Bath & North East
Somerset Council

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Date: 20th July 2015
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To: All Members of the Health and Wellbeing Select Committee

Councillor Francine Haeberling
Councillor Geoff Ward
Councillor Bryan Organ
Councillor Paul May
Councillor Eleanor Jackson
Councillor Tim Ball
Councillor Lin Patterson

Cabinet Member for Adult Social Care & Health: Councillor Vic Pritchard

Chief Executive and other appropriate officers
Press and Public

Dear Member

Health and Wellbeing Select Committee: Wednesday, 29th July, 2015

You are invited to attend a meeting of the **Health and Wellbeing Select Committee**, to be held on **Wednesday, 29th July, 2015** at **10.00 am** in the **Kaposvar Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Mark Durnford
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 Mark Durnford who is available by telephoning Bath 01225 394458 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 Mark Durnford 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 Mark Durnford 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.

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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.

Health and Wellbeing Select Committee - Wednesday, 29th July, 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. CLINICAL COMMISSIONING GROUP UPDATE

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

8. CABINET MEMBER UPDATE

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

9. HEALTHWATCH UPDATE

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

10. PUBLIC HEALTH UPDATE

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

11. MENTAL HEALTH IN-PATIENT REVIEW / HILLVIEW LODGE RE-PROVISION UPDATE (Pages 7 - 20)

This paper presents an update on the planned B&NES inpatient re-provision at Hillview Lodge, which includes the transfer of the Ward 4 dementia inpatient services from St Martin's Hospital to the Royal United Hospital site into a new build specialist mental health unit.

12. RUH UPDATE ON INTEGRATION OF RNHRD (Pages 21 - 30)

This report updates the B&NES Health and Wellbeing Select Committee on the integration of the Royal National Hospital for Rheumatic Diseases (RNHRD) post acquisition by the Royal United Hospitals Bath NHS Foundation Trust (RUH) in February 2015.

13. YOUR CARE, YOUR WAY UPDATE

The Select Committee will receive a presentation on this item.

14. LGA ADULT SAFEGUARDING PEER CHALLENGE AND DRAFT ACTION PLAN (Pages 31 - 54)

A Peer Review team visited B&NES Council and Local Safeguarding Adult Board (LSAB) in March 2015. The LSAB and Council Officers seek to share the Peer Review teams' findings with the Health and Wellbeing Committee and also the corresponding

Action Plan which was approved by the LSAB in June 2015.

15. PRESENTATION - COMMISSIONING LANDSCAPE FOR HEALTH & SOCIAL CARE

The Select Committee will receive a presentation on this item.

16. SOUTH WESTERN AMBULANCE SERVICE (NORTH AREA) JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Pages 55 - 62)

The South Western Ambulance Service (North Area) Joint Health Overview and Scrutiny Committee ('Ambulance JHOSC') includes scrutiny member representatives nominated from B&NES. Given recent elections, and changes to scrutiny membership, fresh nominations are required for B&NES members to join the Ambulance JHOSC.

17. SELECT COMMITTEE WORKPLAN (Pages 63 - 66)

This report presents the latest workplan for the Select Committee.

The Committee Administrator for this meeting is Mark Durnford who can be contacted on 01225 394458.

Bath & North East Somerset Council		
MEETING:	Health and Wellbeing Select Committee	
MEETING DATE:	29 July 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: AWP B&NES inpatient re-provision briefing		

1 THE ISSUE

1.1 This paper presents an update on the planned B&NES inpatient re-provision at Hillview Lodge, which includes the transfer of the Ward 4 dementia inpatient services from St Martin's Hospital to the Royal United Hospital site into a new build specialist mental health unit.

1.2 In particular it includes an update on the principles underpinning the plans to re-provide in-patient services on an interim basis during a rebuild at Hillview Lodge.

2 RECOMMENDATION

The Health and Wellbeing Select Committee is asked to note:

2.1 The progress of the planning process as it relates to the business cases, and what has been done since the last report to the Wellbeing Policy Development & Scrutiny (PDS) Panel in January 2015.

2.2 The intended approach to the interim re-provision of beds (decant plan).

The Health and Wellbeing Select Committee is asked to agree that:

2.3 The proposals around the decant plan, in so far as they have been established, are in line with the wider panel expectations. The process to crystallise the decant plan involving stakeholders and the B&NES CCG is adequate to enable continued proposal development for a new build mental health and dementia unit on the RUH site.

3 FINANCIAL IMPLICATIONS

The report indicates that the "core commissioner requirement" of a direct replacement of the existing 35 beds at Ward 4 and Sycamore and community services, by three 12 bed wards of total 36 beds, comes within the existing financial envelope of £5.6m.

The preferred option was to build three wards of 15 beds each (total 45 beds). This was considered to be a more economic ward model and one which would allow for future growth.

Activity indications from 2014/15 are that B&NES has used more than its commissioned in-patient capacity. This has resulted in some use of out of area facilities at a higher cost than we would pay for local beds. In addition to this over-usage and in line with the demographic pressures outlined in the Joint Strategic Needs Assessment, we are investigating whether we may need to commission (when the unit opens) a further 5 out of the additional 9 inpatient beds, so that the additional usage as identified in 2014/15 can be placed in area. The marginal costs of building and staffing additional beds in the unit is significantly less than external bed prices or fully absorbed internal bed costs. The preferred option would lead to a relatively low unit bed cost and result in savings to the health community.

The remaining 4 beds would be used initially by AWP to relieve the inpatient pressure across the other CCG areas.

4 THE REPORT

4.1 Specialist Acute In-Patient Mental Health services

The report summarises the paper that went in January 2015 to the PDS Panel. It highlighted the urgent need for a re-provision of inpatient services 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.

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

The report summarises the B&NES inpatient review that had taken place, which indicated a future growth over ten years of inpatient demand especially dementia beds. 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 AWP B&NES inpatient re-provision at Appendix 1 describes the preferred option and current thinking.

4.3 Local community engagement and impact assessment

The report also summarises the local engagement and impact assessment of the proposed move of older people's services from Ward 4 at St Martin's Hospital that was done prior to the last report to the PDS Panel in January 2015. There was a substantial amount of engagement by AWP between April and 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 were shown to the PDS Panel in January 2015.

4.4 Additional services in the new unit

The report mentions the possibility of adding an additional four bed observation suite and a section 136 suite. The option of an observation suite has yet to be discussed with the RUH on how to staff the unit and whether they would want this in principle or not. The option of a section 136 suite will need to be considered in the light of plans to create a more permanent multi-bed suite in the Bristol Bath areas. A decision on these two options will be taken by the project board prior to the Outline Business Case being submitted to the Trust Development Agency (TDA).

4.5 Overall project progress

The project is well under way, but there is still much to do before a build can start. AWP have appointed a cost advisor and have signed up to the Procure 21+ NHS approved process. This process has been used successfully by the RUH in its recent developments. It relies upon the use of approved contractors with a much more slimmed down accreditation process. It also contains a maximum price guarantee. The next steps are the choice of contractors and the submission of

detailed plans for planning permission. The timings proposed in the Strategic Outline Case (SOC) to the TDA is a completion for December 2016. This represents a tight timescale and this could easily run into 2017.

4.6 Interim reprovision of beds during rebuild - Decant Plan

The preferred option of a rebuild on the existing Hillview Lodge site means that there has to be a good decant plan. The building phase, including demolition of the existing site, has been estimated as lasting 18 months. The report summarises the approach to the decant plan. A separate project has now been set up to explore options over the next three weeks. A short list of options will be taken forward by the project manager who has now been appointed, and this process will include engagement with stakeholders, staff, service users and CCG/Council Commissioners.

5 RISK MANAGEMENT

5.1 The strategic risks associated with in-patient service redesign are being managed as part of the whole AWP project. There are identified risks which are to do with the following broad areas, which have been identified in the latest Strategic Outline Case and will be included in a decant plan. Mitigating actions are in place and the plan is being actively monitored by the Project Board

- Footprint risks – does the existing land provide enough space to for the intended unit.
- Planning risks – will the planned building obtain planning permission from the local Council.
- Programme and timing risk – will the project come in on the planned timing constraints.
- The affordability and staffing risk – Will the costs be as planned and can the staff needed be recruited.
- Model of care risk – there is a risk that the models of care will change over the years and parts of the new unit will be unsuitable for the new models.
- Decant risks – there is a risks around the decant plan and how this impacts on the service users and carers and staff.

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. Equalities will be taken into account in the separate decant options appraisal and plans.

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.

7.2 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.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

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

9 ADVICE SOUGHT

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

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Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

B&NES Health and Wellbeing Select Committee briefing

B&NES Inpatient re-provision

July 2015 - Update

Avon and Wiltshire Mental Health Partnership NHS Trust	
Project Name:	**B&NES Inpatient re-provision**
Project Executive/Director:	**Iain Tulley chair, executive lead Sue Hall**
Project Manager:	**Chris Hedges (Capita)**

Version	Date	Comments	Composed	Authorised	Status
1.0	10.7.2015	Initial draft for comment	R Beath		Draft
2.0	13.7.2015	Second draft to A Morland	R Beath		Draft

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1. INTRODUCTION AND BACKGROUND

1.1. Purpose of this briefing paper

The purpose of this paper is to brief the B&NES Health and Wellbeing Select Committee on the progress of plans for the re-provision of inpatient services in B&NES.

1.2. History and background

Inpatient services in B&NES consist of:

- Hillview Lodge (in the grounds of the RUH and built in 1995) Sycamore ward with 20 adult acute beds and 3 older adult functional beds.
- Ward 4 at St Martin's Hospital which has 12 beds for older adult dementia patients.

