‘Making a difference’

Health & Adult Social Care Overview and Scrutiny Panel

Wednesday 18 September 2013 at 6.00pm

HMS Phoebe Committee Room, Town Hall, Bournemouth

Agenda

Panel Members:

Councillor David d’Orton-Gibson, Chairman
Councillor Malcolm Davies
Councillor Cheryl Johnson
Councillor Rae Stollard
Councillor John Wilson
Councillor Lynda Price, Vice-Chairman
Councillor Ben Grower
Councillor Chris Mayne
Councillor Michael Weinhonig

For further information please contact: Matthew Wisdom, Democratic and Overview & Scrutiny Officer, Legal and Democratic Service Directorate. Tel: 01202 451107. E-Mail: matthew.wisdom@bournemouth.gov.uk

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Members of the Public and any Councillor are welcome to attend this meeting.

A loop system for hearing impairment is provided, together with disabled access to the building.

If Councillors and visitors wish to attend meetings and have particular needs they should inform the Council before arriving at the meeting.

Public information:

Request to speak – ‘Deputation’:
Persons may send a request for a deputation in relation to items on this agenda. The request must be sent in writing or electronic mail to Matthew Wisdom at the address shown above.

Public Questions:
Any member of the public whose name appears on the Electoral Roll for Bournemouth - which includes a person under the age of 16 years living in Bournemouth and who is escorted by a qualifying adult - may ask a question in relation to items on this agenda. Questions must be sent in writing or electronic mail to Matthew Wisdom at the address shown above.

THE DEADLINE FOR RECEIVING REQUESTS TO SPEAK AND PUBLIC QUESTIONS IS TUESDAY 17 SEPTEMBER 2013 AT 6:00 PM

Items for Discussion with the Press and Public Present

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. SUBSTITUTE MEMBERS

The Service Director, Legal and Democratic will report on any changes to the membership of the Panel notified in advance in accordance with Procedure Rule 89.

3. DECLARATIONS OF INTERESTS

Members are asked to declare any disclosable pecuniary interests at the meeting, under Rule 5. Members are also asked to state fully the nature of the interest(s), which will be recorded in the record of decisions. If any member has a query on any particular matter, please contact the Democratic Services Officer in advance of the meeting.

4. SIGNING OF MINUTES

To confirm and sign the minutes of the Panel meeting held on 8 May 2013. These can be viewed on the Council's website at the following address:
http://www.bournemouth.gov.uk/CouncilDemocracy/Councillors/BoardsPanels/HealthOverviewScrutinyPanel.aspx

5. PUBLIC ISSUES

a. PUBLIC QUESTIONS

To receive any Public Questions under Procedure Rule 32.

b. DEPUTATIONS

To receive any deputation requests under Procedure Rule 37.

6. THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST AND POOLE HOSPITAL NHS FOUNDATION TRUST – MERGER PROCESS – PROGRESS REPORT

6.05 pm To receive a verbal update from the Chief Executive of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

7. THE ROYAL BOURNEMOUTH HOSPITAL – ACCIDENT AND EMERGENCY DEPARTMENT – GENERAL MEDICAL COUNCIL REPORT

6.25 pm To receive a verbal update from the Chief Executive of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. Members are invited to establish methods of monitoring appropriate improvements at the Royal Bournemouth Hospital, following the recommendations of the General Medical Council.

The full report by the General Medical Council is circulated at **'A'**.

8. ADULT SOCIAL CARE CHARGES – IMPLEMENTATION UPDATE

6.45 pm To consider a report by the Service Manager, Business Planning and Policy, circulated at **'B'**.

9. TRANSFORMATION CHALLENGE AWARD – THE 'BETTER TOGETHER' PROGRAMME

7.05 pm To consider a report by the Service Director, Adult Social Care, circulated at **'C'**.

10. PERFORMANCE MANAGEMENT OF THE CORPORATE PLAN

7.20 pm To consider a report by the Policy and Performance Officer, circulated at **'D'**. The Chairman will lead discussions on this item.

11. WORK PROGRAMME AND TASK AND FINISH GROUP UPDATES

7.35 pm

a. CORE SERVICE TRANSFORMATION PROGRAMME – ADULT SOCIAL CARE PHASE ONE AND PHASE TWO

a. Phase one – to receive an update on the work of the monitoring Task and Finish Group from the Service Director, Adult Social Care.
b. Phase two – to establish the allocation of workstreams to three Task and Finish Groups.

b. TASK AND FINISH GROUP – NEW CARERS' STRATEGY

To receive a progress update from Councillor Chris Mayne.

c. WORK PROGRAMME 2013/14

Following the Health and Adult Social Care Overview and Scrutiny Panel workshop in July, members are asked to approve the initial Work Programme document, circulated at **'E'**. Furthermore, members are invited to consider a further workshop session in Spring 2014, to further plan the Panel's Work Programme for Autumn 2014.

12. BOURNEMOUTH – HEALTH AT THE HEART

7.55 pm To consider the Chairman's proposal to encourage all Overview and Scrutiny Panels to consider the health implications of their work.

13. ANY OTHER BUSINESS

8.00 pm To consider any other business of which prior notice has been received and by special circumstances, which shall be specified in the minutes, the Chairman is of the opinion that the items should be considered as a matter of urgency.

A

General Medical Council

Regulating doctors
Ensuring good medical practice

Check	Targeted check
Date	22 January 2013
Location Visited	Royal Bournemouth General Hospital
Team Leader	Professor Jacky Hayden
Visitors	Professor Simon Carley Dr Jennie Lambert Ms Jill Crawford
GMC staff	Dr Mujtaba Husain, Clinical Fellow
Observers	Dr Mike Masding, Wessex Deanery*
Serious Concerns	Yes

Purpose of the check

We have undertaken a series of checks to emergency medicine departments across England and the Channel Islands to explore risks to training in this specialty, to identify and disseminate areas of good practice and to gain further insight into local and national challenges including difficulty in the recruitment and retention of doctors specialising in emergency medicine, and a continued rise in attendances and the severity and complexity of patient conditions presenting, without provision of adequate resources for assessment and admission.**

*Health Education Wessex is referred to as Wessex Deanery due to the time of the visit

**College of Emergency Medicine Statement

These checks were prompted by an increasing number of concerns reported to the GMC about emergency medicine and particularly relating to very junior doctors in training working at night unsupervised. In April 2012 we completed an audit of emergency department rotas, which found 20 sites that did not clearly demonstrate on-site supervision from a senior doctor in the emergency department overnight. In particular our standards for the supervision of foundation Yr2 doctors were being breached.

