Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Bath and North East Somerset Health & Wellbeing Board

Democratic Services Riverside, Temple Street, Keynsham, BS31 1LA	Direct Line:	01225 394452
	Ask For:	Jack Latkovic
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	Date:	8 July 2014

To: All Members of the Health & Wellbeing Board

Members: Dr. Ian Orpen (Member of the Clinical Commissioning Group), Councillor Katie Hall (Bath & North East Somerset Council), Ashley Ayre (Bath & North East Somerset Council), Councillor Simon Allen (Bath & North East Somerset Council), Bruce Laurence (Bath & North East Somerset Council), Dr Simon Douglass (Member of the Clinical Commissioning Group), Councillor Dine Romero (Bath & North East Somerset Council), Jo Farrar (Bath & North East Somerset Council), Pat Foster (Healthwatch representative), Diana Hall Hall (Healthwatch representative) and John Holden (Clinical Commissioning Group lay member)

Non-voting member Douglas Blair (NHS England - Bath, Gloucestershire, Swindon and Wiltshire Area Team)

Observers: Councillors Vic Pritchard and John Bull

Other appropriate officers
Press and Public

Dear Member

Health & Wellbeing Board

You are invited to attend a meeting of the Board, to be held on **Wednesday, 16th July, 2014** at **10.00 am** in the **Brunswick Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
Committee Administrator

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

1. **Inspection of Papers:**
   Any person wishing to inspect minutes, reports, or a list of the background papers relating to any item on this Agenda should contact Jack Latkovic who is available by telephoning Bath 01225 394452 or by calling at the Riverside Offices Keynsham (during normal office hours).

2. **Public Speaking at Meetings:**
   The Partnership Board encourages the public to make their views known at meetings. They may make a statement relevant to what the meeting has power to do. Advance notice is requested, if possible, not less than *two full working days* before the meeting (this means that for meetings held on Wednesdays notice is requested in Democratic Services by 4.30pm the previous Friday).

3. **Webcasting at Meetings**:-
   This meeting is being filmed for live and archived broadcast via the Council's website: www.bathnes.gov.uk/webcast

   At the start of the meeting, the chair will confirm if all or part of the meeting is to be filmed.

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

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

4. **Details of Decisions taken at this meeting** can be found in the draft minutes which will be published as soon as possible after the meeting, and also circulated with the agenda for the next meeting. In the meantime details can be obtained by contacting Jack Latkovic as above. Appendices to reports (if not included with these papers) are available for inspection at the Council's **Public Access Points:**

   - Guildhall, Bath;
   - Riverside, Keynsham;
   - The Hollies, Midsomer Norton;
   - Public Libraries at: Bath Central, Keynsham and Midsomer Norton.

5. **Substitutions**
   Members of the Board are reminded that any substitution should be notified to the Committee Administrator prior to the commencement of the meeting.

6. **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.

   (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.

7. Attendance Register:

Members should sign the Register which will be circulated at the meeting.

8. Emergency Evacuation Procedure

If 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 & Wellbeing Board

Wednesday, 16th July, 2014
Brunswick Room - Guildhall, Bath
10.00 am - 12.00 pm

Agenda

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

   Delivery of health and wellbeing services is in transition until the Board is formally established in April 2013. During the interim 'shadow' period, the Board is not a formal decision making body so formal declarations are not needed. Clear guidelines about Board Members' declarations will be in place before April 2013.

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

6. PUBLIC QUESTIONS/COMMENTS

7. MINUTES OF PREVIOUS MEETINGS

   To confirm the minutes of the above meeting as a correct record.

8. LONELINESS AND ISOLATION (40 MINUTES)

   This report sets out local context and information in regard to this priority. It does not aim to provide an exhaustive account of all the activities across our area which contribute to the theme, but instead sets the basis for a conversation about how Health and Wellbeing Board agencies can work more closely together to deliver it. Examples of local innovation are cited along with a series of questions designed to stimulate discussion.

9. COMMISSIONING OF PRIMARY CARE (20 MINUTES)

   On 1st May 2014, the Chief Executive of NHS England announced plans to allow CCGs to develop new models for co-commissioning of primary care services. The proposal was intended to bring a number of benefits including: -

   - Bringing a holistic approach to the commissioning of services for local populations
   - Achieve greater integration of health and care services and particularly out of hospital care
   - Raising standards of quality within general practice services
   - Enhancing public and patient involvement in developing local services
   - To contribute to the agenda of tackling inequalities

   All CCGs were invited to submit an Expression of Interest (EOI) by the 20th June 2014

with EOIs based on individual CCG preferences. Following local discussions with NHS England it was agreed there were 3 options for CCGs i) to influence, ii) to jointly commission or iii) to have delegated responsibility.

BaNES CCG submitted an EOI to jointly commission primary care services with NHSE.

The attached paper sets out the CCG's submission. 183 EOIs were submitted from 211 CCGs.

NHSE will consider an outline process for the assessment and approval of EOIs at its meeting on the 3rd July 2014. The approvals and governance process will vary according to which of the 3 categories of commissioning CCGs wish to undertake.

10. HEALTHWATCH B&NES ANNUAL REPORT (20 MINUTES)

Healthwatch Bath and North East Somerset will present the Annual Report.
The Board is being shown the Annual Report for information.

11. SPECIAL EDUCATIONAL NEEDS AND DISABILITY REFORM UPDATE (30 MINUTES)

Update on work to implement SEND reform in B&NES to date, key issues and proposed approaches to take this work forward.

The Board is asked to consider the following questions:

1. Do Board Members support the approaches proposed?
2. How can Members help with the challenges?
3. What challenges or suggestions do Members have for the continuing SEND reform project?

12. TWITTER QUESTIONS

The Committee Administrator for this meeting is Jack Latkovic who can be contacted by telephoning Bath 01225 394452

Bath and North East Somerset Council

NHS Bath and North East Somerset

HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Wednesday, 14th May, 2014, 10.00 am

Dr. Ian Orpen	Member of the Clinical Commissioning Group
Councillor Katie Hall	Bath & North East Somerset Council
Ashley Ayre	Bath & North East Somerset Council
Councillor Simon Allen	Bath & North East Somerset Council
Bruce Laurence	Bath & North East Somerset Council
Dr Simon Douglass	Member of the Clinical Commissioning Group
Councillor Dine Romero	Bath & North East Somerset Council
Jo Farrar	Bath & North East Somerset Council
Pat Foster	Healthwatch representative
John Holden	Clinical Commissioning Group lay member
Ian Biggs	NHS England

1 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

2 EMERGENCY EVACUATION PROCEDURE

The Democratic Services Officer drew attention to the evacuation procedure as listed on the call to the meeting.

3 APOLOGIES FOR ABSENCE

Diana Hall Hall and Douglas Blair sent their apologies for this meeting. Ian Biggs (NHS England) was a substitute for Douglas Blair.

4 DECLARATIONS OF INTEREST

There were none.

5 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There was no urgent business.

6 PUBLIC QUESTIONS/COMMENTS

Pamela Galloway (Warm Water Inclusive Swimming and Exercise Network) asked if there was a minimum period for a consultation, organised by the Council, to run. Pamela Galloway explained that the Network had been asked to feed into the 'Fit For Life' Strategy (previously known as Leisure Strategy), though they had not received any notification that the consultation started on the 1st of May this year.

The Chairman responded that an answer would be provided within 5 working days from today.

7 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting were approved as a correct record and signed by the Chair.

8 CONNECTING FAMILIES REPORT (30 MIN)

The Chairman invited Paula Bromley (Connecting Families Manager) to introduce the report.

The Board made the following comments:

The Chairman highlighted complexity of work with families who had been involved from the start of the programme. The Chairman congratulated Paula Bromley and her team on a successful outcome of the programme so far. The Chairman asked Pamela Bromley if she had seen any blockages in the programme and whether it could be something that the Board could help with. The Chairman also asked how other organisations, such as Job Centre Plus and/or Department for Work and Pensions (DWP), had been interacting with the programme.

Councillor Dine Romero asked if the Council's Connecting Families Programme had been seen, by the Government, on shaping the national agenda considering the successful outcome of the programme so far. Councillor Romero also said that she was pleased that this programme would continue, in more-less the same formula as it was happening so far, beyond the next national and local elections.

Pat Foster commented that it would be interesting to see the phase 2 of the programme and how mental health and physical health issues would be included. Pat Foster asked about geographic spread of families which had been participating in the programme.