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. There was also concern that Ward 4 – which is not a specialist dementia facility – would not be a good enough facility for modern dementia in-patient assessment and treatment.

This was reinforced to the Trust following a Care Quality Commission (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 and some of the challenges about working in a non-specialist environment. Whilst these concerns were varied the most serious of them concerned anti-ligature facilities, the provision of single sex accommodation and the general ability of the environment to reduce people's level of distress. As a consequence considerable work has taken place – especially on Sycamore ward and including reducing their beds from 23 to 15, due to safety concerns – and CQC were satisfied with the facilities on re-inspection on the understanding that longer term rebuild for Hillview Lodge was implemented.

Ward 4 at St Martin's. In the days when Bath Mental Health Trust was based at St Martin's Hospital, there were three Mental Health wards on site, for people with "organic" conditions e.g. dementia. Since 2008, in consultation with local stakeholders, these wards have been closed and all the money reinvested in community services for people with dementia, supported by Ward 4 dementia inpatient service (still at St Martins). It has been recognised for some time by AWP and commissioners that the ward does not have the environmental characteristics which professionals would now

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consider essential. For instance, a recommendation from the engagement processes in 2008 was that if future ward changes were considered that a move to a unit on the RH site with other mental health services should be explored.

Co-location with other Mental Health services was seen as providing 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 *currently* by stakeholders and staff.

Mental Health Strategies and Inpatient Review. BaNES CCG recently commissioned a capacity and flow modelling report for 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 review indicated an increased need for inpatient beds in the next ten years.

Emerging plans for the re-provision and general redesign of services. The Mental Health Strategies results confirmed the view that service models needed to be changed. The related community services have been modified as a result of the review and in November 2013 AWP agreed at the Investment and Planning Group to engage with the local community and staff to re-provide inpatient services both from St Martins and from Hillview.

1.3. *Future demand and demography*

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 inside the 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 with all types of mental health problems will increase. Indeed, AWP in line with al services nationally, has seen an increase on demand for beds.

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1.4. The case for change

The case for change is therefore centred around the increasing need to replace the not-fit-for-purpose buildings, with a facility which will enhance the new models of care and benefit the whole of the area. The whole unit will house both older people and adults, and this will aid the cross over between these two main groups of patients and allow complex needs to be dealt with in a much easier way, with facilities being adjacent to the RUH and acute services

1.5. Project board

The formal project board, which was set up by AWP in December 2014 with Iain Tulley (the Chief Executive) as chair, has continued to take this project forward. The project board includes as members Andrea Morland (Joint Commissioner for the Local Authority and CCG) and Sarah James (Director of Finance – CCG). A more dedicated project manager from Capita with estates experience has since been appointed.

1.6. B&NES Council Wellbeing Policy Development and Scrutiny Panel – January 2015

The B&NES Council Wellbeing Policy Development Scrutiny Panel met on the 16th January 2015. For this meeting a strategic outline case (SOC) prepared jointly by AWP and B&NES CCG was submitted. An impact assessment was also submitted and considered, which involved stakeholders. In the SOC all the various main options for re-provision were noted. The panel accepted the options that were being considered by AWP. The engagement which fed into the impact assessment was with the following groups:

- 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)

1.7. *Options appraisal and strategic outline business case*

Extensive investigation and discussions with partners has gone on to complete an options appraisal, which was presented to the project board on 2nd February 2015. The project board recommended the preferred option, which is shown below. A strategic outline case (SOC) has been drafted and sent to the Trust Development Agency (TDA) on the 9th July 2015. The SOC outlines the preferred option as follows:

- To build a new 45 bed three ward unit on the existing Hillview site using NHS capital for the sum of around £14.5m (excluding VAT). The choice of three 15 bed wards as opposed to three 12 bed wards, was made because, not only is a 15 bed ward considered to be a more economic unit, but also the additional 9 beds will allow growth into the future in line with the inpatient review over a ten year period.

- The site will include a seclusion suite, administrative and community team space, and some common rooms for the alcohol service. Some of the building would be at second storey level. The unit could also include a four bed observation suite and a section 136 suite.

1.8. *Current project progress*

The project board have agreed to use the Procure 21+ system for the building of the new premises. This is the same process as has been used successfully by the RUH in its recent developments and can help with reduced costs and reduced time. The choice of contractor is going on at the moment and the contenders are all approved by the Procure 21+ process. A cost advisor has been appointed.

2. ACTIVITY AND FINANCE

2.1. *Core commissioner requirement*

The financial modelling has been built up from what is termed the "core commissioner requirement" and added to by certain services which it was deemed to be beneficial to B&NES overall health community. The core commissioner requirement is for a straight forward replacement of the current level of inpatient beds, which is thirty-five. This can be accomplished by building a three ward unit of 12 beds in each ward (making a total of 36 beds). For the sake of identifying the costs and benefits, the cost to build a 36 bed unit housing only the existing services has been calculated. The costs and benefits of the additional services have then been added on. The additional services being considered are:

- Nine additional beds making the total to be three wards of 15 beds.

- A section 136 suite
- A four bed observation ward

2.2. *Activity projections and potential savings*

The 2014/15 inpatient activity indicated increased usage by B&NES of in-patient beds to a level over the commissioned capacity. This was dealt with by some beds being used in other AWP areas and other service users going out of area to other hospital facilities. If it was assumed that this level of inpatient usage would continue, then commissioning more internal beds would not only save money but be a better care pathway for the B&NES population. The marginal costs of building and staffing these additional beds are significantly lower than paying external bed prices. This pattern of usage would indicate that a potential further 5 beds could be commissioned from the 9 additional capacity in the new unit.

2.3. *Revenue affordability*

The revenue financial figures are at this stage in draft and estimate form. The latest estimates have established the following broad principles

- The revenue cost of the "core commissioner requirement" for a new three ward unit with 36 beds, housing the existing services at Hillview and Ward 4 St Martin's only, comes within the existing financial envelope. The existing financial envelope is £5.6m per year.
- The additional 9 beds would be funded through savings in the additional out of area costs currently being experienced by B&NES and other AWP commissioners. It is proposed that B&NES commission initially an additional 5 inpatient beds.
- The additional 4 bed observation suite and section 136 suite could be added to the build and be dealt with through discussions with the RUH on staffing and utilisation of the section 136 suite funding at Southmead.

3. DECANT OPTIONS

The preferred option, following full engagement with stakeholders and as presented to the previous Panel, is for a rebuild on the existing Hillview site. This relies on having a good plan to re-provide in-patient care for the duration of the build for those patients using Sycamore ward (Please note this does not have any impact upon Ward 4). This section deals with how this will be approached. The estimated time to build from demolition of the existing premises to moving in is 18 months.

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A separate and detailed plan for re-providing the in-patient services on an interim basis is currently being prepared. A long list of options has been prepared internally within AWP. A project manager has been employed to work through the options appraisal short options and form plans working with members of B&NES CCG who are on the project board. There are a number of key value assumptions that will be in the forefront of plans. These are:

- The short listed options will be shared and discussed with staff and service users and stakeholders as part of the planning process, before a plan is finalised.
- Patients already in Sycamore ward will be housed as close to their homes and / or support group as possible. This will also be the principle for any new patients from B&NES.
- Capacity in Bristol will be utilised for B&NES patients as much as possible. Capacity outside Bristol to relieve the pressure in Bristol will be considered.
- Staff will be kept and temporarily redeployed to other units close as possible to where they are used to operating.

Dick Beath

Head of investment and planning

13 July 2015

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Bath & North East Somerset Council		
MEETING/ DECISION MAKER:	**Health & Wellbeing Select Committee**	
MEETING/ DECISION DATE:	**29th July 2015**	EXECUTIVE FORWARD PLAN REFERENCE:
TITLE:	**Royal United Hospitals Bath NHS Foundation Trust Update on the Integration of the Royal National Hospital for Rheumatic Diseases**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: None		

1 THE ISSUE

1.1 Part 1: Update to B&NES Health and Wellbeing Select Committee on the integration of the Royal National Hospital for Rheumatic Diseases (RNHRD) post acquisition by the Royal United Hospitals Bath NHS Foundation Trust (RUH) in February 2015.

1.2 Part 2: Integration of clinical services and proposed service relocations

2 RECOMMENDATION

The Committee are asked to:

(i) review and note the report,

(ii) comment on and confirm support for the proposed approach going forward

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

Not applicable.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

Not applicable

5 THE REPORT

See following paper.

6 RATIONALE

This paper has been prepared to ensure that the committee are kept up-to-date with the integration of the two hospitals post-acquisition.

7 OTHER OPTIONS CONSIDERED

Not applicable

8 CONSULTATION

The RUH are working with the Local Health Economy (LHE) Forum, whose membership includes Executives from BaNES, Wiltshire and Somerset Clinical Commissioning Groups (CCGs), NHS England, RUH Governor and patient representation, to agree the process for communication and engagement activities to support the potential relocation of clinical services over the next three years.

9 RISK MANAGEMENT

The integration programme governance structure ensures that any programme issues are identified and if required this can be added to the RUH risk register.

Contact person	*Clare O'Farrell, Associate Director for Integration, RUH* *Tracey Cox, Chief Officer, NHS Bath and North East Somerset Clinical Commissioning Group*
Background papers	
Please contact the report author if you need to access this report in an alternative format	

Part 1: Update on integration of the Royal National Hospital for Rheumatic Diseases post-acquisition by the Royal United Hospitals Bath NHS Foundation Trust.