Our recent London regional visit highlighted issues with supervision, handover due to shift patterns and support for doctors in training which varied depending on the emergency department. We took the audit information together with evidence from the national training survey, deanery and college scheduled reporting and data from external partners including the Care Quality Commission (CQC) to identify seven local education providers to check.

The check was undertaken in a day and comprised five meetings: foundation and core doctors in training; higher specialty doctors in training; hospital senior management team; emergency medicine consultants and the head of the emergency department. Feedback was provided to the senior management on the day and by email within 48 hours.

Evidence

The Royal Bournemouth General Hospital (RBGH) reported to the GMC through our audit of emergency department rotas, that there is consultant cover 12 hours a day, 8am until 8pm. Middle grades supervise doctors in training between the hours of 8pm and 3am. The LEP highlighted a gap in supervision between the hours of 3am and 8am where the highest grade in the department may be a Foundation Year 2 doctor (F2). As a result of the audit the Wessex Deanery engaged with the LEP requesting that supervision arrangements be strengthened. At the time of the check this had not yet been resolved and we raised a serious concern as detailed below. The College of Emergency Medicine recommends having a minimum grade of an ST4 trainee on duty within the department to supervise at night time.

The national training survey 2012 reported that RBGH had above outliers for induction and local teaching with a below outlier in workload. An October 2012 report stated that the Wessex Deanery had concerns regarding out of hours supervision of F2 doctors in training. No patient safety comments were made about RBGH in the 2012 national training survey.

RBGH had 2,758 incidents reported to the Patient Safety Agency's National Reporting and Learning System (NRLS) between October 2011 and March 2012. However 62.2% of the incidents reported to the NRLS had no degree of harm to patients.

Summary of site

The RBGH emergency department is open 24 hours a day, 365 days per year and is consultant led. The department treats up to 70,000 patients per year from Bournemouth and the surrounding areas.

The LEP has no paediatrics, obstetrics and gynaecology or orthopaedics services on site; however Poole Hospital is less than eight miles away and offers these services. The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust will merge in 2013, it is anticipated that the emergency medicine service would be provided on a single site. Currently some rotas are shared across both sites. Education departments from each site have been discussing training and the senior management team thinks this merger will strengthen educational opportunities.

Levels of clinical supervision at night time are low and there is a gap in on-site supervision between 3am and 8am. All doctors in training we spoke to are happy with the training they receive and they feel they get good exposure to complex patient cases.

Concerns raised during the check

During night time and weekend working there is a lack of appropriate supervision for doctors in training. Between the hours of 3am and 8am there are three doctors in the emergency medicine department - all are either F2s, GPSTs or 'Trust SHOs' with no middle grade cover. Our understanding is that the 'Trust SHOs' have varying levels of experience from one year post foundation to two years post foundation and not necessarily all in emergency medicine. GPSTs may never have worked in emergency medicine previously and we heard that it is possible, other than in the early weeks in August, for all three doctors in training to be F2s. This, combined with a lack of paediatric and obstetrics and gynaecology services on site, constitutes a serious risk to patient safety. Junior doctors in training may have to deal with a very sick patient with no senior cover on site or available from those specialities. Although the LEP was intending to extend middle grade cover during the week, this would still leave gaps on weekend evenings which the LEP proposed to cover with locum middle grades, resulting in continued risk to patients and doctors in training.

While part of the hospital at night team, F2s were being asked to sign prescriptions for patients they had not examined and in clinical cases where they did not feel competent to make a judgement. This included paracetamol and fluids prescriptions for patients not seen, and in haematology, changes to antibiotic regimes where the F2s have had no haematology training and did not feel competent to make that judgement.

The LEP's Response

The trust have been very responsive to our concern and have implemented methods to remove the risk within 48 hours.

The LEP brought forward the middle grade 24/7 rota to start on the Friday 25 January 2013. In relation to the weekend gaps on the rota that we identified, they would have been previously covered by known locum doctors but arrangements were put in place to be covered by substantive contracted posts.

In relation to the concern around prescribing and the 'junior grade' input in to the hospital at night team, the LEP has since reviewed and risk assessed the situation, and the data shows on average there would be two to three calls per night. To rectify the issue the bleep was taken away from the training grades in the emergency department from the 25 January 2013.

The Report

Good practice

1.	Simulation training access for all doctors in training in paediatric emergency care is a good learning opportunity. (Domain 6 TD 6.11)
2.	All doctors in training have the opportunity to learn with and from other healthcare professionals including the liaison psychiatrist working within the emergency department. (Domain 6 TD 6.17)

Requirements

1.	The LEP must ensure that working patterns are appropriate for learning in accordance with the curriculum, add educational value and are appropriately supervised. (Domain 6 TD 6.10)
2.	The LEP must ensure that those supervising doctors in training are clearly identified, are competent to supervise and are accessible and approachable at all times. (Domain 1 TD 1.3)
3.	The LEP must ensure that rotas allow for core and foundation doctors in training to attend regular timetabled teaching. (Domain 5 TD5.4)

Findings

Patient Safety

At night there is a single consultant covering the emergency departments in both Bournemouth and Poole. The split site responsibilities may compromise the ability of consultants to respond to patient concerns in both emergency departments. This also means that doctors in training may be supervised at

weekends and evenings by consultants with whom they are unfamiliar, as they are based at a different site.

In some cases F2 were required to sign prescriptions and make judgements in cases where they did not feel competent and have not had relevant haematology training.

Induction

The LEP runs a two day induction which includes information about equality and diversity, paediatrics, fractures and hospital protocols. Doctors in training said that this prepared them well, however it would have been beneficial to have more time spent on paediatrics. The LEP is aware of this and trying to address it through the simulation training in paediatrics.

Handover

Morning handover is working well. The emergency department currently uses an electronic patient management system which assigns doctors to patients. This means that everybody can view the patient list and who is assigned to each patient. Each weekday morning there is a consultant handover and either a consultant or middle grade will hand over in the morning at the weekend. All clinicians within the emergency department attend these sessions. At other times throughout the day clinicians rely on individual patient handover and patient management systems. There is also review of patient notes in the morning if a patient has been discharged without review by a middle grade.