Paula Bromley responded that she would be happy to work with the Healthwatch. Paula Bromley also said that families were spread across the area, and not just to a

specific ‘pocket’ or Ward in the area. Services were not accessible for some areas because they were not there, or those services were far away from those families.

Paula Bromley said that working with the Job Centre Plus and DWP had been slightly difficult, though with some good outcomes which had helped the programme to become successful.

Jo Farrar commented that she was pleased with the programme which engaged families who found it hard to work with the Council in the past. The Council had been receiving constant positive feedback from the Government and this was all down to Paula Bromley and her team, who built strong relationship with a range of partners, with tendency to engage with more health service partners.

John Holden asked if there were any ways of measuring societally value of the programme and if it would possible to achieve more for less in this programme.

Paula Bromley responded that the programme had been working quite well with health visitors and other health services, with a prospect to develop stronger links with more services which would benefit the programme.
Paula Bromley also said that the team had been using some sort of mapping process in evaluating progress. The government just developed a new cost benefit analysis tool, which could be tailored locally.

Paula Bromley commented that everyone would have to be clear what the set outcomes were in terms of what the Council wanted and what the families were encouraged to achieve. Also, work in partnership with other people and organisations had been crucial.

Bruce Laurence commented that this was quite impressive work. Bruce Laurence also said that this programme would be a challenge for the Board.

Ian Biggs also praised the work of Paula Bromley and her team.

Ashley Ayre said that measuring the benefits had been one of the biggest challenges to the Council.

Ashley Ayre also said that phase 2 of the programme would need to include existing services and how this programme would engage with health services.

Ashley Ayre praised the work done by Paula Bromley and the team, and highlighted programme’s progress so far considering that there was a slow start of its implementation.

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

The Board also passed their thanks to the Connecting Families Team for the excellent work so far. The Board offered to assist the Connecting Families Team if they needed any help in future.

9 **BATH HEALTH COMMUNITY - WINTER REPORT 2013/14 (30 MINUTES)**

The Chairman invited Dr Simon Douglass to introduce the report.

The Chairman also invited Dominic Morgan (Clinical Commissioning Group), Clare O'Farrell (RUH Bath) and Helen Mee (Sirona) to give a presentation to the Board (attached as Appendix to these minutes).

The Board made the following comments:

The Chairman welcomed the presentation and said that many organisations had been working together to improve the service. The Chairman asked what plans had been put in place for January 2015.

Councillor Romero commented that mainly older population were in a need for these services and asked if there was any impact on paediatric services within urgent care.

Councillors Romero and Hall also asked about the effect that mild winter had on urgent care.

Dominic Morgan responded that there was no significant impact on paediatric unit within urgent care. Dominic Morgan also explained about planning on capacity with urgent care for older patients.

Dominic Morgan explained that despite of having mild winter this year there was still a significant demand for urgent care. The demand had been similar as it would be in winter period though not with peaks in the urgent care demand which occurred during cold snaps in previous years.

John Holden commented that some airline companies suffer significant losses during winter period, though they make significant profits during summer period, which was all part of the planned forecast. John Holden suggested that the NHS bodies should take the same approach and plan better for winter periods in terms of necessary resources rather than waiting for crisis to happen, and then react.

Dominic Morgan responded that we would have to be realistic as these systems were quite complex health care systems. The point made about business case from some airline companies was a valid. Dominic Morgan said that one of the biggest challenges had been about staffing levels during winter months. It had been quite difficult to bring the staff on just for that period of the year, because all of the staff needed to go through a proper training before they start working. The biggest challenge for all providers during the winter months was about workforce.

Clare O'Farrell commented that the RUH had received a lot of funding from the government, to deal with Urgent Care, and explained how that funding had been invested in different services for the benefit of patients.

Helen Mee explained to the Board about the work that Sirona had been undertaking in terms of the development of the Virtual Ward and Multi-Disciplinary Team. Helen Mee also said that Health Visitor for active ageing had been in place since February.

It was **RESOLVED** to note the report and presentation and to receive a further update in six months.

10 BATH AND NORTH EAST SOMERSET JOINT ANNUAL ACCOUNT 2014 (30 MINUTES)

The Chairman invited Helen Edelstyn (Strategy and Plan Manager) to introduce the report.

Members of the Board welcomed the report, in particular the layout and how it was written.

The Board unanimously agreed that the Joint Annual Account represents close working relationship between organisations in the area.

It was **RESOLVED** to agree with the Joint Annual Account 2014 and to agree with a system of Boar Member 'leads' for each Joint Health and Wellbeing Strategy priority area.

11 FIT FOR LIFE STRATEGY (PREVIOUSLY KNOWN AS LEISURE STRATEGY) (20 MINUTES)

The Chairman invited Marc Higgins (Business Development Manager) and Jameelah Ingram (Public Health Development and Commissioning Manager) to give a presentation to the Board.

March Higgins and Jameelah Ingram highlighted the following points in their presentation (attached as Appendix to these minutes):

- Vision
- Evidence Base
- What would be the Strategy contributing to
- 2017 targets
- Helping people in staying healthy
- Improving the quality of people's lives
- Creation of fairer life chances
- Four key themes in the Strategy
- Priority groups
- Procurement
- Consultation
- Proposed consultation on draft

The Board welcomed the Strategy by outlining how it correlated with the Joint Health and Wellbeing Strategy and also with the Clinical Commissioning Group 5 Year Plan.

The Board asked about levels of activity for younger people and also what work had been undertaken in reaching those 'hard to reach' areas.

Jameelah Ingram responded that initiatives, such as Director of Public Health Award, had been put in place and proved to be quite successful. Jameelah Ingram also said that the Council had been working with a range of partner organisation (i.e. Curo in Foxhill) to engage more people in the 'Fit For Life' programme.

It was **RESOLVED** to support the consultation process and to request from officers to produce an update in one year.

12 TWITTER QUESTIONS AND COMMENTS

The Chairman read out the relevant tweets from the public that were posted during the meeting.

The meeting ended at 12.10 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Bath Health Community Winter Report 2013/14

Bath and North East Somerset Clinical Commissioning Group


The Sunday Telegraph

A&E is 'grinding to a halt'

Ambulance heroes warn of crisis putting lives at risk in letters seen by Telegraph

Patients facing eight-hour waits in ambulances outside A&E departments

Sick patients have been forced to wait up to eight hours in ambulances queuing outside Accident & Emergency units amid a crisis in the system.

Bath and North East Somerset Clinical Commissioning Group

Actions Taken

- Route Cause Analysis (RCA) process carried out across the system and Royal United Hospital (RUH)
- Emergency Care Intensive Support Team (ECIST) review (this was already in hand)
- Urgent Care system simulation exercise
- Demand & Surge winter planning process reviewed
- Additional winter monies identified

Bath and North East Somerset Clinical Commissioning Group

Review Findings

The subsequent RCA process and UCS analysis highlighted some root causes that led to the whole UCS Black escalation period

- Winter planning was not adequate to cope with the increase in demand that occurred over the Christmas period.
- Lessons from previous RCAs had not been integrated into future planning
- There was a community-wide failure to escalate in the face of what was a predictable period of high demand.
- UCS Leadership was not clear
- Resources not matching demand (7 day working)
- Winter plans not robust enough

Bath and North East Somerset Clinical Commissioning Group

UCS Response

- UCS leadership - provided by the CCG
- Planning - single phase to continuous planning cycles
- Demand, Capacity & Escalation planning (DC&E).
- Operational Performance Management Framework (OPMF)
- Whole System Measurement - Urgent Care Dashboard (UCD)/Daily Monitoring and Direction
- Peer to Peer Challenge - Peer to Peer forum
- Empowering Leadership - through a leadership forum
- Post Winter Peer to Peer Review - to support the recurring commissioning of successful schemes

Bath and North East Somerset Clinical Commissioning Group

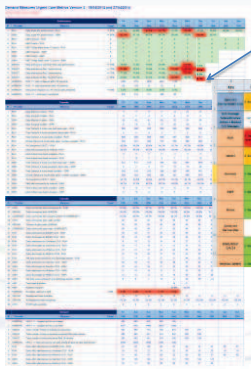
Continuous Planning Cycle

Bath and North East Somerset Clinical Commissioning Group

Operational Performance Management Framework (OPMF) - Structured Approach

Bath and North East Somerset Clinical Commissioning Group

Urgent Care Dashboard - measuring the UCS



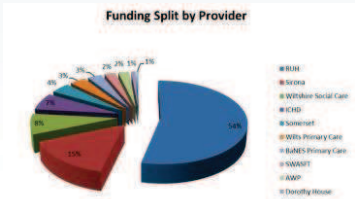
Daily Status Report - monitoring the status and response