1. Introduction

The Royal National Hospital for Rheumatic Diseases (RNHRD) was acquired by the RUH on the 01 February 2015 in order to resolve its long standing financial challenges and to preserve the valued services of the small specialist hospital. The RNHRD and the RUH agreed a set of overarching principles for the transaction which are outlined below:

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

1.2 Following acquisition all RNHRD clinical services have continued unchanged with the exception of Endoscopy, which transferred to the RUH site on the 01 February 2015.

1.3 In January 2015 the RUH Board of Directors approved key integration programme objectives to be delivered by the 04 May 2015, and included:

- Completion of the transfer of Endoscopy services from the RNHRD site to the RUH site.

- Approval of a clear Information Technology plan for the RNHRD site for 2015/16.
- Commencing a cultural integration workstream.
- Completing a detailed space utilisation review for the RNHRD site.
- Commencing integration of teams.
- Completing the integration of corporate governance and clinical governance systems.

2. Progress to date

2.1 Endoscopy service transfer

Following a period of engagement with patients, the clinical team and other key stakeholders the Endoscopy service successfully transferred to the RUH site on the 01 February 2015. To date the RUH gastroenterology team have received no negative patient or staff feedback. A post transfer review has been completed to inform any future service relocations.

2.2 Approve a clear IT plan for the RNHRD site

A review of the current IT system (track care) has been completed with the decision to upgrade to the Millennium system in 2015/16. RNHRD clinical and support staff have been fully involved in this process. Inpatient services went live on 15 June 2015 and are working well. All staff have been fully trained and it has been well received. Outpatient services have a provisional 'Go Live' date of 01 September 2015.

2.3 Commence a cultural integration workstream

A cultural integration project group has been established, led by the Associate Director for Learning and Development, and has identified a set of key objectives to be delivered in 2015/16 which include;

- Communicate the RUH's integrated and refreshed vision and mission widely.
- Co-create the RUH's values with staff and patients.
- Provide team building interventions to support teams impacted by the integration.
- Implement a formal shadowing scheme which encourages staff based on the two sites to learn about each other's roles and services.
- Implement a buddying scheme.

2.4 Complete a detailed space utilisation review for the RNHRD site

A space utilisation review has been undertaken to identify opportunities to improve clinical adjacencies, making sure that the right services are located together, and identifying the location of staff across the site. Employees have been fully engaged in the process.

2.5 Commence integration of teams

Integration of non-clinical departments has been progressing well. These teams have been integrated early in response to staff feedback and to reduce duplicate processes. Any consultation process undertaken has been approved by the Trust Consultation and Negotiating Committee (TCNC) before commencing. To date the following teams are now integrated and located on the RUH site: Human Resources, Estates and Facilities, Communications, Learning and Development, Finance, Quality Centre. In addition the post of Clinical and Operational Head for RNHRD site was established, with the post holder commencing in March 2015.

2.6 Complete the integration of corporate and clinical governance systems

Corporate and clinical governance integration has been completed. The programme has incorporated the review and plan for areas including; RNHRD Governance Structure, RNHRD Membership, RNHRD Accounts, Quality Accounts and Annual Report, RNHRD Charitable Funds, RNHRD Corporate Records, RNHRD and RUH Clinical Guidelines and Policy Integration,

Care Quality Commission registration and NHS Litigation Authority, Medical Revalidation. Also, Clinical Governance meetings have been established at specialty level and fully integrated into RUH governance structure.

3. How Integration has been continually monitored

The RUH's Integration Operational Group has monitored the integration process through regular meetings and reporting. This group has recently completed an evaluation of the first 100 Days post acquisition. Findings from this evaluation highlighted the timescales from RUH authorisation as a Foundation Trust and the date for the acquisition to take place as challenging. However, early liaison within the acquisition phase for the clinical teams led to greater ease of integration and staff engagement in the first 100 days, and the level of manager and executive presence on the RNHRD site has been well received by staff groups and seen as very supportive.

3.1 Monitoring of complaints

The Integration Operational Group has closely monitored patient complaints during the initial integration period. To date, no formal patient complaints have been received relating to the integration.

4. Next steps

A number of objectives have been agreed for the next phase of the integration programme and include;

- Complete the Trust's integrated R&D strategy.
- Complete the Cultural Integration workstream objectives.
- Complete the Millennium IM&T project.

Implementation of the integration plan will continue to be monitored by an Operational Group and overseen by the Strategic Integration Group, chaired by the RUH Chief Operating Officer.

5. Summary

The acquisition and subsequent integration of the RNHRD with the RUH has gone smoothly and been successful. The RUH set, and successfully delivered, its key objectives for the first 100 days post-acquisition. Staff engagement has remained high and clinicians report that clinical services have not been adversely impacted. The majority of corporate services have been co-located onto the RUH site and have integrated well. Governance has been well maintained during the integration and high standards of care have been maintained throughout this process.

Part 2: Integration of clinical services and proposed service relocations

1. Introduction

Throughout the acquisition process, the RUH has clearly stated its intention to relocate services from the RNHRD site to the RUH site or, where clinically appropriate and to maximise patient benefit, to suitable community settings. The relocation of services from the RNHRD site will allow the following benefits to be realised for the patients and communities served, principally:

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

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

  The ability to fully integrate and align services on a single site was a core component of the original business case for acquisition and sustainability of services. It will improve efficiency and effectiveness, maintaining patient experience and quality of service delivery as well as increasing value for the money from the public purse.

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

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

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

- **Research and Development:** The combined organisation has the second largest R&D portfolio amongst medium-sized hospitals in the NHS.

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

- **Environment:** It is recognised that whilst the RNHRD building is highly regarded by the patients it serves, it is unlikely to be a cost effective or suitable base for high quality service provision in the longer term.

It is expected that services will continue to be delivered from the existing RNHRD building for up to three years post acquisition. During this time work will be undertaken within the wider estates plans at the RUH to develop purpose designed environments which benefit patient experience and wellbeing whilst supporting improved efficiency and effectiveness of delivery through appropriate scaling, workflow design and co-location with other services. Opportunities for branding of elements of the new estate will also ensure that the long-term legacy of the RNHRD can be protected.

2. Current position & future proposals

The plans for relocation of services, including identification of suitable new accommodation or new buildings, is being managed through the RUH 'Fit for the Future' redevelopment programme. The RUH seeks to ensure this programme provides the best possible opportunities for engagement and consultation with our key stakeholders including patients, employees, public and healthcare partners to inform estate development plans.

Services currently provided from the RNHRD and potential timing for relocation, taking into account co-dependencies, are outlined in the table below:

Phase	Service	2015/16	2016/17	2017/18
1	• Sexual Health*		Quarter** 1 tbc	
2	• Paediatric fatigue • Paediatric rheumatology	Quarter 4		
3	• Adult fatigue			Quarter 4
4	• Rheumatology • Biologics • Orthopaedics • Dermatology • Therapies • Clinical measurement (DEXA, x-ray etc.)			Quarter 4
5	Pain services			Quarter 3

*Service is not provided from RNHRD site but will potentially require relocation as part of the RUH redevelopment programme.

** Quarter's based from the start of the financial year from April e.g. Quarter 1 will be April to June

3. Consultation and engagement

3.1 Scale and scope

Services are commissioned by a wide range of organisations and a number are highly specialised in nature, serving small numbers of patients. Aside from the RUH's own sexual health services, general rheumatology is the largest service area to be impacted – serving approx 3000 patients in B&NES, similar numbers in Wiltshire and a further 4000 nationwide in 2014/15. Dermatology is the smallest service serving just 35 patients nationwide. Paediatric fatigue and paediatric rheumatology services, which are proposed to relocate in Q4 2015/16, nationally serve 451 and 140 patients respectively.

A Local Health Economy (LHE) Forum (comprising key commissioning and public/patient representation) was established in 2014 to support the acquisition process and ensure ongoing stakeholder support for the transaction. At a meeting of this Forum on the 2 July 2015 it was proposed that BaNES CCG would lead on consultation and engagement activities on behalf of the other commissioners. This will reduce complexity and ensure the approach to co-dependent services e.g. Rheumatology and Therapies, is addressed appropriately.

3.2 Approach – Two phase engagement/consultation
The proposed destinations for the two paediatric services and the sexual health service have been identified. However, destinations for the remaining services are being determined alongside new build and estate development plans. Clinical teams continue to be integral to the planning for these and a number of patient engagement events have taken place.

In order to develop the accommodation required for service relocation over the 3 year period outlined in the original principles of acquisition, the RUH Board of Directors is required to sign off an outline business case for estates development investment in December 2015. To achieve this, it is important for the Board to understand whether the general principle of service relocations is accepted.

It is likely that most service relocations e.g. paediatric services will be simply a change of site (similar to the transfer of the endoscopy service from the RNHRD to the RUH site which took place following appropriate engagement earlier this year). However, where clinically appropriate and to maximise patient benefit, suitable community settings could also be considered.

3.2.1 Phase one – Broad overarching consultation and engagement
In order to ensure that feedback gained during engagement activities can inform the RUH estates development programme and meet the December timeframe for investment decision making, there will be broad engagement/consultation on relocating all services outlined above to gain agreement in principle to transfer the services from the RNHRD site.

3.2.2 Phase two – Service specific consultation and engagement
Further specific engagement activities for each of the services will then take place as detail regarding proposed locations and dates for potential transfer of services become clear aligned to the phasing outlined in the table above.

3.3 Timing
In order to meet the timescales outlined, allow timely movement of paediatric services and ensure that the RUH estates programme can proceed without undue delay, phase one of the engagement and consultation around the proposed service moves is proposed to commence in September 2015.