Rotas

Clinical shifts for core and foundation doctors in training in the emergency department were incompatible with effective training at the time of the check. The shifts were frequently of long duration and doctors in training expressed difficulty in taking adequate breaks and were exhausted as a result of runs of 12 hour shifts and one in four night shifts.

The high proportion of out of hour shifts combined with the current level of consultant out of hours cover and variability of experience and competence of middle grades, reduced the training and supervision opportunities for core and foundation doctors in the emergency department.

All doctors in training within the emergency department have an opportunity to access simulation training for paediatric emergency care.

Historically the LEP has relied on a crisis team for mental health patients, however the crisis team had a large area to cover and it was often a challenge to get the patients seen in a timely manner. The LEP has now appointed a liaison psychiatrist who works five days per week in the

emergency department. This role provides clinical support, and training to core and foundation doctors in training on treating emergency department patients with mental health concerns.

There is low attendance at formal foundation teaching due to the high proportion of out of hours work. Foundation doctors in training we spoke to said they had not been able to attend one teaching session since starting their post in emergency medicine in December. However higher specialty doctors in training had no problem in attending the teaching, which was encouraged by consultants.

Training is supported by a motivated group of consultants with a unified, mature and pragmatic vision. Consultants are dedicated to their roles as clinical and educational supervisors and are very supportive of doctors in training, which doctors in training of all grades acknowledged. Doctors in training we spoke to said that consultants are always willing to attend at night when on call, and are very supportive when asked for advice and they feel like they work in a good team.

Meeting current challenges in emergency medicine

The LEP is creative in its response to challenges with an increase in emergency attendances; it is trying to manage the admissions and transfer of patients safely and ensure timely discharge. The emergency department works well with colleagues in other specialties including the liaison psychiatrist and the local social care team. The LEP has created a general practice led ward to relieve the emergency department and this is working well.

Conclusion

Our findings support the good induction programme noted in the 2012 national training survey. However attendance at local teaching was reported to us as a problem for core and foundation doctors in training. We have set a requirement for the LEP to ensure that rotas allow doctors in training to attend local teaching. Workload was a below outlier for this LEP; all doctors in training we spoke to noted the high workload and intensity however this did not generally affect their educational experience.

Monitoring	The Trust is responsible for quality control and will need to report on what action is being taken regarding the requirements listed above in the attached action plan. The action plan must be sent to quality@gmc-uk.org copying Health Education Wessex by 30 September 2013.

Response to findings	Dr Tanzeem H Raza, Director of Medical Education
Good practice	It is encouraging to note that the Trust's investment in simulation have been acknowledged as 'good practice'. With the appointment of a simulation trainer, we are extending simulation training within ED as well as the rest of the hospital. The 'team' approach to this training has been particularly welcome. The Trust continues to work towards more multidisciplinary training and team building.
Requirements	Rota has been changed to improve the working pattern. Educational and clinical supervision has also improved with more consultant and middle grade presence. The doctors in training have direct access to seniors for advice. All consultants have completed training courses as education supervisors. ED runs its own time tabled teaching programme which cover major parts of Foundation Curriculum. It was agreed with the deanery that those F2 doctors in training who are based in ED will attend ED teaching sessions instead of the Trust teaching sessions. That ensures maximum attendance. They also attend teaching at Bournemouth University with other F2s within Dorset.

Report to Health and Adult Social Care Overview & Scrutiny Panel

B

Subject:	Update report on the implementation of Adult Social Care Charging changes
Cabinet Portfolio:	Councillor Blair Crawford, Adult Social Care
Corporate Lead:	Jane Portman Executive Director, Adults and Children
Service Director:	Andy Sharp, Service Director Adult Social Care
Meeting Date:	18 September 2013
Status:	Public
Contact:	Sally-Ann Webb, Service Manager Business Planning & Policy ☎ 01202 458216 ✉ sally-ann.webb@bournemouth.gov.uk

1.0 Purpose:

1.1 This report updates Health and Adult Social Care Overview & Scrutiny Panel on the impact of the changes to charges for Adult Social Care Services introduced with effect from April 2013.

2.0 Recommendations:

- **That the Panel considers and comments on the impact of the changes to Adult Social Care charges.**

3.0 Reason for recommendations:

3.1 It was anticipated that there would be a number of enquiries made after the first invoices had been sent in May 2013 and that people may consider cancelling or reducing the service they currently receive.

Supporting Information:

4.0 Background detail:

4.1 At it's meeting in October 2012, Cabinet approved changes to charging for Adult Social Care Services to be introduced with effect from 1st April 2013. This followed extensive consultation with service users and the general public. The reasons for the changes were for a fairer, simpler and more transparent system so people understand that whilst charges are based on the actual cost of the services, they will only pay as much as they can afford, determined by a financial assessment. This was in line with national guidance and many other authorities have adopted this approach. Cabinet also agreed that Health Overview & Scrutiny Panel would monitor implementation of the changes.

4.2 In May 2013, an update report was presented to Health Overview & Scrutiny Panel on the progress made of informing service users and carers about the changes to charges for Adult Social Care Services with effect from April 2013. A further report was requested as, at that time, it was too early to assess the impact on service delivery and anticipated income from client contributions.

5.0 Consultation

5.1 Consultation on the proposals for changes was undertaken from 31 May 2012 to 17 August 2012. A copy of the full consultation report is available on the consultation tracker at www.bournemouth2026.org.uk/.

6.0 The Impact on Service Delivery

6.1 During the consultation, day centre users and carers highlighted that some people may choose to seek alternative activity rather than attend Council run day centres. We recognise that attending a day centre additionally supports informal/family carers by providing valuable respite from their caring role.

6.2 In presenting the proposals, analysis was undertaken on the financial impact of lower attendance at day centres. At that time, if everyone affected by the changes stopped attending day services, there would be a 26% reduction in attendance. However, we believed this was unlikely, although recognised that some people may choose to reduce their attendance rather than stop completely. Satisfaction rates in day centres were good and we believed that people would want to continue using our service, particularly those people with complex needs.

6.3 We have identified that there are 76 people who have either decreased or ended their day service between 31st March 2013 and 12 July 2013. 35 of these were identified as having been affected by the increase in charges so the reasons for the changes were established. It was found that 17 people had reduced or stopped day care attendance due to the increase in charges. This equates to 50 sessions, 2.4% of all day centre sessions.