Bath and North East Somerset Clinical Commissioning Group

ECIST and Winter Pressure Schemes

The RUH undertook significant changes in response to the ECIST review

Bath and North East Somerset Clinical Commissioning Group



Projects covered areas such as:

Increasing Capacity - (Increase in reablement/Stroke/Neuro/Social care beds/primary care)
Extending 7 Day Working - (AWP/EOL/Therapy/Primary Care)
Enhancing Support - (Independent living teams/Discharge Coordination)
Improving Early Senior decision Making - (RRT/RUH SWOT)
Smoothing Demand - (PSV Support)

Bath and North East Somerset Clinical Commissioning Group

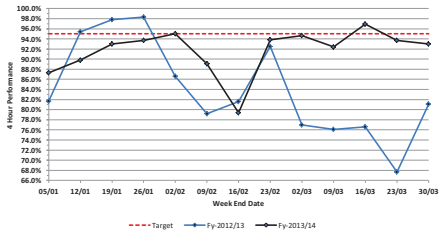
Royal United Hospital Bath NHS Trust

RUH RUH Urgent Care Programme 2013/14

Royal United Hospital Bath NHS Trust

RUH Four Hour Performance

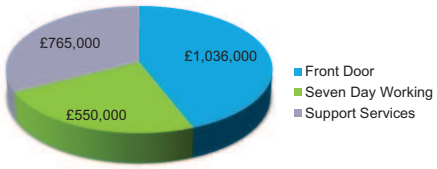
RUH ED 4 Hour Weekly Performance Comparison



Healthcare you can Trust

Royal United Hospital Bath NHS

RUH Winter Investment 2013/14: £2.351m



Healthcare you can Trust

Royal United Hospital Bath NHS

RUH Investment Overview: Front Door £1.3m

- Emergency Department
- SWAT
  - Nurses
  - Porters
  - Flow assistants
- Medical Ambulatory Care
- ACE –OPU
- Urology Nursing
- Pharmacy
- Acute Oncology
- Acute Diabetes
- Cardiac Technicians

Healthcare you can Trust

Royal United Hospital Bath NHS

RUH Investment Overview: Seven Day £0.55M

- Emergency Surgical Ambulatory Care (ESAC)
- Acute Oncology
- Therapies
- Discharge Coordinators
- Ward Clerks

Healthcare you can Trust

Royal United Hospital Bath NHS

RUH Investment Overview: Support Services £0.77m

- Radiology
- Transport
- Cardiac
- SALT Stroke
- Clinical Assistants
- Critical Care Outreach

Healthcare you can Trust

Royal United Hospital Bath NHS

RUH Senior with a Team (SWAT)

- Rapid patient assessment and rapid treatment, improving waiting time to treatment and supporting patient flow through the Emergency Department

60 minutes → 44 minutes

Healthcare you can Trust

Royal United Hospital Bath NHS

RUH Medical Ambulatory Care

- Medical Ambulatory Care is a Consultant led service for providing opinion, assessment and treatment. The team is made up of senior clinician, GP Liaison and nurse practitioners. Referrals are received via GP liaison, contacting ambulatory care direct, medical take and the consultant advice line. Service supports patient flow through the Emergency Department

107 patients per month → 219 patients per month

Healthcare you can Trust

Royal United Hospital Bath NHS

RUH ACE-OPU

- Rapid clinical assessment, investigation and interventions to support early discharge, reducing the length of time patients have to stay in hospital. Aim for a length of stay ≤ 72 hours. Improved MDT working with the community with the daily white board rounds
- Overall reduction in LOS, many hitting 72 day target.

11.2 days → 5.2 days

Healthcare you can Trust

Royal United Hospital Bath NHS

RUH Emergency Surgical Ambulatory Care (ESAC)

- ESAC is a consultant led service providing opinion and assessment within 24/48 hours. Referrals are received from the GP direct, surgical take and the consultant advice line
- ESAC provides a location for the assessment of less sick patients who are likely to be able to return home the same day to await admission focusing on admission avoidance, the service supports patient flow through the Emergency Department

0 Patients per month → 132 Patients per month

Healthcare you can Trust

Royal United Hospital Bath NHS

RUH Radiology

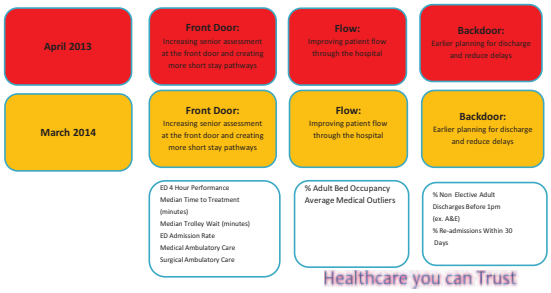
- Increased porter support– more timely movement of patients during periods of peak demand supporting the front door.
- Improved turnaround of radiology reporting, supporting patient flow.
- Increase capacity for MRI and CT due to the appointment of Radiographer coordinator effective scheduling/management of capacity.
- Increased % of In-Patient CT/MRI requests scanned the same day

44% → 63.3%

Healthcare you can Trust

Royal United Hospital Bath NHS

RUH Overall Programme Assessment



Healthcare you can Trust

Royal United Hospital Bath NHS

RUH Patient Experience

- Friends and Family Test March 2014 +73
- Thank you letters *"Exceptional"', "First Class", "Compassionate", "Caring"*
- Good CQC report December 2013
- Reduction in complaints received

Healthcare you can Trust

Royal United Hospital Bath NHS

RUH Evaluation Outcomes

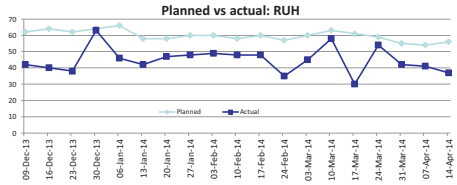
- Funding – Early confirmation
- Recruitment – Lead in time
- Integrated clinical pathway projects – Time to plan
- Capacity – ECIST

Healthcare you can Trust

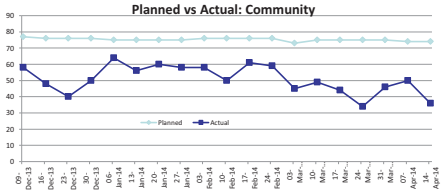
Demand and escalation planning, winter 2013-14

- Capacity based on activity from 2012/13
- Triangulated with predicted discharge requirements from RUH data
- Identified potential shortfall
- Bids submitted for additional resource to meet shortfall
- Collaborative approach coordinated by CCG

Discharges from RUH



Admission Prevention from the Community



The Services involved;

- Community Hospital admissions (including transfers from RUH and Direct admissions to Paulton)
- Early Stroke Discharge team
- IMPACT (Respiratory Service)
- Reablement urgent referrals
- Reablement non-urgent referrals
- Night support workers
- Reablement bed admissions
- Placements to care homes (from RUH and community)
- Implementation of packages of care (from RUH and community)
- Referrals to district nursing services from RUH

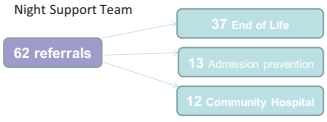
Additional Services 2013/14

- Additional reablement beds in residential homes supported by therapists and discharge liaison nurse
- Night support workers working with people at the end of life to be able to remain at home
- Increased resource for Early Stroke Discharge Team

Outcome

- Reduction in long term placements of 21%

- Night Support Team



Outcome

- Reablement beds outcome for service users;

71% Discharged home → 82% without increased POC

- Early Stroke Discharge delivered an increase in capacity to 18 places throughout period

Lessons learnt

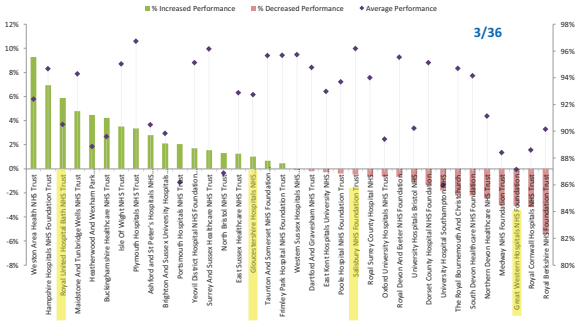
- Maintain reporting process throughout the year
- Longer lead in time for recruitment and planning services
- Reablement beds to consist of both nursing and residential capacity
- Clear leadership from CCG to maintain focus and communication
- To work with domiciliary care agencies to improve access particularly out of hours

What Happened?