3.4 Engagement to date
A number of engagement activities have already been undertaken to inform the RUH redevelopment work. To date three focus groups have taken place with patients that currently use the therapies departments at the RNHRD and RUH. Representatives also attended from the National Ankylosing Spondylitis Society and the National Osteoporosis Society. The groups discussed access to the department and how they would like the hydrotherapy, gym and changing areas, outpatient and waiting areas to look and feel. The outputs from these sessions will be shared with the architect to influence the design.

There will also be events for patients to feedback on designs for all RNHRD services including, therapies (incorporating hydrotherapy) rheumatology and pain services.

4. Overarching principles
It is a complex set of changes that is proposed due to the phasing and interdependencies of the services and the redevelopment of the RUH site. An overarching set of principles will be developed which will outline the patient benefit, and the RUH's commitment to further improve services and the delivery of high quality care in purpose built surroundings which have been designed with the clinical teams and the patients they care for.

5. Next steps & approvals

We will continue to update members of the Health and Wellbeing Select Committee as work progresses and we will invite committee members to any public meetings we may hold as part of engagement activities. If there are any specific questions the committee would like to see included in engagement activities, we would welcome this input.

The committee is asked to note this report, and confirm support for the proposed two phase approach to public engagement/consultation including the requirement for a decision in principle on the relocation of services to inform the RUH's strategic planning and investment decisions in December 2015.

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<table>
<tr><td colspan="3">Bath & North East Somerset Council</td></tr>
<tr><td>MEETING/
DECISION
MAKER:</td><td colspan="2">Health and Wellbeing Select Committee</td></tr>
<tr><td rowspan="2">MEETING/
DECISION
DATE:</td><td rowspan="2">29th July 2015</td><td>EXECUTIVE FORWARD PLAN REFERENCE:</td></tr>
<tr><td></td></tr>
<tr><td>TITLE:</td><td colspan="2">LGA Adult Safeguarding Peer Challenge Report and Action Plan</td></tr>
<tr><td>WARD:</td><td colspan="2">All</td></tr>
<tr><td colspan="3">AN OPEN PUBLIC ITEM</td></tr>
<tr><td colspan="3">List of attachments to this report:
Attachment 1 LGA Adult Safeguarding Peer Review Report
Attachment 2 Peer Review Report Action Plan</td></tr>
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1 THE ISSUE

1.1 A Peer Review team visited B&NES Council and Local Safeguarding Adult Board (LSAB) in March 2015. The LSAB and Council Officers seek to share the Peer Review teams' findings with the Health and Wellbeing Committee and also the corresponding Action Plan which was approved by the LSAB in June 2015.

2 RECOMMENDATION

2.1 Proposal 1: Consider the Peer Review Report and corresponding Action Plan and highlight any additional areas the Committee would like to add to the Plan.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 None

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 The Council has statutory responsibility for ensuring adults with care and support needs are safeguarded effectively (Care Act 2014)

4.2 Since April 2015 LSABs have been placed on a statutory footing and the Council is responsible for facilitating the LSAB and ensuring multi-agency partners work effectively together to safeguard adults at risk of abuse. The other key statutory partners on the LSAB are health and the Police – both of which are named in the Care Act 2014 guidance.

4.3 Given the above statutory responsibility the Peer Review Report and Action Plan are presented to the Health and Wellbeing Committee for consideration.

5 THE REPORT

5.1 The Association of Directors for Adult Social Services (ADASS) are responsible for implementing a Sector Led Improvement Programme which is designed to support Local Authorities in delivering adult social care policy. This programme is supported by the Local Government Association (LGA). One of the mechanisms for implementing the Improvement Programme is the participation in a Peer Reviews (sometimes also called Peer Challenge).

> *'A peer review is designed to help an authority and its partners assess current achievements, areas for development and capacity to change. The peer review is not an inspection. Instead it offers a supportive approach, undertaken by friends – albeit 'critical friends'. It aims to help an organisation identify its current strengths, as much as what it needs to improve. But it should also provide it with a basis for further improvement.'*
> (p 3 of Attachment 1 – The Report)

5.2 A Peer Review team consists of the following members, an LGA representative, a Director of Adult Services, an Assistant Director of Adult Services (or equivalent) and a Lead Member. The Review team which visited B&NES was made up of the following:

Stephen Chandler, Director for Adult Services, Shropshire Council

Fran Leddra, Strategic Lead, Safeguarding, Complex Care and Social Work, Thurrock Borough Council
Councillor Ruth Dombey, Leader of the Council, London Borough of Sutton
Kay Burkett, Challenge Manager, Local Government Association

5.3 The South West ADASS members agreed that Peer Reviews would take place over three days. The initial agreement across the South West was for all Local Authorities to identify specific areas in their adult safeguarding system they would like reviewed and to that end a specific safeguarding adult review framework was agreed. Towards the end of Review timetable some South West Local Authorities agreed to change the area they wanted their Peer Review to focus on, however in B&NES we agreed to continue with the adult safeguarding system.

5.2 The scope for the B&NES Review was discussed with the LSAB. Together the LSAB and Council agreed the following scope:

- Is it clear and understood by all where accountability for safeguarding adults sits?
- How do the individuals/bodies/organisations with accountability for safeguarding adults get assurance and provide upwards assurance?
- Are these assurance mechanisms and processes robust, providing genuine *assurance* rather than reassurance?
- Is the safeguarding adults system/arrangement future proofed in terms of the Care Act 2014

5.3 In addition to the local scope the Peer Review team also consider the following areas as set out in the safeguarding adult review framework:

(1) Leadership, Strategy and Commissioning

(2) Outcomes for and the experiences of people who use services

(3) Service Delivery and Effective Practice, Performance, Resource Management

(4) Working together – Safeguarding Adults Board

5.4 The Peer Review team met approximately 60 internal and external stakeholders during their three day visit (23th – 25th March 2015).

5.5 On the third day the 'team' set out their findings which included areas of strength, areas for further consideration and recommendations for change / improvement. The attached report (Attachment 1) is the formal report received from the Peer Review team.

5.6 Four key recommendations were made as set out on page 13 of the report:

(1) Progress at pace the implementation of Making Safeguarding Personal (MSP)

(2) The Quality Assurance, Audit and Performance Management Sub Group – in line with MSP, could develop more qualitative ways of auditing safeguarding

(3) Revise the two day decision rule in relation to MSP

(4) Consider how you reaffirm the citizen at the centre of everything you do

5.7 In response to the recommendations above and to other areas highlighted in the report for consideration, the Council has developed an action plan (Attachment 2) which was approved by the LSAB at its meeting in June 2015.

5.8 The Council and LSAB found the Peer Review a useful mechanism to help with identifying future improvements to be made.

6 RATIONALE

6.1 For the Health and Wellbeing Committee to consider the actions outlined in the Action Plan to enable the continued improvement of the adult safeguarding system.

7 OTHER OPTIONS CONSIDERED

7.1 None

8 CONSULTATION

8.1 LSAB members and all internal and external stakeholders involved in the Peer Review.

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.

9.2 The LSAB has also approved its own Risk Register.

Contact person	Lesley Hutchinson, Head of Safeguarding and Quality Assurance
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

Local Government Association

Bath & North East Somerset Adult Safeguarding **Peer Review Report**

March 2015

Executive Summary

As part of the South West ADASS programme of sector led improvement quality assurance and improvement Bath & North East Somerset Council (B&NES) requested the Local Government Association undertake an Adult Safeguarding Peer Review. B&NES was seeking an external view on the quality, processes and procedures of Adult Safeguarding in the context of B&NES local integrated arrangements and the delivery of key adult safeguarding functions by Sirona and Avon and Wiltshire Mental Health Partnership Trust (AWP). The scope of the peer review is to review and "test" the clarity of accountability and the associated assurance systems, processes and mechanisms with particular emphasis on context-specific learning and improvement.

After due consideration across the variety and complexity of the adult safeguarding business of B&NES, the Peer Review Team made a number of recommendations covered in the detail of this report. Participants in the peer review process told us that the process of participating in the review was helpful in itself as it focused on what needs to be done and actions were already being taken as a result.

Headline messages

Bath & North East Somerset Council and the Clinical Commissioning Group (CCG) have shown real system leadership in the way integration has been progressed over a period of four years. The development of Sirona as a community interest company providing a wide range of publicly-funded care and support services, including community healthcare, children's healthcare, public health services and adult social care services and generic social work, put you ahead of the curve A strong focus has been maintained on assurance and development of robust processes to support this.

There is strong recognition by the Council and CCG of the need to continue the journey of integration. This is evident in the creation of a new post across both organisations to progress joint commissioning and the vision of integrated services through the '*your care, your way'* two year project to review, design and deliver integrated community services in partnership with local people. All of the partners, managers and staff the Peer Review Team met are clearly committed and enthusiastic to 'get things right' in relation to adult safeguarding, thus providing an opportunity to progress integration at all levels - and with some pace.

There is a real importance to ensure the safeguarding prevention and early intervention narrative is 'live' for citizens and practitioners. This would include being clear for those trying to implement it what is understood by 'prevention and early intervention' within the context of your aim to empower people to remain in control of their own lives. Making Safeguarding Personal is starting to offer solutions that will be evaluated to help in understanding the effectiveness of interventions, complement your renewed focus on outcomes and provide a platform for best practice sharing.

The Council and its partners have identified a desire to improve engagement and co-production. Co-production needs to become your new 'norm' so that you not only retain assurance but can unleash further your potential for creativity and innovation. As co-production goes further than engagement there needs to be a plan as to how

service users, and carers, will be involved in the design preparation and implementation of changes in order to demonstrate true co-production.