6.4 Analysis was also undertaken with regard to the number of people declining services due to the cost. The numbers were not significant. From April 2013 to July 2013, there were 4 people, previous year's data for the same period, was 2 people. However, this may not include service users who have declined part of a care package.

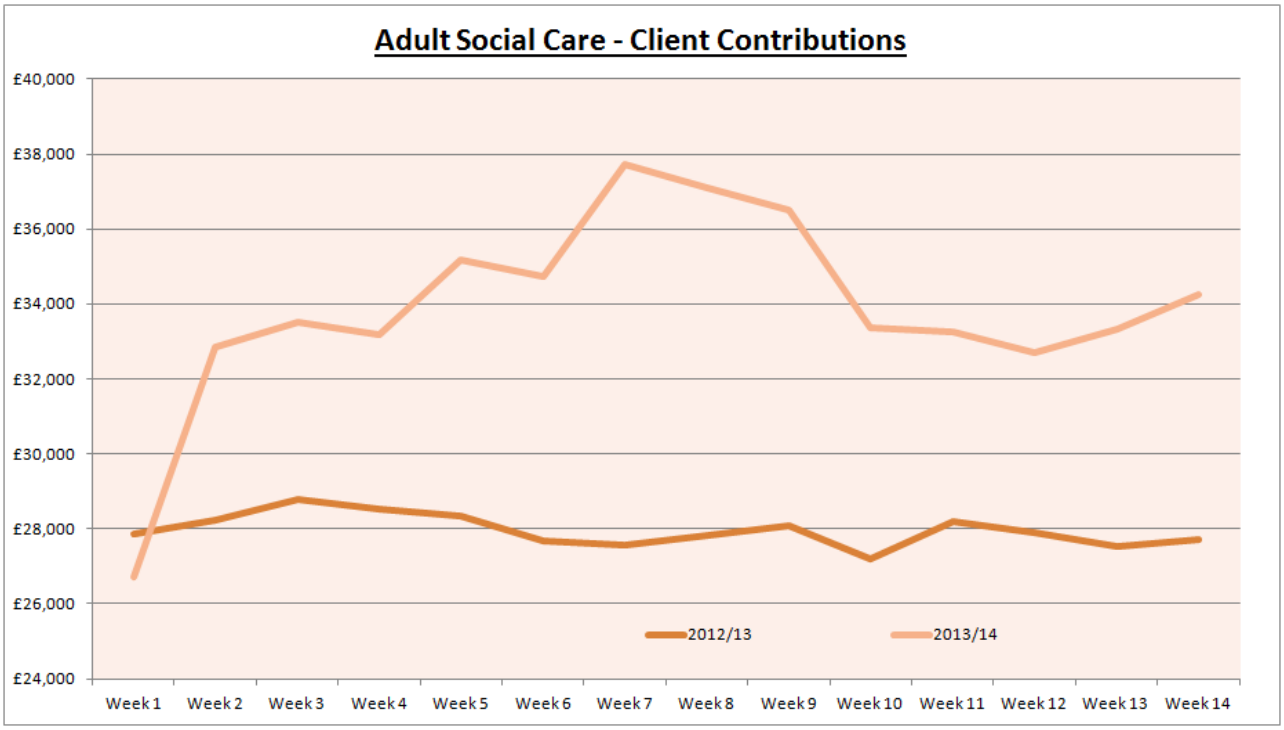
6.5 It was considered likely that those people who receive home care only and were previously paying the subsidised full charge, would continue with our service as market analysis suggests that our rates are competitive with the local market. Further analysis will be undertaken regarding this.

6.6 For those people who have chosen to reduce their services, it was agreed that we will make a follow up call six months later to review their current circumstances.

7.0 Summary of Financial/Resource Implications – including comments from the Council's Chief Financial Officer:

7.1 By introducing the charging changes, anticipated additional income from Client Contributions was estimated between £126k and £645k per annum. The exact amount of extra revenue would depend on the extent to which people chose to continue using our services or arrange their care privately.

7.2 Analysis of client contribution for the first 14 weeks of this financial year shows an average weekly increase in income by £5924 per week as shown in the chart below. This will continue to be monitored together with the outstanding debt position.



7.3 15 people who had previously chosen not to have a financial assessment and pay the subsidised full charge for the service they receive, decided to be assessed and visits by the Financial Assessment & Benefits team were undertaken. Of those, 4 people still had capital over the limit, 3 were nil charge, and the remaining 8 people were assessed as no longer being required to pay the full charge as their disposable income was less than the cost of service.

8.0 Summary of legal implications – including comments from the Monitoring Officer

8.1 Section 17 of the Health and Adult Community Services and Social Security Adjudications Act 1983 (HASSASSA Act 1983) gives the Council power to charge adults for non residential services they receive.

8.2 The Department of Health has issued guidance on how the Council should charge for services in the following documents:

- Fairer Charging Policies for Home Care and other non-residential Social Service dated September 2003
- Fairer Charging Contributions Guidance 2010 – Calculating an Individual's Contribution to their Personal Budget
- Guidance on direct payments for community care, services for carers and children, services
- Charging for Residential Accommodation Guide (CRAG)

8.3 There are also changes to be introduced under the Health and Social Care Act; In 2015:

- The introduction of a universal deferred payment scheme for the payment of residential care fees.
- The capacity for the assets from house sales to be deferred for the lifetime of a service user may mean (in a housing market downturn) equity in unsold properties remains on the local authority accounts as a debt for a long time.

- Introduction of national minimum eligibility to make access to care more consistent around the country.
- Carers will have a legal right to support to meet their needs

In 2017 (The Chancellor's published Budget March 2013 has brought this forward a year to 2016):

- The introduction of a cap on care costs, providing an annual update and maintaining a Care Account
- increase lower and upper capital thresholds for means-tested support for those in residential care
- extended means testing requiring people with modest assets to pay less for their care and a change in the amount of disability benefits payments a local authority can use towards the cost of care
- increase in local authority carrying out more assessments

9.0 Summary of Environmental Impact

9.1 The environmental impact checklist was completed on the proposals to Cabinet through discussion with the Environmental Strategy and Sustainability Manager and there were no material environmental impacts.

10.0 Summary of Equalities and Diversity Impact

10.1 Previous analysis undertaken did not identify any gender implications associated with this change. Service users with a learning disability will be least affected by the changes and those with a mental health condition most affected. With regard to age, service users under 65 years would be least affected and those over 65 years the most affected.