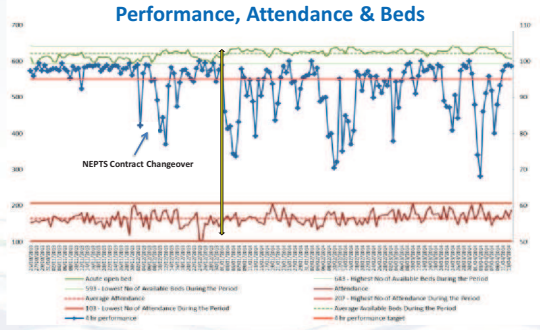
- Crisis was avoided
- The RUH entered black escalation on 3 occasions across the winter period
- The Bath Health Community delivered very strong 4 hour performance during the first half of winter in Quarter 3, however while the whole UCS remained safe for patients, the second half of winter Quarter 4 saw lower performance
- The UCS still did not have enough responsive and flexible capacity to fully protect performance

Bath and North East Somerset Clinical Commissioning Group

A small majority of providers improved their performance

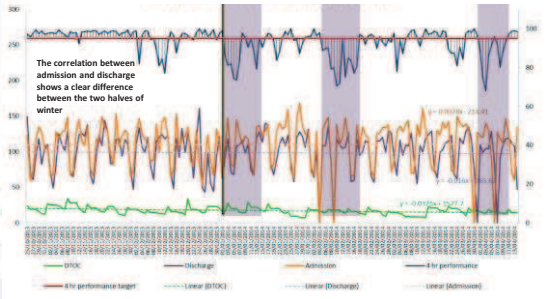


Performance, Attendance & Beds



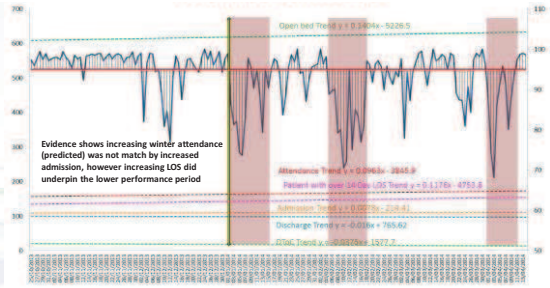
Bath and North East Somerset Clinical Commissioning Group

Performance, Admissions & Discharge



Bath and North East Somerset Clinical Commissioning Group

Performance, Open Beds, Admissions, Discharge & LOS



NHS Bath and North East Somerset Clinical Commissioning Group

Conclusions and Recommendations

- Patients and high quality patient care must be at the heart of everything we learn from these experiences
- Leadership is a core and necessary component
- We require a full paradigm shift in our approach to the delivery of UCS services to provide highly responsive out of hospital services
- Early intervention and senior clinical decision making supported by 7 day solutions
- There is a coloration between the drop in performance and the opening of additional capacity
- Delays in the transfer (DToC) of older patients, directly adversely impacts on their care, their experience and their long term outcomes

NHS Bath and North East Somerset Clinical Commissioning Group

Conclusions and Recommendations

- Overall and individual capacity is not sufficient and not flexible enough
- Escalation while improved across this winter is still not providing the required UCS response to meet the need
- We need to enhance our whole system oversight, predictability and collective action (National influence)
- Escalation status needs to be consistent and driven by capacity measurements
- Demand, Capacity & Escalation planning requires further embedding into normal practice (National influence)
- Overall we have learnt the challenge is significant, however so are the collective understanding and abilities of our providers and their staff. We are better together

NHS Bath and North East Somerset Clinical Commissioning Group

New Collective Primary Lines of Enquiry

- Increased demand, where this has occurred by type and nature
- Increased acuity/complexity
- Redistribution of demand by area and time
- Increased volatility in demand
- Reduced capacity in Trusts to meet demand
- Increased resource use in response to demand

National Direction and Key Conclusions

UECR - Key messages

NHS Bath and North East Somerset Clinical Commissioning Group

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Bath & North East Somerset Council

Fit for Life – An Active Living Strategy

May 2014

Bath & North East Somerset Council

Vision

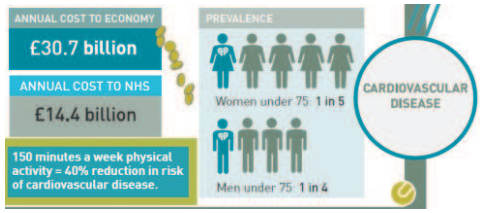
» To get more people, more active, more often, leading to improved health and wellbeing and the creation of stronger, safer communities for all

» "Lack of activity destroys the good condition of every human being while movement and methodical physical exercise save it and preserve it"

Plato

Bath & North East Somerset Council

Evidence Base



Bath & North East Somerset Council

Strategy contributes to addressing:

» Ageing population
» Rising obesity levels
» Health inequalities
» High prevalence of depression
» Worklessness
» Complex families
» Anti-Social behaviour

Bath & North East Somerset Council

By 2017 we want more people to

» Be Active ... for healthier lifestyles
» Be Greener ... for a better and sustainable environment
» Be Outdoors ... to enjoy the natural environment
» Be Involved ... to make a positive difference
» Be together ... to have fun and enjoy being active

Bath & North East Somerset Council

Helping People to Stay Healthy

» Ensuring the provision of programmes aimed at the prevention of ill-health, the promotion of wellbeing and the reduction of health inequalities
» Reduced rates of childhood and adult unhealthy weight through increased activity levels among young people and targeted programmes at those with most need
» Promoting active workplaces to improve employees' health & wellbeing and enhance productivity.
» Create Healthy and sustainable places – providing fit for purpose leisure facilities with investment as identified through this strategy aimed at attracting new types of customers and increasing participation levels

Bath & North East Somerset Council

Improving the quality of people's lives

» Reduced rates of mental ill health through targeted exercise on prescription programmes
» To support people to take a greater ownership of their own health and wellbeing through increased physical activity and the provision of educational material
» Supporting older people to live independently for longer through improved and targeted programming and interventions to increase activity levels delivering health and mobility benefits

Bath & North East Somerset Council

Creating fairer life chances

» Reduction in health inequalities through targeted programmes in the areas of highest need
» To engage the groups who have low levels of activity and those not currently taking part in sport
» Improve Skills and employment through training, development and volunteer opportunities
» Increased resilience of people and communities including action on loneliness through community engagement in sport and physical activity

Bath & North East Somerset Council

The strategy has 4 key themes

» Active Lifestyles
» Active Travel
» Active Design
» Active Environments (Facilities and outdoor space)

Bath & North East Somerset Council

Priority Groups

» Ethnic Minorities
» 14-18 year olds (particularly females) – this is the age where levels of activity start to drop
» Middle aged men
» Families
» Those experiencing health inequalities
» Older People
» Those who are carrying excess weight (children and adults)
» Those with long term health conditions
» Those with disabilities

Bath and North East Somerset – *The* place to live, work and visit

Bath & North East Somerset Council

Procurement

» Strategy provides steer for procurement in terms of built facilities, but leaves flexibility for dialogue – more detail/evidence base in built facilities strategy to shape discussions
» Strategy to be attached to ISOS documents with contractors asked to detail how they will support the delivery of it. They will be scored their response.

Bath and North East Somerset – *The* place to live, work and visit

Bath & North East Somerset Council

Consultation to shape draft:

» Stakeholder workshop - July 2013
» Meetings with health sector partners and stakeholders (Clinical Commissioning Group (Operational Leadership Team), People Directorate Senior Management Team, Health and Wellbeing Board and Cllrs Simon Allen and David Dixon) – July/August 2013
» Street survey of 1000 people – November 2013
» Economic and Community Development Policy Development and Scrutiny Panel December 2014
» Survey of sports clubs – December 2013/January 2014
» Focus groups/interviews with underrepresented groups – February 2014
» Stakeholder input in draft strategy under headings – February 2014
» Stakeholder workshop – March 2014

Bath and North East Somerset – *The* place to live, work and visit

Bath & North East Somerset Council

Proposed consultation on draft

- Electronic consultation with partners, stakeholders and the public over the web
- Bath City conference and other key local area meetings
- Economic and Community Development Policy Development and Scrutiny Panel – May 2014
- Final adoption July 2014
- There will also be consultation as part of the procurement process where the detail of the built facility plans will be refined and consulted upon

Bath and North East Somerset – *The* place to live, work and visit

HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Wednesday, 4th June, 2014, 10.00 am

Ashley Ayre	Bath & North East Somerset Council
Councillor Simon Allen	Bath & North East Somerset Council
Bruce Laurence	Bath & North East Somerset Council
Dr Simon Douglass	Member of the Clinical Commissioning Group
Councillor Dine Romero	Bath & North East Somerset Council
Diana Hall Hall	Healthwatch representative
John Holden	Clinical Commissioning Group lay member
David Trethewey	Bath and North East Somerset Council
Douglas Blair	NHS England

13 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

14 EMERGENCY EVACUATION PROCEDURE

The Democratic Services Officer drew attention to the evacuation procedure as listed on the call to the meeting.