Whilst it took a strong commitment to get to the front with integration and the creation of Sirona you now need to use your strong partnerships and four years of learning as a basis to consider how you move forward together with focus and pace to stay ‘ahead of the game’.

Report

Background

1. As part of the South West ADASS programme of sector led improvement quality assurance and improvement Bath & North East Somerset requested the Local Government Association undertake an Adult Safeguarding Peer Review.

2. The Council intends to use the findings of this Peer Review as a marker on its improvement journey. The specific scope of the work was:

   a) The quality, processes and procedures of Adult Safeguarding in the context of B&NES local integrated arrangements and the delivery of key adult safeguarding functions by Sirona and Avon and Wiltshire Mental Health Partnership Trust (AWP).

   b) Review and "test" the clarity of accountability and the associated assurance systems, processes and mechanisms with particular emphasis on context-specific learning and improvement

3. A peer review is designed to help an authority and its partners assess current achievements, areas for development and capacity to change. The peer review is not an inspection. Instead it offers a supportive approach, undertaken by friends – albeit 'critical friends'. It aims to help an organisation identify its current strengths, as much as what it needs to improve. But it should also provide it with a basis for further improvement.

4. The basis for the context of the review was the LGA Standards for Adult Safeguarding (Appendix 1). A range of guidance, tools and other materials has been produced by national and local government, the NHS, police and justice system in recent years. The LGA Standards reflect this. The contextual themes used were:

   - Outcomes for and experiences of people who use services
   - Leadership, Strategy and Commissioning
   - Service delivery and effective practice, performance and resource management
   - Working together – the Safeguarding Adults Board

The main focus of the review was the following questions:

- Is it clear and understood by all where accountability sits?
- How do the individuals/bodies/organisations with accountability get assurance and provide upwards assurance?
- Are assurance mechanisms and processes robust, providing genuine *assurance* rather than reassurance?

5. The members of the Peer Review Team were:

   - Stephen Chandler, Director for Adult Services, Shropshire Council

- Fran Leddra, Strategic Lead, Safeguarding, Complex Care and Social Work, Thurrock Borough Council
- Councillor Ruth Dombey, Leader of the Council, London Borough of Sutton
- Kay Burkett, Challenge Manager, Local Government Association

6. The team was on-site from 23rd – 25th March 2015. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. These activities included:

- interviews and discussions with councillors, officers and partners
- focus groups with managers, practitioners and partners
- reading documents provided by the council, including a self-assessment of progress, strengths and areas for improvement against the three main questions

The review did not include looking at case files.

7. The Peer Review Team would like to thank staff, partners, commissioned providers and councillors for their open and constructive responses during the review process. The team was made welcome and would in particular like to thank Jane Shayler, Director Adult Care & Health Strategy and Commissioning, Lesley Hutchinson, Head of Safeguarding & Quality Assurance and Clare Tozer for their invaluable assistance in planning the review.

8. Our feedback to the Council and partners on the last day of the review gave an overview of the key messages. This report builds on the initial findings and gives a detailed account of the review. The report is structured around the main areas listed above.

9. The Care Act puts safeguarding adults on a statutory footing. Safeguarding remains a complex area of work and case law continues to test the basis on which it is undertaken.

Leadership, Strategy and Commissioning

Strengths

- Joint Health & Wellbeing Strategy (JHWS) sets out a clear vision for prevention, integration and care tailored to meet the needs of individuals
- Good understanding of adult safeguarding and universal commitment in wanting to get it right
- Sirona as a community interest company is an innovative model
- Commissioners and providers work well together with clear expectations and reporting requirements in place
- Commissioning and contracting sets out quality assurance and service standards for safeguarding

Areas for consideration

- Develop the views and experiences of people who have used services so they are incorporated further into strategies, plans and commissioning processes
- Pushing integration much further e.g. pooled budgets, dashboards

10. The JHWS, Better Care Fund plan and the '*your care, your way'* project set a clear commitment to prevention, integration and care tailored to meet the needs of individuals. There has been a focus on strengthening the long term financial sustainability of the health and wellbeing system through a shift in investment to prevention and there is a desire to make use of new opportunities for patients, service users and carers.

11. The procedures and processes for safeguarding are widely understood and universal commitment in wanting to get it right. There are many suggestions from practitioners and providers about ways of improving the response to adults experiencing abuse, as well as ways of supporting carers and wider family members. Ways of harnessing these suggestions whilst Making Safeguarding Personal (MSP) is being piloted should be a consideration, including for those adults not entering the safeguarding process.
12. Sirona Care and Health was created in October 2011as a Community Interest Company (CIC) to provide integrated health and social care and was one of the first in the country to include both health and social care practitioners. Creating the CIC demonstrates positively the strength of political and strategic management leadership in this endeavour. As an innovative model it has provided a wide range of care and support services, including community care and community, health services, mental health support and children's health care.

13. Health and social care providers spoke positively of their experience of working with commissioners and there are many examples of the benefits for service users resulting from these strong working relationships. Collaboration rather than 'blame' has enabled an open learning culture where honest conversations take place on a regular basis to complement the formal reporting structure.

14. There are clear benefits of improved and integrated commissioning, including specifications for safeguarding which are also integral in the procurement frameworks for social care services. There are quality standards in place and contract and commissioning officers are part of the quality reviews looking at safeguarding and report back to the safeguarding team any areas of concern.

15. There is a commitment to considering feedback from patients, service users and carers in the design and commissioning of safe services that can be developed further in line with your vision for person centred care.

16. In developing and implementing your 'Making it Real' action plan to embed the principles of personalisation, co-production and integration of adult health and social care commissioning there is an opportunity to consider ways of pushing integration much further. The pooled budgets for mental health and learning disability from April 2015 will also help to progress intervention. The Better Care Fund (BCF) also provides an opportunity to streamline performance reporting to

reflect integration by bringing together aspects of the dashboards that currently duplicate each other.

Outcomes for and the experiences of people who use services

Strengths

- The four ‘test beds’ provide a really strong framework to make safeguarding personalised and truly involve people
- There are services available to support carers that could be developed further to ensure their voices shape services
- Good examples in commissioning for People with Learning Disabilities

Areas for consideration

- Consider how the voice of Users and Carers can be listened to in a comprehensive and systematic way, particularly in relation to safeguarding procedures & processes
- Develop more qualitative understanding of safeguarding to inform regular reviews of your processes
- How do boards know if they are making a difference?

17. The four ‘test beds’ for Making Safeguarding Personal (MSP) are being implemented with enthusiasm and energy by practitioners and they are already providing case studies to evidence how this approach is making a difference in relation to defining and achieving clear outcomes for people (victims, perpetrators and families). Use MSP to help you consider how to respond to low level alerts that do not enter the safeguarding process and identify ways of managing less repeat referrals and/or stopping them going so far into the process.

18. There is a joint Carers Strategy in place, a Carers Centre, LSAB consultation and open sessions and signposting to information and services via the Carers' Gateway. Services and processes for carers are monitored but there is currently less emphasis on understanding and responding to the experiences of carers in relation to safeguarding.

19. Learning Disability outcome based commissioning is well established with combined responsibility for social care, specialist health and complex health needs. There is evidence of reshaping the market to provide independent living, shared lives and some employment opportunities. This approach could be used as a model for other commissioning areas e.g. older people and safeguarding. Commissioning development should ensure that the Council and CCG are able to influence commissioning decisions in a timely way, particularly in relation to continuing healthcare.

20. A more systematic way of ensuring the voice of service users and carers in relation to safeguarding is required. Supporting people to develop their capacity for decision making will need to be demonstrated to fulfil your commitment to increasing prevention, self-care and personal responsibility as well as in meeting

Care Act requirements. Mapping existing methods for capturing the voice of individuals e.g. The ‘Friends & Family Test’ currently used in relation to care homes and patient experience surveys could help inform what could be co-ordinated better across the health and care system so you are assured that people’s experiences are not lost within often complex and multiple processes

21. The LSAB and LSCB are committed to making a difference and are keen to put extra impetus into taking safeguarding messages out to wider communities and to develop a more qualitative understanding of safeguarding. A case study was presented at the last LSAB meeting and this approach, if adopted in a more systematic way, could provide valuable information to inform reviews of processes and services.

Service Delivery and Effective Practice, Performance, Resource Management

Strengths

- Strong focus on performance of processes and procedures
- People are clear about how to make a safeguarding alert
- Learning is shared at practitioner level
- GP email account and the use of IRIS software is innovative

Areas for consideration

- Use the people at the frontline to redesign the system with individuals and carers
- Are language and processes restricting creativity and innovation?
- Keep the perspective on helping people and families to be more resilient
- Consider to what degree risk management enables people to take more responsibility for themselves

22. There is a strong focus on performance and processes supported by lots of data informing regular reports to the LSAB and Health and Wellbeing Board (HWB). Resources have been put in place to enable the safeguarding process to be enhanced following monitoring of processes and data trends e.g. the introduction of safeguarding chairs and in respond to an increase in referrals and re-referrals.

23. A stronger focus on outcomes rather than outputs will be the next stage of developing your performance management framework to help evaluate the impact of interventions and inform reviews of the safeguarding system. Enhance this by using people at the frontline to shape the system going forward putting the experience of people and their stories at the heart of redesign.
.

24. People are clear about how to make a safeguarding alert and are keen to work together to make the system work. There is a universal pride in wanting to get it

right for people and are likely to be supportive of any changes made to improve the efficiency and effectiveness of procedures and processes.

25. The use of the GP email reporting system and the use of IRIS demonstrates the progress being made in embedding safeguarding within partners at both a system and service level.