10.2 Analysis of those who have reduced or ended their day centre attendance due to the increase in charges is as follows;

Learning Disability	1 person
Mental Health	5 people
Physical & sensory Disability/frailty	11 people

	Female	Male	Total
Asian or Asian British-Any other Asian	1	1	1
Not Known		1	1
White British	6	8	14
White- European		1	1

All were over 65 years of age.

Background papers:

The report on Charges for Adult Social Care Services was considered by Cabinet 17 October 2012
http://www.bournemouth.gov.uk/CouncilDemocracy/Councillors/CouncillorCommitteeMeeting/Cabinet/2012/10/17/Agenda/121017-agenda-and-reports-package.pdf

C

REPORT TO HEALTH & ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

Subject:	Transformation Challenge Award – the "Better Together" Programme
Cabinet Portfolio:	Councillor Blair Crawford, Adult Social Care
Corporate Lead:	Jane Portman Executive Director Adults & Children
Service Director:	Andy Sharp, Service Director, Adult Social Care
Meeting Date:	18th September 2013
Status:	Public
Contact:	Andy Sharp, Service Director, Adult Social Care ☎ 01202 458707 ✉ andy.sharp@bournemouth.gov.uk Jane Portman, Executive Director – Adults & Children ☎ 01202 456104 ✉ jane.portman@bournemouth.gov.uk

1.0 Purpose:

1.1 To inform Members of the partnership bid to the Department of Communities and Local Government (DCLG) Transformation Challenge Fund and the linked bid to Department of Health to be a 'Pioneer in Integrated Care and Support' and update the panel on progress.

1.2 The Transformation Challenge Award bid has given genuine impetus to the three local authorities and their NHS partners in their drive towards integrated, person centred care at reduced cost in the Dorset area. The Programme sponsors, at their systems leadership event and through other communications, have demonstrated a level of shared ownership and consensus for integrating and transforming health and social care that is hugely encouraging. This has been mirrored with dedication and enthusiasm at a series of well attended Programme Board meetings, at which an innovative programme of work has been initiated. Inclusion on DCLG's Public Sector Transformation Network has increased the momentum further, and success with the Transformation Challenge Award bid, if achieved, would give the "Better Together" Programme a major boost.

2.0 Recommendation:

2.1 The Panel supports and endorses the "Better Together" programme for integrated health and social care across the Dorset area.

2.2 The Panel requests further updates as the programme progresses.

3.0 Reason for recommendation:

3.1 The Better Together programme aims to secure:

- improved health and social outcomes for residents;
- an improved and more integrated business model for the delivery of adult care and health in the Dorset area;
- cost reductions for all partners.

4.0 Background detail:

4.1 Discussions between Bournemouth Borough Council, the Borough of Poole and Dorset County Council about combining key activities such as commissioning, direct provision and fieldwork services with key health partners are already well advanced. We already have some joint posts in place across Children's Services and we have an ambition to expand the model into the much larger service area of adults. Some combined posts already exist in Adult Services between Bournemouth Borough Council, Borough of Poole and the NHS. Submitting a bid for DCLG's Transformation Challenge Award, based upon an innovative and transformational programme of integration between Adult Social Care and Health, is therefore a logical extension of our stated commitment to joint working, already demonstrated by our fully shared Public Health Services with fully integrated staff structures and budget management.

4.2 At their meeting of 28 March 2013, the Leaders and Chief Executives of Bournemouth, Dorset and Poole agreed to submit a joint bid to DCLG by 14 July 2013 for up to £2m of the Transformation Challenge Award, and requested the Chief Executives and relevant Executive/Strategic Directors prepare a draft bid for confirmation by the Leaders and Chief Executives. The decision to proceed was based upon discussions with Paul Rowsell, the Deputy Director for Local Democracy from DCLG, who addressed the meeting. The three Chief Executives jointly submitted a formal Expression of Interest to DCLG on 15 April 2013.

4.3 In summary, the purpose of the bid is to support a proposal that is focussed on the benefits of joint working and integration of the respective Councils' adult social care functions with the health sector, including the Dorset Clinical Commissioning Group (CCG), Dorset HealthCare University Foundation Trust, the Royal Bournemouth and Christchurch Hospital, Poole Hospital and Dorset County Hospital. Closer working will also be explored with the district and borough Councils of Dorset, in particular with their Accessible Homes and Independent Living Services, which are being recommissioned during 2013-15.

4.4 On 24 May a Project Board consisting of senior representatives of the three local authorities and the five NHS bodies discussed and agreed a Project Initiation Document (PID) that set out the vision for the bid and the subsequent programme of work, the scope and approach for the bid preparation project, and the techniques and structures that would be employed to ensure that a high quality and innovative bid is submitted by the DCLG deadline. The three Councils and the five NHS bodies are, therefore, joint signatories for the bid. A key feature of the bid is a coherent jointly owned vision and key principles for innovative whole system approaches for adult care and health in the area that will deliver cost reductions for all partners; improved health and social outcomes for residents; and greater personalised support for individuals and their families, in particular the frail elderly and people with long term conditions, ensuring that care is whenever possible delivered in, or closer to, people's homes.

4.5 At its meeting of 12 June 2013, the Dorset Health and Well-Being Board gave support to the three upper tier local authorities in Dorset and the five NHS bodies to submit a joint bid to DCLG for a share of its Transformation Challenge Award. Through the award, DCLG is seeking to provide support for radical innovations involving two or more local authorities combining their operations across all or a major part of their service delivery and back office, whilst maintaining their separate identity and political representation. The total fund is £9m, and individual single multi-authority awards could be up to £2m.

4.6 A Programme Board was formed, made up of senior representatives of the eight partner authorities. During a series of regular meetings through June and July the Board discussed and agreed a transformation programme – "Better Together" - comprised of a jointly owned vision, key principles and component projects to deliver whole system approaches for adult social care and health in the Dorset area, cost reductions for all partners, improved health and social outcomes for residents and greater personalised support for individuals and their families, in particular the frail elderly and people with long term conditions.

4.7 At the LGA conference on 3 July, Eric Pickles, Secretary of State for Communities and Local Government, announced that the Dorset-area partnership would be one of the first nine areas to receive innovative support from DCLG's Public Transformation Network. The network is comprised of expert consultants from across the public and private sectors, and will give the partnership access to dedicated support to help develop practical reforms and deliver improved services at reduced cost at a local level.