15 APOLOGIES FOR ABSENCE

Councillor Katie Hall, Jo Farrar, Dr Ian Orpen and Pat Foster had sent their apologies for this meeting. David Trethewey was a substitute for Jo Farrar.

16 DECLARATIONS OF INTEREST

There were none.

17 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There was no urgent business.

18 PUBLIC QUESTIONS/COMMENTS

There were none submitted in advance of the meeting

The Chairman informed the meeting that any questions or queries related to the remit of the Board could be submitted during the meeting. Also, members of the public would have the opportunity to ask questions, or make their comments via Twitter.

19 HEALTH AND WELLBEING NETWORK FEEDBACK

The Chairman invited Ronnie Wright (Healthwatch B&NES) to take the Board through the report.

Ronnie Wright said that the Healthwatch B&NES Health and Wellbeing Network session on Tuesday 13th May 2014 had been attended by 35 people from a range of different organisations. The session was an opportunity for interested organisations and people to hear an update on the NHS B&NES CCG draft Strategic 5 Year Plan and discuss the priorities and next steps for putting the plan into action.

As part of the session, two workshops had been held with attendees, who discussed the CCG's priorities on Prevention and self-care and Care for frail older people.

A range of points were highlighted by the participants and a summary of the key themes had been provided by Ronnie Wright, as per the report.

Councillor Romero commented that the Healthwatch B&NES Health and Wellbeing Network session on Tuesday 13th May 2014 had been a good session although, as per Councillor Romero's view, there was a lack of consideration for children's' and young people health and wellbeing issues. Councillor Romero asked for those issues to be considered at the next network session.

Ronnie Wright responded that the Healthwatch B&NES Health and Wellbeing Network was separate from Children's Network, though there was nothing to stop those two networks to organise joint session in near future.

Dr Simon Douglass asked if future plans had been too ambitious.

Ronnie Wright commented that plans might appear to be too ambitious, though it has been more about deliverability of those plans that people were anxious about.

The Chairman welcomed the report and praised the network session held on 13th May 2014. The Chairman felt that a comment from Councillor Romero should be noted and for that reason he suggested that Children and Young People Network be invited for the next meeting of the Board.

It was **RESOLVED** to note the report and to invite the Children and Young People Network for the next meeting of the Board.

20 **NHS BANES CCG 5 YEAR STRATEGIC PLAN 2014/15-2018/19**

The Chairman invited Dr Simon Douglass to introduce the report.

The Chairman informed the meeting that this would be Dr Douglass' last meeting on the Board, thanked Dr Douglass for his contribution, and wished him all the best in future.

Dr Douglass explained that the purpose of the plan was to identify their strategic vision for the next 5 years and describe their role as a high performing CCG to lead health and care system collaboratively through the commissioning of high quality, affordable, person centred care which harnesses the strength of clinician led commissioning and would empower and encourage individuals to improve their health and wellbeing.

The 5 Year plan still requires further refinement and would be submitted on the 20th June 2014. The final version would:

- Articulate more clearly the CCG's plans for implementation
- Articulate the impact of the changes on providers and the whole health care system.

The Chairman welcomed the report with the acknowledgement on the amount of hard work put into this report. The Chairman suggested that patient stories should be included in the final version of the Plan.

John Holden agreed with the Chairman by saying that this Plan has been a substantial piece of work. John Holden said that B&NES area had been identified as one of the best in the country for people to get an appointment with the GP (according to The Times).

John Holden also said that, in his view, an implementation of the Plan would be an issue, with plenty of work to be done.

Councillor Romero also welcomed the Plan and asked if the CCG took into consideration that population would grow.

Dr Douglass replied that the CCG had had discussions with different organisations about this matter. Dr Douglass reminded the Board that the Plan would not address problems about future workforce.

Bruce Laurence also welcomed the Plan though he expressed a slight concern on implementation of it.

Dr Douglass said that the CCG would have significant challenges ahead of them. The CCG had had quite proactive and supportive engagement from the stakeholders throughout this process. Dr Douglass highlighted the importance of partnership work within the Better Care Fund which could be used as a template for joint work with other agencies and bodies.

Douglas Blair commented that this Plan has been a clear step forward. Douglas Blair also said that some might see this Plan as ambitious though people who

created the Plan could make it happen.

David Trethewey highlighted the importance of community engagement, best use of resources and also on the engagement of public agencies.

Councillor John Bull asked about '7 day services'.

Dr Douglass explained that '7 day services' were designed for the Urgent Care System. There was no financial or workforce support for 7 days access to GPs.

Ashley Ayre said that the Plan was very strong and one of the main issues would be its implementation. Ashley Ayre also said that the role of the Board would be in challenging agencies.

Councillor Romero asked about data exchange with the neighbouring authorities.

Dr Douglass responded that there was a lot of good evidence that data exchange would be successful though the biggest challenges would be in linking with social care system and some other agencies.

It was **RESOLVED** to support the direction of the 5 Year Strategy and its consistency with the Joint Health and Wellbeing Strategy.

21 NHS ENGLAND: BGSW AREA TEAM OPERATIONAL PLAN FOR 2014/15 AND 2015/16

The Chairman invited Douglas Blair to introduce the report.

Douglas Blair said that NHS England was responsible for directly commissioning a number of services:

- Primary care services (including GP services, dental, optometry and pharmacy services)
- Secondary care dental services
- Secondary healthcare services for armed forces serving personnel and families
- Public Health services under Section 7a
- Specialised healthcare services
- Healthcare services for offenders and those within the justice System

This draft delivery plan sets out the strategic framework for the development of health services in the Bath, Gloucestershire, Swindon and Wiltshire (BGSW) area commissioned by the NHS England.

The Chairman asked more about the commissioning intentions.

Douglas Blair explained that there were no set models or fixed views on expression of interest from the NHS England and the CCG in terms of the expression of interest.

The Chairman asked about the NHS England part in the spatial strategy.

Douglas Blair responded that the NHS England would have to be part of the planning in order to understand demand for primary care at new development. The demand for primary care would depend not only from new development but also from the existing population in the area.

John Holden commented that this was the first time that such plan was produced by the NHS England. John Holden asked about link between the CCG's 5 year plan and the 2 year NHS England plan.

Douglas Blair responded that Strategic Health Authority did not have commissioning responsibilities. The 2 year plan had been created as one plan, for the whole area, though when separated documents were needed, for the specific CCG areas, then those would be generated. Douglas Blair also said that due to changes in commissioning arrangement for the NHS England there were some differences in budget balances. Douglas Blair also explained that the NHS England would co-commission with the CCG in areas such as GP services and similar.

Bruce Laurence welcomed the new direction of the NHS England and Public Health England. Bruce Laurence commented that one of the biggest issues for the NHS England would be primary care workforce.

Douglas Blair commented that specialised services had been also under the NHS England and historically there had been always a lot of pressure on specialised services. The NHS England had been getting familiar with the primary care workforce, together with the CCG.

Dr Douglass said that the issue around the demographic of the workforce was an important one. One of the interesting outcomes around urgent care was on a focus on getting clinical expertise early on in patient's journey. That would have to be part of the primary care as well. In terms of the co-commissioning between the CCG and the NHS England – local area team had been quite clear what were their expectations from it.

David Trethewey said that our main challenge was to ensure that our local strategies and national strategies around economy recognise the value of the health and social services.

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

22 **TWITTER QUESTIONS**

There were none.