26. Your clear focus on the development of strong systems and progresses has many strengths, but also risks restricting creativity and innovation. You should seek to use more “test and learn environments’ to both support innovation yet providing reassurance.

27. In the next reiteration of your safeguarding system be assured that commissioning specifications help people to be resilient and there is a strengthened core relating to people taking more responsibility for themselves and the management of risk. Reflect these changes in the information and training provided by the LSAB.

Working together – Safeguarding Adults Board

Strengths

- Strong and well established partnerships have enabled closer working and the development of services
- Children’s and Adults working increasingly closer e.g. safeguarding boards and creation of Head of Safeguarding & Quality Assurance
- LSAB has engaged partners and good participation at the board and sub groups

Areas for consideration

- There is scope to develop the capacity of the voluntary sector to help with prevention and shaping future direction of travel
- Consider how to reduce barriers to engagement and influence at the LSAB e.g. volume of paperwork and use of jargon/acronyms
- Volume of bureaucracy
- Utilise existing methods for safeguarding engagement e.g. ‘your care, your way’ and Area Forums

28. There are well established partnerships in B&NES with many strong and productive working relationships. These include the Council and CCG, commissioners, contract teams and providers, and the local safeguarding boards. Regular meetings mean there are forums to discuss issues and monitor processes.

29. Children’s and Adults are working increasingly closer with the safeguarding boards planning to share and/or integrate their business support & co-ordination, quality assurance and training. The appointment of the current LSCB Chair as the new Chair of the LSAB will provides an opportunity to raise further the profile and visibility of the LSAB in its new statutory role.

30. You have a strong and committed voluntary and community sector in B&NES who want to be part of shaping the development of services. Enabling more capacity in the third sector will help increase safeguarding awareness and contribute to your prevention and early intervention ambitions. Consider ways of involving the voluntary sector more in assurance e.g. by ensuring everyone new to the LSAB has an induction and is supported to contribute fully and in timely way to discussions and developments.
31. The LSAB has proactively engaged all partners and the right people are at the board. Going forward consider how to reduce barriers to engagement and influence at the LSAB e.g. by reducing the volume of paperwork and use of jargon/acronyms. To further support participation ensure good ideas are encouraged to be brought forward for discussion at the board and sub groups and be clear about how they will be taken forward.
32. Every opportunity must be taken for taking safeguarding messages out into the wider community and to non-traditional audiences, even where it is not the primary focus on the agenda, e.g. Area Forums. The role of elected members and frontline staff can be enhanced by supporting all of them to champion safeguarding in their communities and services through training and briefing sessions. This will add value to your commitment to 'Making Every Contact Count'.

Is it clear and understood by all where accountability sits?

Strengths

- Processes are in place to ensure that safeguarding procedures are applied consistently
- The Quality Assurance Framework is clear and widely understood
- Safeguarding Chairs are adding value to the case management work

Areas for consideration

- Review how accountability is shared e.g. give more autonomy to Sirona
- Do people going through safeguarding process understand where accountability sits?

33. The concentrated focus in developing and implementing the Quality Assurance Framework has succeeded in providing assurance that safeguarding procedures and processes are applied consistently. The role of the Safeguarding Chairs has been widely welcomed and there are examples of where they are adding value to the case management work and in the application of the procedures.

34. As the strength of the Quality Assurance Framework has been established the time is right to continue to build the confidence in your processes and procedures by considering how more autonomy could be given to Sirona in relation to safeguarding. 'Walk through' your processes with Sirona and other partners with a fresh look at where accountability could lie e.g. would a straightforward

safeguarding investigation need to be taken back into the Council and might there be a different way to respond to low level incidences?

How do the individuals/bodies/organisations with accountability get assurance and provide upwards assurance?

Strengths

- Lead member has regular meetings with senior officers and provides strong challenge
- Strong partnership with children's will lead to good outcomes
- Use of case studies at the LSAB a good way to know if it is making a difference
- LSAB Chair is inclusive and encourages participation
- LSAB Annual Report goes to HWB and Wellbeing Policy Development & Scrutiny Panel for challenge
- Wide range of methods used to gather data and intelligence regarding risks in services for the risk register e.g. staff feedback forms, service reviews, CQC reports and whistleblowing

Areas for consideration

- Be assured about your outputs and timescales but make it proportionate to a revitalised emphasis on outcomes
- Quarterly Domiciliary Care Strategic Partnership meeting with providers could be utilised better to look at progress in implementing learning & recommendations from safeguarding
- Build on strong commitment from Wellbeing Policy Development & Scrutiny to identify further opportunities to undertake 'deep dives' e.g. in relation to safeguarding prevention and review of procedures and processes to further develop a personalised approach
- CSE/ASE - develop work post 18 to ensure young child is not lost in the system
- Do all alerts have to follow the process – might there be a different way to respond to low level incidences?
- Involve voluntary sector more in assurance e.g. LSAB induction
- Improve feedback to referrers the outcome from an alert e.g. what activity if it doesn't meet the threshold

35. The Cabinet Member for Wellbeing and Co-chair of the Health and Wellbeing Board (HWB) has been proactive in ensuring he is well informed about the adult safeguarding agenda. He attends the LSAB and has been supported well by the Council, CCG and Sirona senior officers with planned meetings established to enable information sharing and challenge to be provided on a regular basis. A newly formed HWB sub group, the Transformation Group, will provide a forum

where challenging issues and opportunities from across the health and wellbeing system can be raised; this is intended to facilitate wider ownership of the safeguarding agenda.

36. Strategic oversight of safeguarding arrangements is provided by the Local Safeguarding Adults Board, the Council, CCG and HWB. Strategic oversight of social care is through the integrated commissioning arrangement and HWB

37. Strong partnership with children's safeguarding processes places you in a great position to support good outcomes. It is important that the opportunities for greater effectiveness and efficiencies though the review of LSAB subgroups gives a place to start the next stage in safeguarding development.

38. Governance arrangements are established with regards to adult safeguarding demonstrated by LSAB annual reports going to the HWB and Wellbeing Policy Development & Scrutiny Panel. The Scrutiny Panel Chair and the Cabinet Member for Wellbeing meet on a regular basis. There is an opportunity for the LSAB to build on the strong commitment from the Scrutiny Panel to identify further opportunities to undertake 'deep dives' e.g. in relation to safeguarding prevention and review of procedures and processes to further develop a personalised approach

39. In relation to Child Sexual Exploitation (CSE) and Adult Sexual Exploitation (ASE) develop work post 18 to ensure young child is not lost in the system.

40. There are a wide range of methods used to gather and triangulate data and intelligence regarding risks in services for the risk register e.g. staff feedback forms, service reviews, CQC reports and whistleblowing. Commissioning teams consult with providers, meet with service users and have developed a stronger focus on prevention in relation to supported housing e.g. by working with providers on ways to avoid hospital admissions.

41. The services that both Sirona and AWP deliver are quality assured through the integrated commissioning performance management arrangement. Service specifications are in place and there is a specific one for safeguarding.

42. During the peer review process it was widely acknowledged that a focus on getting processes and procedures right within the Quality Assurance Framework meant there is further opportunity to ensure that the voice of people is heard through the design of the safeguarding system. Continue to be assured about your outputs and timescales but make it proportionate to a revitalised emphasis on outcomes.

43. Quarterly Domiciliary Care Strategic Partnership meeting with providers could be utilised better to look at progress in implementing learning & recommendations from safeguarding. Other forums might also benefit from an emphasis on shared learning, and look at ways of capturing and scaling up the informal practitioner to practitioner learning.

44. Improve feedback to referrers the outcome from an alert e.g. what activity has been taken if it doesn't meet the threshold.

Are assurance mechanisms and processes robust, providing genuine *assurance* rather than reassurance?

Strengths

- Regular safeguarding audits take place with quality and safeguarding high on the agenda e.g care and nursing home commissioning
- Quality Checkers – very focused and inspiring who feel valued, utilise them more and develop beyond LD
- Transition Assessment has strong safeguarding element

Areas for consideration

- How do people living in B&NES contribute to the LSAB agenda?
- Focus on process and structure rather than outcomes, more needed to understand the impact on people's lives from safeguarding processes
- Consider ways of streamlining audits across partners (self-assessments, case file audits

45. Regular safeguarding audits take place with quality and safeguarding high on the agenda e.g. care and nursing home commissioning and there are examples of pragmatic responses to potential issues e.g. putting an interim registered manager in place in a care home and provision of specific training for a domiciliary care provider. Consider ways of streamlining audits and join up where this is possible.

46. You are starting to put Quality Checkers at the heart of quality assuring learning disability services by listening to what they are telling you and being clear about what has changed as result of their findings. Utilise them more and take the principle of the 'lived experience' across to other areas to add value to more traditional assurance processes.

47. Transition Assessment has a strong safeguarding element with transition planning commencing from age 14 and having a strong risk management focus.

48. More focus is needed to understand the impact on people's lives from safeguarding processes. There is a growing recognition by service users about needing to be more involved helped by MSP. Consider ways of service users being supported to attend strategy meeting, where is possible and appropriate, and ensure the professionals who attend them can add real value. The focus is not everything to do with the person's life it should be those people who are relevant to the safeguarding aspect.

49. The LSAB has reaffirmed for itself the need to raise its profile and continue to reach out to the wider community to enable people living in B&NES to contribute to the agenda.

Key Recommendations

- Progress at pace the implementation of Making Safeguarding Personal (MSP)

- The Quality Assurance, Audit and Performance Management Sub Group – in line with MSP, could develop more qualitative ways of auditing safeguarding

- Revise the 2 day decision rule in relation to MSP

- Consider how you reaffirm the citizen at the centre of everything you do

Next Steps

After due consideration of the issues and recommendations in this summary report the Peer ReviwTeam assume you will take forward aspects of this report in your future plans. We suggest you disseminate the key messages to staff and partners and seek to publish the report.