4.8 On 12 July, a bid was submitted to DCLG which described the "Better Together" programme in detail. The bid is included here at Appendix A. In addition, a similar bid was submitted, rather more speculatively, to the Department of Health (DH), which was inviting expressions of interest from local areas to become integration 'pioneers'.

4.9 Full details of the proposed programme are at Appendix A. However, in summary, individual projects are being developed across four areas:

- **managing demand** - universal front-end, information and advice (including for self-funders), reablement/ intermediate care, technology, accessible homes (with our district councils);
- **improving effectiveness** - a new operating model and care management process across the three local authorities supported by one ICT system;
- **integrating commissioning** - shared commissioning functions across the CCG and the three local authorities: use of resources, pooled and aligned budgets, common principles and priorities and market positioning;
- **integrating service delivery** - integration for acute, community and primary health and social care, with enhanced community health and social care co-located services which are fully integrated with all primary health services.

4.10 Final decisions about the Transformation Challenge Award will not be made by DCLG until October. On 9 August we were, however, informed by DH that our application for "Pioneer" status had not been successful. The feedback given to us explained that while our application demonstrated a well presented vision, and evidence of good stakeholder engagement, we had an insufficient track record of innovative service improvement to be considered a pioneer in the field. Nevertheless DH were impressed with the range of ambitious plans and initiatives already underway and very keen for us to remain involved and to be part of a network of support.

5.0 Consultation:

5.1 Consultation and engagement will form a key part of the "Better Together" transformation programme. The programme structure includes a consultation and engagement sub-group who will develop and oversee a communications strategy. The Transformation Challenge bid ("Better Together") has been to Dorset Health & Wellbeing Board and the recent Bournemouth & Poole Health and Wellbeing Board Development Session.

5.2 A central requirement of the "Better Together" programme is that it contributes to the successful delivery of the Joint Health and Wellbeing Strategy.

6.0 Alternative options considered and rejected:

- Not applicable

7.0 Summary of Financial/Resource Implications – including comments from the Council's Chief Financial Officer:

7.1 Will be considered as part of the development of individual projects within the overall programme.

8.0 Summary of legal implications – including comments from the Monitoring Officer

- Not applicable

9.0 Summary of Environmental Impact

9.1 Will be considered as part of the development of individual projects within the overall programme.

10.0 Summary of Equalities and Diversity Impact

10.1 As the programme is implemented, full Equality Impact Needs Assessments will be carried out for any proposed changes of policy.

11.0 Summary of Risk Assessment:

11.1 Risk will be considered as part of the development of individual projects within the overall programme.

Background papers:
None

D

REPORT TO HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

Subject:	Performance of Corporate Priority Outcomes
Cabinet Portfolio:	Cllr Mike Greene, Cllr Blair Crawford/Cllr Nicola Greene and Cllr Jane Kelly
Corporate Lead:	Jane Portman, Adults and Children, Executive Director, Deputy Chief Executive
Service Director:	Richard Saunders, Service Director Strategic Services
Meeting Date:	18 September 2013
Status:	Public
Contact:	Vicky Edmonds and Kerstin Cummings, Corporate Performance Management Officers ☎ 01202 454958 vicky.edmonds@bournemouth.gov.uk kerstin.cummings@bournemouth.gov.uk

1.0 Summary

1.1 This report sets out the 2013/4 Quarter 1 performance of the corporate priority outcomes for the Health and Adult Social Care Overview and Scrutiny Panel. This report covers the period April – June 2013.

2.0 Recommendations

2.1 That the Health and Adult Social Care Overview and Scrutiny Panel consider and comment on the performance of corporate priority outcomes, for action by the appropriate performance manager, as necessary.

3.0 Background Information

3.1 Following the last meeting of the panel, Members sought clarification on the RAG status used in the report. The definitions are as follows:
Red – Below target and tolerance level
Amber – Below target but within tolerance
Green – On or above target

3.2 The RAG status compares latest performance against the target. The direction of travel compares latest performance against the previously reported performance.

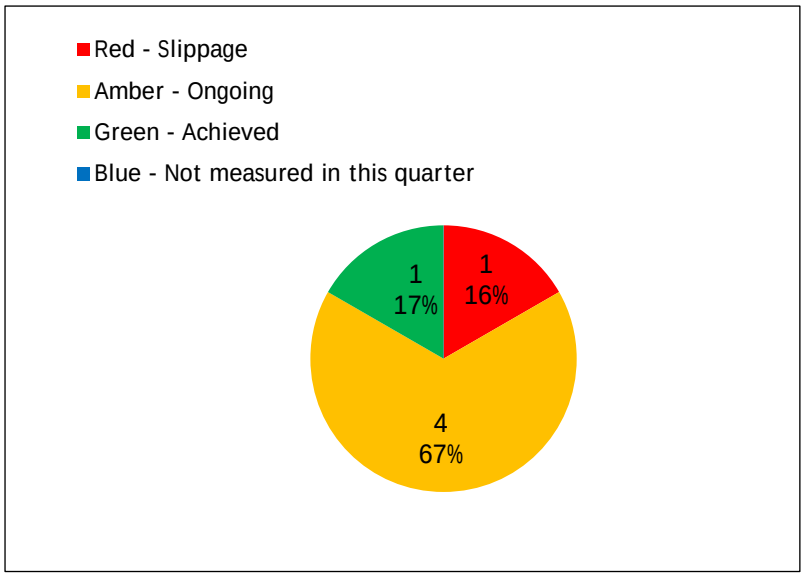
Report to Health and Adult Social Care Overview and Scrutiny Panel - 18 September 2013 2013/14 Quarter 1

Report on Performance of Corporate Priority Outcomes: **Reporting Period : April - June 2013**

2.2: Vulnerable adults and children safeguarded - Cabinet Member lead - Cllrs Blair Crawford/Nicola Greene (led by Children's Services/Adults O&S Panels)
2.3: Increased prevention and early intervention - Cabinet Member lead - Cllrs Blair Crawford/Nicola Greene (led by Children's Services/Adults O&S Panels)
2.4: Increased public awareness of health issues and targeted activity in areas of health inequality - Cabinet Member lead - Cllr Mike Greene
2.5: Improved engagement and consultation with the public - Cabinet Member lead - Cllr Jane Kelly