The meeting ended at 11.25 am

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**16/07/2014**
TYPE	**An open public item**

Report summary table	
Report title	Increasing the resilience of people and communities including action on loneliness - a multi-agency conversation
Report author	Andy Thomas (01225 394322)
List of attachments	• Appendix One - Examples of local projects which contribute to this theme • Appendix Two - Examples of innovation nationally • Appendix Three - Campaign to End Loneliness – Toolkit
Background papers	None
Summary	This report sets out local context and information in regard to this priority. It does not aim to provide an exhaustive account of all the activities across our area which contribute to the theme, but instead sets the basis for a conversation about how Health and Wellbeing Board agencies can work more closely together to deliver it. Examples of local innovation are cited along with a series of questions designed to stimulate discussion.
Recommendations	The Board is asked to agree that: 1. It note the report and appendices 2. It receive a report on the outcomes of the Health and Wellbeing Network session on this issue 3. It receive a presentation on the national context for this issue from Jolanthe de Koning, Department for Health at the University of Bath. 4. It consider its response in the light of these reports and updates 5. It establish a working group to examine longer-term options for joint commissioning against loneliness and isolation outcomes, to comprise representatives from partner agencies and the voluntary and community sector, to report back to the Board in 6 months
Rationale for recommendations	The recommendations are based on the Board's role in delivering its priority as agreed in the Joint Health and Wellbeing Strategy.
Resource implications	None in this report. There is the potential for agencies to work more closely together to align commissioning budgets to deliver outcomes relating to this issue. There are also opportunities for attracting external funding to deliver these outcomes.

Statutory considerations and basis for proposal	Relevant considerations include equalities, human rights and public health. The reports aims to deliver the Joint Health and Wellbeing Strategy which is a statutory document,
Consultation	Consultation was undertaken with the Strategic Director, Chair of the Board, and nominated representatives of the Chief Financial Officer and the Monitoring Officer Vernon Hitchman
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

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

1.2 There are many strengths locally in relation to this theme, particularly within our local voluntary organisations and community networks. No attempt has been made to produce an exhaustive list of relevant work but Appendix One contains some examples of local schemes and projects and the Health and Wellbeing Network session will help build this picture.

1.3 The Campaign to End Loneliness has awarded Bath & North East Somerset its "Gold" standard for our Joint Health and Wellbeing Strategy. However, with an estimated 3,000 additional residents aged over 75 living in our area by 2021, there is now an opportunity for the Board to further develop its approach to meet emerging challenges. The Board will wish to:

(1) Base decisions on evidence of need. The Campaign to End Loneliness identifies some specific risk factors for social isolation in older age including bereavement, disability and mobility and has developed a "toolkit" (see Appendix Three). In addition, our JSNA identifies a number of factors as potentially leading to social isolation which are not related to age. For example, audits of deaths from suicide have identified a need for better ways to reach isolated men and offer opportunities to improve their wellbeing. The Health and Wellbeing Network session on this topic is asking:

- What do we know about the impact of loneliness and isolation on health?
- What factors can contribute to people becoming lonely and isolated

(2) Understand our local strengths. With one of the highest rates of volunteering in the country, there are many local projects which build resilience and address loneliness and isolation. These include lunch clubs, befriending schemes, community transport schemes and village agents. The Health and Wellbeing Network is seeking to identify:

- What contribution local projects, including local community development projects, make in helping to reduce loneliness and isolation
- What the gaps are in support that we know about

(3) Use partner community and voluntary resources available to us in as innovative a way as possible. The CCG is further developing community services built around its 5 Community Cluster Team model and there may be opportunities to build on this approach to strengthen community ties and better target services. Age UK has established a pilot hub based at the Stoke Inn, Chew Stoke which it is using as a base for its "Finding the lost voice of older people' pilot project. Digital Unite's research has shown that 86% of older people who use the internet say it has had improved their lives; 72% say going online had reduced their sense of isolation. However, 5m over 65s in the UK do not using the internet. The Health and Wellbeing Network will also be identifying the barriers to people being able to provide support and how they are overcome

(4) Appendix Two sets out some examples of innovation in this theme. The Bath Social Innovation Programme, based at the University of Bath, provides help and support for innovation in the healthcare and wellbeing sectors.

1.4 In order to maximise opportunities from these and other approaches, it is proposed to establish a working group of the Board to examine in more detail this issue. This would review local need and current service provision in this field and examine the potential for further innovation and joint commissioning.

Appendix One - Examples of local projects which contribute to this theme

- Age UK Bath and North East Somerset provides a wide range of services to support older people to remain active, healthy and independent. Services include information and advice (including at the Council's one-stop shop), a befriending service (with over 150 volunteers), "Fit as a Fiddle" clubs and activities, day services and lunch clubs.

- Our Village Agents provide direct help and support to people across 20 parishes in Bath and North East Somerset. As well as home visits, Village Agent "Roadshows" are held at local village halls and have covered subjects such as "healthy happy feet" and falls prevention. The Norton Malreward Roadshow saw a "myth busting" quiz to publicise the many free services available.

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

- The Council's Supporting People service have identified over 80 contracts which contribute to this theme, ranging from community meals to independent advocacy services. There is also a clear crossover with the delivery of the Strategy's priority to improve services for older people which support and encourage independent living, to which many local providers contribute.

Appendix Two - Some examples of innovation in this theme nationally

- "The Good Gym" connects runners with tasks that benefit the community whilst keeping people fit. This can include working on community projects, "one off" support for vulnerable people or a longer term commitment to visiting an isolated older person.

- Innovative uses have been made of the internet to encourage and build social networks and to make life easier for carers. A number of these are highlighted in the NESTA report "Who cares?: The Role that Entrepreneurs and Technology can Play inn Improving Informal Care in the UK". and include:

  (1) "Jointly" is a simple app developed by Carers UK to help take the stress out of caring. It enables multiple carers to share a calendar, task lists and group messaging, and it stores information for example, on medication.

  (2) "Hometouch" is a digital service with a tablet–based interface for care recipients. It offers simple communication tools such as messaging and video call, and a care dashboard for carers including a shared calendar, medication reminders, mood and activity tracking, access to specialist advice and emergency carer call.

  (3) "Casserole"- Casserole is a digital tool that connect older people with their neighbours. Participants share portions of home cooked food with older people who are not able to cook for themselves.

(4) “Breezie” is a simple tablet–based interface that makes it easy for people to get online and stay connected with family and friends. It responds to the user’s level of ability. By using simple icons and prompts, it makes social media accessible to older adults who are not familiar with technology.

Appendix Three - Campaign to End Loneliness Toolkit

http://campaigntoendloneliness.org/toolkit/

Please contact the report author if you need to access this report in an alternative format

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MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**16/07/2014**
TYPE	**An open public item**

Report summary table	
Report title	Update on Commissioning of Primary Care Services – Expression of Interest from BaNES CCG to Co-Commission with NHS England
Report author	Joel Hirst, Senior Commissioning Manager for Medicines Management & Primary Care
List of attachments	• Appendix One - BaNES CCG's Expression of Interest Proposal to Co-Commission Primary Care Services
Background papers	Press Release on 1st May 2014
Summary	On 1st May 2014, the Chief Executive of NHS England announced plans to allow CCGs to develop new models for co-commissioning of primary care services. The proposal was intended to bring a number of benefits including: - • Bringing a holistic approach to the commissioning of services for local populations • Achieve greater integration of health and care services and particularly out of hospital care • Raising standards of quality within general practice services • Enhancing public and patient involvement in developing local services • To contribute to the agenda of tackling inequalities All CCGs were invited to submit an Expression of Interest (EOI) by the 20th June 2014 with EOIs based on individual CCG preferences. Following local discussions with NHS England it was agreed there were 3 options for CCGs i) to influence, ii) to jointly commission or iii) to have delegated responsibility. BaNES CCG submitted an EOI to jointly commission primary care services with NHSE. The attached paper sets out the CCG's submission. 183 EOIs were submitted from 211 CCGs. NHSE will consider an outline process for the assessment and approval of EOIs at its meeting on the 3rd July 2014. The approvals

	and governance process will vary according to which of the 3 categories of commissioning CCGs wish to undertake.
Recommendations	The Board is asked to: • Note that the CCG has submitted an Expression of Interest to be a Co-Commissioner of Primary Care Services • Consider the opportunities that this presents for delivery of the Health and Wellbeing Board's agenda
Rationale for recommendations	The impact of co-commissioning of primary care commissioning has the potential to be significant for the delivery of the H&WBD's strategic priorities and should enable greater co-ordination of service planning.
Resource implications	CCGs are being asked to manage the impact of supporting the co-commissioning of primary care services within the existing running costs budget. This is challenging for a CCG the size of B&NES and in the context of a requirement to reduce its running costs budget by 10% in 2015/16.
Statutory considerations and basis for proposal	Appropriate frameworks will need to be developed for these new arrangements.
Consultation	The Expression of Interest Proposal sets out in section G the engagement with stakeholders that the CCG undertook in the period leading up to the submission on the 20th June 2014.
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the CCGs and Council's decision-making risk management guidance.