In due course LGA and South West Regional ADASS will evaluate the progress of this work in line with the wider regional sector led improvement work.

Contact details

For more information about the Adult Safeguarding Peer Review of Bath & North East Somerset please contact:

Kay Burkett
Programme Manager
Local Government Association
Email: kay.burkett@local.gov.uk
Tel: 07909 534126

For more information on peer reviews and peer reviews or the work of the Local Government Association please see our website www.local.gov.uk/peer-reviews

Adults Safeguarding resources

1. **LGA Adult Safeguarding resources web page**
http://www.local.gov.uk/web/guest/search/-/journal_content/56/10180/3877757/ARTICLE

2. **Safeguarding Adults Board resources** including the Independent Chairs Network, Governance arrangements of SABs and a framework to support improving effectiveness of SABs
http://www.local.gov.uk/web/guest/search/-/journal_content/56/10180/5650175/ARTICLE

3. **LGA Adult Safeguarding Knowledge Hub Community of Practice** – contains relevant documents and discussion threads
https://knowledgehub.local.gov.uk/home

4. **LGA Report on Learning from Adult Safeguarding Peer Review**
http://www.local.gov.uk/web/guest/search/-/journal_content/56/10180/4036117/ARTICLE

5. **Making links between adult safeguarding and domestic abuse**
http://www.local.gov.uk/web/guest/search/-/journal_content/56/10180/3973526/ARTICLE

6. **Making Safeguarding Personal Guide 2014** – the guide is intended to support councils and their partners to develop outcomes-focused, person-centred safeguarding practice.
http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/6098641/PUBLICATION

Appendix 1 - LGA Standards for Adult Safeguarding Peer Review

The standards are derived from:

- CQC performance and board reports
- The No Secrets Review
- LGA engagement with safeguarding developments
- Broader local government and NHS developments

The standards are grouped into four main themes which are further divided into sub themes:

Themes	**Outcomes for and the experiences of people who use services**	**Leadership, Strategy and Commissioning**	**Service Delivery, Effective Practice and Performance and Resource Management**	**Working together**
Elements	**1 Outcomes** **2 People's experiences of safeguarding** This theme looks at what difference to outcomes for people there has been in relation to Adult Safeguarding and the quality of experience of people who have used the services provided	**3 Leadership** **4.Strategy and** **5. Commissioning** This theme looks at the overall vision for adult safeguarding, the strategy that is used to achieve that vision and how this is led and commissioned	**6. Service Delivery and effective practice** **7. Performance and resource management** This theme looks service delivery, the effectiveness of practice and how the performance and resources of the service, including its people, are managed	**8. Local Safeguarding Board** This theme looks at the role and performance of the Local Safeguarding Board and how all partners work together to ensure high quality services and outcomes

For the complete, detailed version of the LGA Standards for Adult Safeguarding please go to:

http://www.local.gov.uk/web/guest/peer-reviews/-/journal_content/56/10171/3510407/ARTICLE-TEMPLATE

Attachment 2 Peer Review Response – Action Plan

Peer review recommendation	Action	By Whom	Date for completion
Continue with implementation of Making Safeguarding Personal	To extend from the pilot sites to all alerts received in B&NES.	LSAB – Making Safeguarding Personal (MSP) Group	March 2016
Use MSP approach to respond to low level concerns that do not meet the safeguarding threshold and increase the autonomy of decision making in other organisations in relation to low level incident.	Work with Sirona Care and Health and AWP to develop a risk management framework that supports them in the management of complex concerns that do not meet the safeguarding threshold and includes an MSP approach.	LSAB – MSP or Policies and Procedures Group	January 2016
Develop ways of supporting carers and wider family members during the safeguarding process	a) Investigate the approaches used by other local authorities to share with the LSAB. b) Ensure that the Safeguarding procedure refers to the need to include Legal Power of Attorney's for welfare and finance in the safeguarding process. c) Monitor use of advocates in the safeguarding process for those alleged to be responsible for the abuse.	Deputy Safeguarding Adults Lead; B&NES Council Safeguarding Adults and Quality Assurance Team	September 2015 September 2015 March 2016
Consider current performance requirements and streamline requirements for quantatative	Review the current data requirements together with the CCG to establish a coherent data set.	Head of Safeguarding and Quality Assurance, B&NES Council and Director of	December 2015

data between the NHS and Council.		Nursing, Banes NHS CCG	
Revise the 2 day decision rule in relation to MSP	Review the timescales contained within the Safeguarding procedures to ensure they support MSP	LSAB, Quality Assurance, Audit and Performance Management Sub Group and MSP sub group	September 2015
Develop qualitative measures – consider extending the use of quality checkers from Learning Disability (LD) into other service areas	a) Share information with the LSAB on the LD quality checkers and Health watch visits to Care Homes.	Joint Senior Commissioning Manager (LD and PSI) B&NES Council and Banes NHS CCG	September 2015
	b) Review approaches used by other local authorities to obtain the views of those who have experienced the safeguarding process.	LSAB MSP Sub Group	December 2015
	c) Present a revised qualitative framework to the LSAB.	LSAB MSP sub group	December 2015
	d) Undertake an MSP survey amongst those staff that provide safeguarding co-ordination to identify areas of development or training along with examples of good practice. To repeat this survey within 12 months.	Safeguarding and Quality Assurance Team Manager, B&NES Council	July 2015

Map existing methods for capturing the voice of the individual for the LSAB and consider ways of developing this further including the use of services users in developing LSAB strategies and policies.	Undertake mapping of current methods of capturing the voice of the individual Present the Board with recommendations for further development.	LSAB MSP and Awareness Engagement and Communications (AEC) sub groups to work together LSAB MSP and AEC sub groups	December 2015 March 2016
LSAB approach to prevention – supporting people to be resilient and take responsibility for themselves Sharing safeguarding message out to the wider community and to non-traditional audiences.	Review existing public information available on keeping yourself safe, making changes as needed. Review existing public information strategy identifying where information is being shared with the wider community.	LSAB AEC sub group LSAB AEC sub group	March 2016 November 2016
Further develop the links between the LSAB and the LSCB.	Continue to work on developing shared areas of work with the LSCB – for example on sexual exploitation, human trafficking and prevent. Progress work on MISH – considering how both Boards can co-operate on the development of this project.	Board Business Support Manager Multi-Agency Information Sharing Hub Project Leads	December 2016 December 2016

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<table>
<tr><th colspan="3">Bath & North East Somerset Council</th></tr>
<tr><td>MEETING:</td><td colspan="2">Health & Wellbeing Select Committee</td></tr>
<tr><td rowspan="2">MEETING DATE:</td><td rowspan="2">Wednesday 29 July 2015</td><td>EXECUTIVE FORWARD PLAN REFERENCE:</td></tr>
<tr><td></td></tr>
<tr><td>TITLE:</td><td colspan="2">South Western Ambulance Service (North Area) Joint Health Overview and Scrutiny Committee</td></tr>
<tr><td>WARD:</td><td colspan="2">All</td></tr>
<tr><td colspan="3">AN OPEN PUBLIC ITEM</td></tr>
<tr><td colspan="3">List of attachments to this report:
Appendix 1 – Terms of reference for South Western Ambulance Service (North Area) Joint Health Overview and Scrutiny Committee</td></tr>
</table>

1 THE ISSUE

1.1 The South Western Ambulance Service (North Area) Joint Health Overview and Scrutiny Committee (‘Ambulance JHOSC’) includes scrutiny member representatives nominated from B&NES. Given recent elections, and changes to scrutiny membership, fresh nominations are required for B&NES members to join the Ambulance JHOSC.

2 RECOMMENDATION

2.1 To agree three nominees to represent B&NES on the Ambulance JHOSC.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 This is not a new joint health scrutiny committee. Whilst there are members and officer costs in attending scrutiny meetings, none are additional to previous arrangements.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 The council has a statutory duty to promote the health & wellbeing of the inhabitants of its area and reduce inequalities amongst its population.

4.2 Unlike some external bodies, member representation on the Ambulance JHOSC is not statutory. However, it is good practice to maintain good links between local health scrutiny and regional scrutiny bodies.

5 THE REPORT

5.1The Terms of Reference for the Ambulance JHOSC allows B&NES to nominate three councillors.

5.2 B&NES Councillors participating in joint health scrutiny are to be agreed by, and appointed from, the Health & Wellbeing Select Committee.

5.3 The requirement to observe political proportionality in making appointments to joint health scrutiny committees has been waived by councils so as to give each one the maximum flexibility in making its appointments.

6 RATIONALE

6.1 The membership of the health scrutiny function has changed following recent elections. There is the opportunity for three B&NES councillors to sit on the Ambulance JHOSC.

7 OTHER OPTIONS CONSIDERED

7.1 None

8 CONSULTATION

8.1 The council's s151 and Monitoring Officer have had the opportunity to input to this report and have cleared it for publication.

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.