Ref	Description	Page No
Indicators showing red:		
<u>No clear link to a Priority Outcome</u>		
L1B	The number of people receiving personal budgets as a proportion of the eligible people using community based services	5

Overall Summary of Performance



Corporate Plan Performance Monitoring
Report to Health and Adult Social Care Overview and Scrutiny Panel
Quarterly Reporting Period: April - June 2013

Ref	Description	Unit of Measure	Good Performance is H/L figure	Frequency	Previous Data	Latest Data	Target	Direction of Travel ⇧ Improving ⇩ Declining ⇔ Maintained	Previous RAG Status	Current RAG Status	Performance Manager
Priority Outcome 2.2: Vulnerable adults and children safeguarded											
L11	Repeat referrals to adult safeguarding	%	Low	Quarterly	24	16	14 (2013/14 Target)	⇧	Red	Amber	Barbara O'Brien - Adult Social Care
	Comment: The figures for quarter 1 show a decrease in the % of repeat alerts received by adult social care which is a significant improvement on the previous quarter and we continue to work hard to ensure that only appropriate referrals are received by the department. We have reminded staff of the need to ensure that appropriate and robust Protection Planning is in place to minimise the risk of inappropriate repeat alerts being received. In addition we have undertaken a data validation assessment to remove double counting and taken steps to ensure that reviews and assessments are undertaken in a robust and timely manner. As part of focusing activity around our safeguarding processes we have taken additional steps to ensure that all safeguarding referrals are allocated to a practitioner with immediate effect.									

RAG status
Red - Slippage
Amber - Ongoing
Green - Achieved
Blue - Not measured in this quarter

Corporate Plan Performance Monitoring
Report to Health and Adult Social Care Overview and Scrutiny Panel
Quarterly Reporting Period: April - June 2013

Ref	Description	Unit of Measure	Good Performance is H/L figure	Frequency	Previous Data	Latest Data	Target	Direction of Travel ⇧ Improving ⇩ Declining ⇔ Maintained	Previous RAG Status	Current RAG Status	Performance Manager
Priority Outcome 2.5: Improved engagement and consultation with the public											
3C	The proportion of carers who report they have been consulted about the person they care for	%	High	Every 2 years (Current survey undertaken Nov 2012 - Interim survey to be undertaken late 2013 - Results early 2014)	N/A	67.7 Survey undertaken November 2012	74 (2013/14 Target)	N/A	Not available until target set (when comparative data available)	Amber	Andy Sharp - Adult Social Care
	Comment: This figure was generated through a national survey of carers. The survey is a new initiative - and therefore there is no previous performance has been set for this measure until final comparative data is available. Initial assessment of our performance shows we are below national (England) and comparator authorities / statistical neighbours: Bournemouth: 67.70% Statistical neighbours: 73.40% South West: 73.70% England: 72.80% Our policy is to consult with known carers during assessment / review processes as part of service user assessment in recent months. Intensive work was undertaken to complete overdue assessments and reviews and these will also capture the carers perspectives. We have reviewed our processes for carers assessments, including the provision of an on-line option. Carers also told us they would welcome the opportunity for the assessment to be undertaken outside of their own home and therefore social workers are now using local libraries for this process. Performance should be looked at in conjunction with overall satisfaction of carers with services (3B) currently 46% - which is higher than all comparators (Regional performance being 46%, England 4% and Comparator authorities is 45.5%) A research project currently being undertaken is looking at the factors affecting carers Quality of Life, both of which are influenced by the assessment and review process. This will be reported later in the year.										

RAG status
Red - Slippage
Amber - Ongoing
Green - Achieved
Blue - Not measured in this quarter

Corporate Plan Performance Monitoring
Report to Health and Adult Social Care Overview and Scrutiny Panel
Quarterly Reporting Period: April - June 2013

Ref	Description	Unit of Measure	Good Performance is H/L figure	Frequency	Previous Data	Latest Data	Target	Direction of Travel ⇧ Improving ⇩ Declining ⇔ Maintained	Previous RAG Status	Current RAG Status	Performance Manager
No clear link to a Priority Outcome											
L1B	The number of people receiving personal budgets as a proportion of the eligible people using community based services (this figure excluding those people in residential or nursing care AND those receiving 'professional support' and reablement)	%	High	Quarterly	46.6 (Dec 2012)	69 (March 2013)	100 (2013/14 Target)	⇧	Red	Red	Hilary Jenkins - Adult Social Care
	Comment: This local indicator measures only on those people who are eligible for personal budgets (i.e. excludes people in receipt of Professional Support/Reablement / Equipment - as well as those who are in receipt of residential or nursing care - see 1C on page 5). It is a more accurate reflection of real performance in providing Personal Budgets. Performance figures show continuous improvement: April 2012 - 18.8% June 2012 - 21% September 2012 - 26.9% December 2012 - 46.6% March 2013 - 69%										

RAG status
Red - Slippage
Amber - Ongoing
Green - Achieved
Blue - Not measured in this quarter

Corporate Plan Performance Monitoring
Report to Health and Adult Social Care Overview and Scrutiny Panel
Quarterly Reporting Period: April - June 2013

Ref	Description	Unit of Measure	Good Performance is H/L figure	Frequency	Previous Data	Latest Data	Target	Direction of Travel ⇧ Improving ⇩ Declining ⇔ Maintained	Previous RAG Status	Current RAG Status	Performance Manager
1A	Social Care related quality of life Survey	Score (How this is calculated - see comment below)	High	Annual	18.7 (2012)	18.9 (2013)	19.1	⇧	Amber	Amber	Andy Sharp - Adult Social Care/Ivor Cawthorn - Community Learning and Commissioning

Comment: Performance figure is derived through the annual Personal Social Services User Survey and based on responses to the questions relating to people's perspective on control, personal care, food, accommodation, personal safety, social life, occupation and dignity. These factors are assessed by social care staff with service users during the assessment or review processes and the work currently being undertaken to complete overdue assessments and reviews should help on the overall quality of life rates.

The score is calculated by giving the following points to each response:-

No needs met = 0

Some needs met = 1

Needs adequately met = 2

No unmet needs = 3

For all questions this gives a maximum potential score of 24. Bournemouth is currently slightly above the current England average score of 18.5.

