initiatives from AWP and B&NES CCG. These have consisted of:

- Provisional consultation with ward and community teams in B&NES LDU

- Sycamore carers and user forum, community carers forum

- Dementia Care Pathway group,

- Acute care forum

- Your Health, Your Voice.

- Mental Health and Wellbeing Forum

- Healthwatch – public meeting and online survey

19. Risk

19.1. Buildings footprint risk

There is a risk that the piece of land earmarked for the new build in option 3a and 3b is not large enough to accommodate the right size of a three ward inpatient unit. Good preparatory work will be done to ensure the space is adequate for the services.

19.2. Affordability risks

There is a risk that the building costs are more than anticipated and that the revenue costs of this increase in capital means that affordability plans are put in jeopardy. This can be mitigated by a wise choice of building partner. Involvement of those experienced in the field of building hospitals will be sought. Involvement and advice from the RUH and Local Council will also be sought throughout the process.

20. Governance

20.1. Overall governance

Any of the services re-designed will have overall clinical and managerial governance provided by AWP.

20.2. Leadership and responsibilities

AWP will be in the lead position with regard to the pathway management and the clinical input for every service user. The project leadership for implementing the changes and buildings will be AWP.

21. Impact Assessment

The recently completed impact assessment which is presented to the Wellbeing Policy Development and Scrutiny Panel on January 16th 2015 is included with this SOC, and this is attached at Appendix 2. The impact assessment considers the following factors and dependencies.

- Quality impact assessment, Patient safety and experience, clinical effectiveness
- Equality impact assessment (further work will be done throughout the implementation)
- Information, data handling and record keeping

- Staff wellbeing, reputation and finance

The results of the impact assessment and all engagement has been positive support for a move of Ward 4 onto the RUH site into a specialist unit with other Mental Health services in a newly built unit. On that basis we anticipate positive support from the Wellbeing PD&S panel to proceed.

22. Recommendations

It is requested that the B&NES CCG Joint Commissioning Committee note this proposed strategy and make comments on any of the issues presented in order to inform future thinking.

23. Appendices

The Appendices attached to this business case are as follows:

23.1. Appendix 1 –Mental Health Strategies Report

BANES mental health modelling report 13th

23.2. Appendix 2 – Impact Assessment

Impact Assessment Form.doc

Andrea Morland and Dick Beath

22nd December 2014

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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; 16TH JANUARY 2015				
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	
16 Jan 2015	**Wellbeing PDS**	**Rough sleepers report**		Jane Shayler
16 Jan 2015	**Wellbeing PDS**	**Endoscopy Impact Assessment (to be confirmed)**	Tracey Cox	
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 13TH MARCH 2015				
13 Mar 2015	**Wellbeing PDS**	**Update on Dementia**		

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
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	
	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

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