<table>
<tr><td>Contact person</td><td>Emma Bagley 01225 396140</td></tr>
<tr><td>Background papers</td><td>None</td></tr>
<tr><td colspan="2">Please contact the report author if you need to access this report in an alternative format</td></tr>
</table>

South Western Ambulance Service (North Area) Joint Health Overview and Scrutiny Committee

Terms of Reference

Aims and Objectives

To collectively scrutinise the planning, design and delivery of services provided by the South Western Ambulance Service NHS Foundation Trust (SWAS) to:

- Hold SWAS to account for its performance for the North Area, which is the area formerly covered by the Great Western Ambulance Service NHS Trust i.e. B&NES, Bristol, Gloucestershire, North Somerset, South Gloucestershire, Swindon, Wiltshire

- To review and develop policy that affects all local authorities in the SWAS (North Area)

- To scrutinise the impact of the services provided by SWAS on all local communities in the North Area served by the Trust,

- Any issue in relation to the planning, design or delivery of healthcare services by SWAS that impacts on two or more local authorities within the North Area served by the Trust

- To act as the body which will be formally consulted in the event of a decision by two or more participant HOSCs or by SWAS itself that a proposal by SWAS or its lead commissioner to vary or develop services constitutes a “substantial variation”

- To review the impact of legislative changes which directly or Indirectly affect the provision of ambulance services in the SWAS North Area

To have specific responsibility (but not limited to):

- The scrutiny of performance against national and local response time targets

- The scrutiny of performance against other national and local Targets

- The scrutiny of the strategic direction of the planning, design and delivery of healthcare services provided by SWAS

- The scrutiny of the commissioning of ambulance services within the North Area served by the SWAS

- The remit of the South Western Ambulance Service (North Area) Joint Health Overview and Scrutiny Committee excludes:

- The scrutiny of any matters relating to the planning, design and delivery of healthcare services provided by SWAS that impacts on a single local authority, without first seeking the approval of the relevant local authority

- The scrutiny of individual cases

- The scrutiny of the management of staff

Rationale

Local authority Health Overview and Scrutiny Committees (HOSCs) have statutory powers to scrutinise the provision of healthcare services to their local communities. HOSCs have an important role in:

- Involving local people and community organisations in scrutiny activity

- Developing a dialogue with service providers and other stakeholders outside the council

- Taking up issues of concern to local people

- Reviewing whether goals are being achieved

- Examining what can be done to solve problems and enhance performance and achievement

- Assisting SWAS achieve their aims through providing practical support where possible and appropriate

Where health services are delivered by a single provider across a number of local authority areas, as is the case with ambulance services provided by the SWAS, it is recognised that there are benefits of the relevant local authorities coming together to scrutinise the planning, design and delivery of these services in partnership.

This will ensure:

- A co-ordinated approach to the scrutiny process
- A common understanding of issues affecting all local authorities within the SWAS North Area
- A single forum for the discussion and review of issues affecting all local authorities within the SWAS North Area
- An identified body to respond to proposals to vary or develop services that have been determined to be a "substantial variation" by two or more local authority HOSCs or by SWAS

Legal Framework

From April 2013 (under the Health and Social Care Act 2012 and 2013 Regulations) the power of health scrutiny will rest with local authorities, and local authorities have flexibility to determine how to discharge the health scrutiny functions. It could be by full Council, by a Committee appointed under Section 102 of the Local Government Act 1972, by an overview and scrutiny or a joint overview and scrutiny committee.

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 state in Part 4, Paragraph 30:

" two or more local authorities may appoint a joint committee (a "joint overview and scrutiny committee") of those authorities and arrange for relevant functions in relation to any (or all) of those authorities to be exercised by the joint committee subject to such terms and conditions as the authorities may consider appropriate."

Task Groups

The Joint Committee may establish a task group comprising of at least two members to carry out an in depth review of a specific issue. A

named lead officer will administer each Task Group, with additional support by other local authority scrutiny officers as appropriate.

As part of its decision as to whether to establish a Task Group, the Joint Committee will consider any funding and resource implications.

Scrutiny by Individual HOSCs

Individual HOSCs retain the right to scrutinise any matter relating to the planning, design or delivery of ambulance services within their area.

It is requested that individual HOSCs advise the Joint Committee of their intention to carry out such a review in order to:

- Prevent duplication
- Identify whether the issue also impacts on other local authorities
- Identify any support that could be provided by the Joint Committee

The final decision to scrutinise an issue remains with the individual HOSC.

The Joint Committee will ensure that copies of its agenda, minutes and work programme are sent to the Chairs of all individual HOSCs.

Membership

Each participating local authority will nominate 3 members of their HOSC to sit on the Joint Committee. Substitutes may attend if required. The following local authorities are members of the Joint Committee:

- Bristol City Council
- Gloucestershire County Council
- North Somerset Council
- South Gloucestershire Council
- Swindon Borough Council
- Wiltshire Council
- Bath and North East Somerset

The Joint Committee shall be entitled to appoint a number of nonvoting co-optees. This will include a representative from Healthwatch.

The next election of the Chair and Vice-Chair will take place at the meeting in autumn 2015, and annually thereafter. In the absence of the Chair, the Vice-Chair will chair the meeting. In the event that both are absent, a member of the Joint Committee from the local authority at which the meeting is being hosted will be appointed to act as Chair. The Chair will not receive a Chair's allowance.

All meetings of the Joint Committee will be held in public. A 15 minute public forum will be held at the start of every Joint Committee meeting.

Administrative Support

Scrutiny Officers from the participating local authorities will support the Joint Committee. The Scrutiny Officer from Bristol City Council will be the lead officer to co-ordinate support arrangements.

Agenda papers and minutes will be made available on the website of the lead local authority. Each local authority will be responsible for displaying agenda papers and minutes on their own websites.

Support arrangements will be reviewed on an annual basis unless there are unforeseen circumstances.

Funding

Participating local authorities are not required to make a financial contribution for the support of the Joint Committee.

Individual local authority Scrutiny Officers will be responsible for printing papers for their members.

The venue for meetings of the Joint Committee will be rotated amongst the participating local authorities. The host local authority will meet the costs of providing hospitality.

Frequency of Meetings

The Joint Committee will meet on a six monthly basis. Additional meetings may be arranged if required.

Attendance at Meetings and Provision of Information

As outlined in the Health and Social Care Act 2001,and re-iterated in the 2013 Regulations, NHS organisations and now health service providers, are obliged to respond to requests for information made by the Joint Committee and to attend meetings of the Joint Committee if required.

This duty also extends to scrutiny reviews being carried out by individual HOSCs.

Review of Terms of Reference
The effectiveness of the Joint Committee and its Terms of Reference will be reviewed on an annual basis. The next review will take place in spring 2015.

Bath & North East Somerset Council

HEALTH AND WELLBEING SELECT COMMITTEE

This Forward Plan seeks to anticipate all the decisions to be made by the Select Committee.

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 goes beyond the minimum legal requirement for only key decisions to be published over the coming four month period, and demonstrates the Council's commitment to openness and participation in decision making. It assists the Select Committee 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 Mark Durnford, Democratic Services (01225 394458). For meeting items, 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), Civic Centre (Keynsham) and at Bath Central, Keynsham and Midsomer Norton public libraries.

The Council's Consultation Policy may be viewed at: www.bathnes.gov.uk/Bathnes/councilinformation/consultation/default.htm

Ref Date	Dec'n Type	Title Precis	Lead Decision Maker/s	Report Author Contact	Background Papers	Strategic Director Lead	Date First Notified
JULY 29TH 2015							
29 Jul 2015		**Mental Health In-Patient Review / Hillview Lodge Re-provision Update** The Select Committee will receive a report on this matter.	**HWSC** Councillor Francine Haeberling	Andrea Morland Tel: 01225 831513		Strategic Director - People	
29 Jul 2015		**RUH Update on Integration of RNHRD** The Select Committee will receive a report on this matter.	**HWSC** Councillor Francine Haeberling	James Scott Tel: 01225 824032		Strategic Director - People	
29 Jul 2015		**Your Care, Your Way Update** The Select Committee will receive a report on this matter.	**HWSC** Councillor Francine Haeberling	Mike MacCallam Tel: 01225 396054		Strategic Director - People	
29 Jul 2015		**LGA Adult Safeguarding Peer Challenge and Draft Action Plan** The Select Committee will receive a report on this matter.	**HWSC** Councillor Francine Haeberling	Lesley Hutchinson Tel: 01225 396339		Strategic Director - People	
29 Jul 2015		**Presentation - Commissioning Landscape for Health & Social Care** The Select Committee will receive a presentation on this matter.	**HWSC** Councillor Francine Haeberling	Julie-Anne Wales, Dr Ian Orpen Tel: 01225 838563,		Strategic Director - People	

Ref Date	**Dec'n Type**	**Title** Precis	**Lead Decision Maker/s**	**Report Author** Contact	**Background Papers**	**Strategic Director Lead**	**Date First Notified**
29 Jul 2015		**South Western Ambulance Service (North Area) Joint Health Overview and Scrutiny Committee** The South Western Ambulance Service (North Area) Joint Health Overview and Scrutiny Committee ('Ambulance JHOSC') includes scrutiny member representatives nominated from B&NES. Given recent elections, and changes to scrutiny membership, fresh nominations are required for B&NES members to join the Ambulance JHOSC.	**HWSC** Councillor Francine Haeberling	Emma Bagley Tel: 01225 396410		Strategic Director - People	
ITEMS YET TO BE SCHEDULED							
		Non-Emergency Patient Transport Service	**HWSC**				
		NHS 111 update	**HWSC**				
		Loneliness report - update Report.	**HWSC**				
		Homecare Review update (for May 2017)	**HWSC**				
		Dentistry - after May 2015	**HWSC**				

Ref Date	**Dec'n** **Type**	**Title** Precis	**Lead Decision** **Maker/s**	**Report Author** Contact	**Background Papers**	**Strategic** **Director** **Lead**	**Date** **First** **Notified**

The Forward Plan is administered by **DEMOCRATIC SERVICES**: Mark Durnford 01225 394458 Democratic_Services@bathnes.gov.uk