THE REPORT

1.1 Please see attached – Banes CCG Expression of Interest to Co-Commission Primary Care Services.

Please contact the report author if you need to access this report in an alternative format

NHS
Bath and North East Somerset
Clinical Commissioning Group

Expression of Interest for Co-commissioning of Primary Care

Summary

Bath and North East Somerset (BaNES) CCG are expressing an interest to Co-commission Primary Care Services through a Joint Commissioning Arrangement with NHS England Area Team (NHSE).

The CCG believe that a Joint Commissioning role with NHSE will help the CCG and the broader BaNES Health and Wellbeing partnership to: -

- Integrate care outside hospitals in BaNES and deliver a sustainable healthcare system
- Improve engagement across the community and with local clinicians
- Support the design of the most appropriate high quality services for BaNES
- Contribute to the wider and developing CCG programme to minimise local health inequalities

The CCG anticipate Joint Commissioning as a useful first step in developing integrated locally sensitive “Place Based Commissioning” for Primary Care.

This expression of interest links the CCG’s vision expressed in our five year plan regarding the requirement to commission primary care at scale, to the mechanisms and levers for primary care commissioning. The proposed co-commissioning arrangements will be transparent, with robust governance arrangements and with the appropriate safeguards to manage conflicts of interest.

We hope our expression of interest, together with our five year plan, demonstrates our ambition and imagination to create joint commissioning arrangements to maximise our ability with local partnerships to deliver our “Healthier, Stronger, Together” vision for the residents of Bath and North East Somerset.

Introduction

1. Background and Vision for Bath and North East Somerset (BaNES) CCG

The CCG serves a resident population of 177,643 and a NHS registered population of 197,040 with a budget of £220m. Our boundary is co-terminus with B&NES Local Authority. We believe that our role as a high performing CCG is to lead our health and care system collaboratively through the commissioning of high quality, affordable, person centred care which harnesses the strength of clinician led commissioning that will empower and encourage individuals to improve their health and wellbeing.

Reference: Seizing Opportunities – A Five Year Strategy for Bath and North East Somerset, June 2014 http://www.bathandnortheastsomersetccg.nhs.uk/news/five-year-strategic-plan

2. Structure of the CCG and Commissioning Support

The CCG is a relatively small and lean organisation currently consisting of 43 employees and 34 whole time equivalents. Our running costs budget is £4.7m and this will need to reduce by 10% from April 2015.

We anticipate agreeing a Service Level Agreement with Central Southern Commissioning Support Unit for the period September 2014 to March 2016, to create stability in the commissioning system and to enable current arrangements to further develop. This will include an on-going review of service specifications, ways of working and joint organisational development activities. During 2014/15 the CCG is proposing to make changes to the configuration of some of these arrangements by providing some services in-house, in light of a recent review of our current and future needs.

Our expression of Interest

A. CCGs involved in the expression of interest

The application is for BaNES CCG only

In light of the current arrangements within BaNES: an Integrated Health and Social Partnership with B&NES Local Authority, a co-terminus geography with the Local Authority, strong working relationships within BaNES CCG practice members, it is logical to progress the expression of interest as BaNES only.

There have been positive initial conversations with other CCGs in our local geography: BaNES, Gloucestershire, Swindon and Wiltshire (BGSW). BaNES CCG is open to closer working with the other CCGs in the local area if this emerges as the favoured model. There is clearly an advantage to local CCGs and NHSE if there is a consistency of approach across BGSW.

This expression of interest is seen as a first step on the journey of co-commissioning. The CCG is anticipating that any agreed initial models will be tested, reviewed and adapted to maximise benefits to patients and key stakeholders.

B. Intended benefits and benefits realisation

I. Our vision

Our vision for primary care is articulated in our Five Year Strategy. The plan states:

Developing Primary Care at Scale

Our vision has significant implications for the role of primary care in BaNES and primary care provision is integral to the delivery of our five year strategy.

The role of primary care will form the foundation of our approach in enhancing and integrating the care and support of patients and their carers in our community.

We have already identified a clear emerging challenge for the CCG is the impact of managing multimorbidity. We will support primary care to develop in such a way that it is able engage in meeting this challenge by placing personalised care planning at the centre of long term condition management. A multidisciplinary team approach focused on practice clusters will draw on the experience of primary care physicians, practice nurses, pharmacists, social workers, community matrons, district nursing and community therapy staff as well as secondary care advice in order to establish care plans which address the complex needs of patients who experience multimorbidity.

This will be supported by a more efficient use of information technology and administrative support; improved education and support for patients to enhance their sense of control over their lives; a different focus for the primary care practitioner on a more collaborative style of interaction with patients; and the commissioning of services in response to the outcomes of these approaches.

Primary care will need to be able to respond to this ambition. We will collaborate with NHS England, the Local Medical Committee and practices to support this process of transformation.

The key enabler will be the ability for primary care in BaNES to speak with one voice, to ensure:

- *There will be a far more rapid negotiation with practices around implementation of an emerging House of Care Model in BaNES*

- *Primary care is able to take its place as a system player in the health and social care community, for example in re-shaping urgent care and the implementation of the Health and Wellbeing Strategy*

Delivering these required changes during a time when the wider NHS and local health and care economy will face increasing financial pressures will be extremely challenging and will require a co-ordinated focus. **The CCG believes that arrangements for commissioning primary care would be enhanced through a more formal local Joint Commissioning arrangement with NHSE.**

Joining up the commissioning arrangements between NHSE and the CCG will provide greater opportunities to focus on "local levers" to support the delivery of the CCG's five year plan and an opportunity to focus in on specific patient outcomes and health gain relevant to our Health and Wellbeing strategy.

Primary Care is at the heart of our communities and over 80% of all health care activity takes place in GP practices. Joint Commissioning of Primary Care and alignment of all commissioning activities: Adult & Children's Social Care, Health and Primary Care will help to deliver local priorities, remove barriers, improve quality, minimise system inefficiencies and improve patient experience.

Putting clinicians at the centre of commissioning primary care supports the vision set out in the NHS Health and Social Care Act. Utilisation of the skills of local clinicians, through their understanding of the needs of their patients and their local communities will benefit the quality of primary care commissioning.

The joint arrangements allow the focusing of both National and Local contracting arrangements and creates an opportunity to reduce the administrative burden on GP practices and align incentives to the local CCG's and Health and Well-being Strategy priorities. The CCG would welcome the opportunity to develop the current Primary Care Quality and Outcomes Framework (QoF) into a leaner core QoF and to roll all other incentives into a "local QoF". The emphasis would be on local creation with NHSE and delivery aligned to local priorities.

II. How does our proposal for co-commissioning fit with five year strategic plan?

The initial proposal set out in the Barbara Hakin letter (gateway 01599) compliments the CCG vision set out above.

Through a **model of Joint Commissioning** in partnership with NHSE, the CCG will be better placed to achieve its vision of leading our health and care system collaboratively through the commissioning of high quality, affordable, person centred care which harnesses the strength of clinician led commissioning that will empower and encourage individuals to improve their health and wellbeing status.

A model of Joint Commissioning will:

- Bring Primary care into the integrated commissioning partnership arrangements already in place in BaNES with Health and Social Care.
- Align the quality agendas across all health and social care commissioning

- Put clinical leadership at the heart of primary care commissioning
- Enable better engagement with primary care providers through existing CCG mechanisms e.g. GP Forum, Cluster arrangements, practice managers' meetings, practice visits
- Enable better Public and Patient engagement with respect to primary care commissioning

Some of the key elements of the BaNES five year strategy will be better realised be aligning Primary Care Commissioning close to the CCG commissioning processes.

In the CCG five year plan the CCG has identified six priority work programmes for delivering the CCG strategy. These are: -

1. Increasing the focus on prevention, self-care and responsibility
2. Improving the co-ordination of holistic, multi-disciplinary Long Term Condition Management (focusing initially on Diabetes)
3. Creating a sustainable and responsive Urgent Care System
4. Commissioning safe, compassionate pathways for frail older people
5. Re-designing musculoskeletal pathways to achieve clinically effective services
6. Ensuring the inter-operability of IT systems across the health and care system

Primary Care will have a role in each of these priorities. A model of Joint Commissioning provides a greater opportunity to focus all the "discretionary" local contractual levers e.g. LESs, DES, QoF etc. to be aligned to these priorities.

We have a model of practice clusters, each with populations of 30, 000 to 50,000. These population clusters currently form the basis of the development of the Community Cluster Team model in BaNES. We propose that future community based service developments should be based around these five clusters, unless there is a strong argument for providing services at an even greater scale.