We have worked with the Social Care complaints team to ensure either financial or care issues are promptly resolved. The new accreditation processes for residential dementia care services is now being rolled-out and this will enable us to have more confidence in the services provided. The work undertaken through Citizen Checkers (residential care for PWLD) is starting to show a trend towards reported improved experiences for people in this client group. A recent ECHR report has made recommendations on improving domiciliary services which our contracts team (Adult Social Care) are acting upon. Furthermore the Care Quality Commission has recently reported that Domiciliary Standards in the South West compare favourably with other regions (with only the east of England performing better). Adult Social Care Operational and Contracting teams have developed a set of questions, relate to Quality of Life, as asked during reviews of people using care home services. We have continued to develop low level services aiming to improve wellbeing such as the memory boxes.

RAG status
Red - Slippage
Amber - Ongoing
Green - Achieved
Blue - Not measured in this quarter

Corporate Plan Performance Monitoring
Report to Health and Adult Social Care Overview and Scrutiny Panel
Quarterly Reporting Period: April - June 2013

Ref	Description	Unit of Measure	Good Performance is H/L figure	Frequency	Previous Data	Latest Data	Target	Direction of Travel ⇧ Improving ⇩ Declining ⇔ Maintained	Previous RAG Status	Current RAG Status	Performance Manager
1D	Carers reported quality of life	Score	High	Every 2 years (Current survey undertaken Nov 2012 - Interim survey to be undertaken late 2013 - Results early 2014)	None Available	7.7	8.2 (2014/15 Target)	N/A	Blue	Amber	Andy Sharp - Adult Social Care/Ivor Cawthorn - Community Learning and Commissioning
	Comment: This figure was generated through a national survey of carers - a new initiative and therefore there is no previous performance or target data. We are awaiting comparative info - due May 2013. The measure is calculated on the responses to a number of questions in the survey which ask about occupation, control, personal care, safety, social participation and encouragement and support. Initial headline data to be considered by Adult Social Care senior management team in July. A project prioritising Carers Assessments, including offering the assessment service in community venues such as libraries is currently underway. Qualitative research is underway to determine factors influencing Quality of Life in Bournemouth and will be reporting later this summer/autumn.										

RAG status
Red - Slippage
Amber - Ongoing
Green - Achieved
Blue - Not measured in this quarter

Corporate Plan Performance Monitoring
Report to Health and Adult Social Care Overview and Scrutiny Panel
Quarterly Reporting Period: April - June 2013

Ref	Description	Unit of Measure	Good Performance is H/L figure	Frequency	Previous Data	Latest Data	Target	Direction of Travel ⇧ Improving ⇩ Declining ⇔ Maintained	Previous RAG Status	Current RAG Status	Performance Manager
2B	Proportion of older people who were still at homes 91 days after hospital discharge into reablement/ rehabilitation services	%	High	Quarterly	74.5% (Year -end 2012-13)	83% (Jan-March discharges)	80.0%	⇧	Amber	Green	Hilary Jenkins - Adult Social Care
	Comment: Performance in reablement services continues to be strong and we are interrogating data for the previous quarter to understand a previously consistent position. Work currently underway to consider the potential to expand use of reablement to include younger adults aged under 65 years old and all customers at point of review. This work could result in the expansion of our eligibility criteria to include customers with greater levels of need and hence result in lower performance against the measure in the short term . However we would anticipate performance at a level of our comparators (statistical neighbours and England averages) in the longer term.										

RAG status
Red - Slippage
Amber - Ongoing
Green - Achieved
Blue - Not measured in this quarter

WORK PROGRAMME 2013/14 – HEALTH & ADULT SOCIAL CARE OVERVIEW & SCRUTINY PANEL

PANEL MEETING DATE: 18 SEPTEMBER 2013

Subject of review	Reason for review	Desired outcome	Lead service area and portfolio	Action and meeting date
Adult Social Care charges	To monitor the implementation process.		Adult Social Care	
Core Service Transformation – Adult Social Care – Phases 1 and 2	Task and Finish Groups to monitor the progress of the implementation of phase 1 and develop the business case for phase 2.		Adult Social Care	
Transformation Challenge Award	To establish how the Panel will interact with the process going forward, following the bid submission.		Adult Social Care	
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust – Merger Process	To scrutinise contingency plans prepared by the hospital following the Competition Commissions intervention with the merger.		External scrutiny	

PANEL MEETING DATE: 6 NOVEMBER 2013

Subject of review	Reason for review	Desired outcome	Lead service area and portfolio	Action and meeting date
Health and Wellbeing Board – Performance indicators	To seek the supply of information from the Bournemouth and Poole Health and Wellbeing Board to allow the Panel to scrutinise the work of the Board.		Community Learning and Commissioning	
Public Health – 6 month report	To monitor the 6 month progress report of Public Health Dorset. Suggested as a pre-meeting presentation topic.		Public Health Dorset	
Bournemouth and Poole Safeguarding Boards annual reports	To receive the annual reports of the Safeguarding Boards.		External scrutiny	

PANEL MEETING DATE: 12 MARCH 2014

Subject of review	Reason for review	Desired outcome	Lead service area and portfolio	Action and meeting date
NHS Quality Accounts – assigning T&F members	To assign Panel members to Task and Finish Groups tasked with formulating responses to the annual NHS quality account performance reports		External scrutiny	
Core Service Transformation – Phase 2 business case	Final sign off of the phase 2 business cases before Cabinet decision is taken.		Adult Social Care	
Street Sex Workers				

PANEL MEETING DATE: 11 JUNE 2014

Subject of review	Reason for review	Desired outcome	Lead service area and portfolio	Action and meeting date
CST phase 1 update	Monitoring update.		Adult Social Care	
Welfare reforms	To consider appropriate areas of work to assess the impact of the welfare reforms.			
Healthwatch Dorset – 12 months on	12 month progress report from Healthwatch Dorset – an opportunity for the Panel to scrutinise performance and review future monitoring arrangements.		External scrutiny	
NHS Quality Accounts Feedback	Following the submission of quality account responses by the relevant Task and Finish Groups – outcomes and recommendations to be discussed.		External scrutiny	

FURTHER PANEL MEETING DATES: 17 SEPTEMBER 2014 AND 4 DECEMBER 2014....

Subject of review	Reason for review	Desired outcome	Lead service area and portfolio	Action and meeting date
CST phase 2 updates			Adult Social Care	

RESERVED ITEMS:

Subject of review	Reason for review	Desired outcome	Lead service area and portfolio	Action and meeting date