BaNES CCG believes that the linking of six priority work programmes, with the five clusters and the model of Joint Commissioning with NHSE provides a significant opportunity to strengthen the delivery of the CCG's strategy. Examples of this are set out in Table 1.

III. How does our proposal help achieve greater integration of our health system: GPs, Community Services, Mental Health and Social Care? – more joined up and improved outcomes

The CCG and Local Authority in B&NES are developing and framing our thinking about whole system integration in the context of an emerging "Your *House of Care"* Model. This is based on the Kings Fund Report "Delivering Better Services for people with Long- term conditions – Building the House of Care". The House of Care approach sets out four interdependent components that if delivered together will achieve patient centred, co-ordinated care for people living with long term conditions and their carers.

One of the key enablers supporting implementation of the House of Care model is "Primary Care at Scale". Joint Commissioning of primary care with NHSE will

support the alignment and further development of a Primary Care Strategy bringing into the very centre of our Integrated Commissioning arrangements and solutions. The CCG anticipates that the Joint Commissioning of Primary Care will ensure that Primary Care is able to contribute effectively to our integrated model in a more sophisticated and responsive manner.

Table 1 Examples of how Joint Commissioning will help deliver the CCG priorities and the anticipated outcomes

The Six priority work programmes	Joint Commissioning opportunities for Primary Care to help deliver work programme	Anticipated Outcomes
1. Increasing the focus on prevention, self-care and responsibility	• Develop prevention activity, including self-care, amongst the population through primary care • Ensure equality of access to healthcare, targeting resources to those with the greatest need • Utilise opportunities through which prevention and self-care initiatives can be included within existing provider contracts e.g., contracts to include prevention activities and incentivising prevention activities	• Reduction in gap in premature mortality rate from selected causes between least and most deprived areas of BaNES • Increase in levels of primary prevention amongst BaNES residents, • Improved self-management support for patients with selected long term conditions • Reduced unwarranted variation in management of people on selected Long Term Conditions primary care disease registers
2. Improving the co-ordination of holistic, multi-disciplinary Long Term Condition Management (focusing initially on Diabetes)	• Our vision is to shift more care into primary care • There is a significant opportunity through redesign of the Diabetes Care Pathway to ensure that services are delivered by the most appropriately skilled person in the most appropriate setting of care	• Improved patient experience by ensuring patients receive high quality and timely care close to home • Halt the rise in type 2 diabetes and slow the progression of the disease • Sufficient capacity within diabetes services to meet the needs of rising numbers
3. Creating a sustainable and responsive Urgent Care System	• Provide better and more easily accessible information about self-treatment options so that people who prefer to can avoid the need to see a healthcare professional • Provide consistent same-day, every-day access	• Reduced Emergency Department attendances • Improved management of people with long term conditions leading to reduced unplanned elective admissions

	to Primary Care • Work with whole system ensuring Primary Care has a strong voice in redesign work simplifying the pathway for improved access for patients	• Improved patient experience

The Six priority work programmes	Joint Commissioning opportunities for Primary Care to help deliver work programme	Anticipated Outcomes
4. Commissioning safe, compassionate pathways for frail older people	• Embed and develop the Community Cluster Team model and active ageing service in 2014/15 and identify other opportunities for co-ordinating and developing responsive services for frail older people • Align CCG & NHSEs commissioning focus on over 75s e.g. £5/ head and other Primary Care contractual requirements	• Patients receive a seamless and integrated response appropriate to their needs • Treat and care for people in a safe environment and protect them from avoidable harm • Reduced unplanned hospital admissions
5. Re-designing musculoskeletal pathways to achieve clinically effective services	• Support patients to proceed along the most appropriate pathway • Prevent unnecessary referral to secondary care pathways • Maximise impact of Primary Care management of patients in the community	• Earlier diagnosis and appropriate treatment; reducing surgery rates and disability • More care delivered in community setting and reduction in inappropriate acute activity • Increasing patient choice and improving partnership working, patient experience
6. Ensuring the inter-operability of IT systems across the health and care system	• Primary care engagement and the GP Clinical Systems are the linchpin of this work programme	• Enable improvements in patient care due to shared information avoid unnecessary delays in treatment

IV. How does our proposal raise standards of quality within general practice? (Reducing unwarranted variation in quality and where appropriate, provide targeted improvement support for practices)

Joint Commissioning would facilitate bringing together the Quality agenda under one overarching process within BaNES. In particular the CCG would take a strong lead on blending the agendas of patient experience and reducing unwarranted variation in quality.

Table 1 sets out the anticipated enhanced impact of co-commissioning which would result from aligning primary care commissioning to the CCG's strategic priorities. The CCG Quality Committee will monitor and track the quality metrics linked to these priority work streams whilst maintaining a focus on the key primary care quality metrics, which are available through NHSE's Primary Care Quality Dashboard. The monitoring of the clinical effectiveness of contracting interventions would feed into the contract review processes to target the outlier practices and through a programme of visits, the CCG will identify the actions and support required to improve the quality of care.

A joint focus on the six priorities and metrics through joint primary care commissioning will help to identify and align contractual levers and incentives to support the overall delivery of the CCG's priorities related especially to patient safety. These will include the work on patient safety aspects of the diabetes pathway, reducing emergency admissions in the urgent care system, improving the care of the frail elderly, the early diagnosis and reduction in disability linked to musculoskeletal pathway and improving the transfer of clinical information through the inter-operability of IT systems.

V. How does our proposal enhance patient and public involvement in developing services?

Joint Commissioning with NHSE would provide a more coherent and broader approach to the CCG's approach to patient and public involvement. We would expect to utilise the CCG's newly established Patient and Public Involvement Group "*Your Health Your Voice*". The input of the group in the full range of primary care commissioning issues will be sought as required. In addition, there is an opportunity to increase communication with established practice based patient involvement groups with respect to Primary Care Commissioning.

The CCG would build on its experience of the Friends and Family Test which has been piloted across the whole pathway in Primary, community and secondary care for patients with heart failure. This project included recording patients' perceptions at three separate points on the clinical pathway including within General Practice. There are opportunities to improve patient experience and "hard wire" this into our day to day approach by applying the learning from this scheme into any whole pathway redesign and accessing patients through primary care.

Joint Commissioning of Primary Care also opens up the stronger opportunity of supporting the development of one of our key priorities “Increasing the focus on prevention, self-care and responsibility”; by working with community groups and our third sector providers to support innovative ideas to develop our Primary Care venues into a broader community hubs of health prevention and self-care.

VI. How does our proposal tackle health inequalities? Improving quality of primary care in more deprived areas and for groups of peoples such as people with mental health problems or learning difficulties?

Joint Commissioning of primary care provides a greater opportunity for a joint focus on Health Inequalities.

The local Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy both identify key health inequalities across BaNES (inequalities in health including the life expectancy gap, variations in the incidence of disease, and specific groups at higher risk of avoidable differences in health outcomes) and make a commitment to tackling the issues that contribute to these inequalities. In the current period of limited resources, the need to focus programmes and services on those with the highest needs is greater than ever.

The CCG and NHSE, in partnership with public health colleagues, will be better placed to agree to target resources to identified priority areas and to focus on the local priorities which drive inequalities in health within localities.

In particular as part of the co-commissioning in primary care we will be looking to:

- Ensure that the quality including access rates and waiting times, is at least as good in communities with poorer health outcomes as the rest of the BaNES
- Identify and reduce unwarranted variation and improve the quality of primary and secondary prevention, management and provision for conditions contributing to early mortality and disability (as identified in our 5-year strategic plan)
- Identify and reduce variation in referrals to hospital and community services, focussing on practices whose referrals rates appear to be lower than might be expected as well as those that are higher, and agreeing remedial action with the practices where necessary
- Undertake Equality Impact Assessments of co-commissioning actions, ensuring that at least they do not unfairly impact on communities with poorer health, and seeking to ensure that the co-commissioning arrangements does improve healthcare and health for those communities
- Further develop primary and secondary prevention activities, focusing a higher penetration of prevention strategies e.g. higher prevalence of child obesity in deprived areas

One of the CCG strengths has been its integrated partnership with the Local Authority which has allowed the pooling of budgets and posts as a result of Joint Commissioning of services for people with Mental Health and Learning Disabilities. The Joint Commissioning of primary care will provide additional opportunities to focus on areas of primary care where access to or quality of primary care services to vulnerable adults and children contributes to health inequalities. For example whilst

BaNES generally benchmarks well on access to annual health checks for people with learning disabilities, we can utilise the primary care contracting to focus more strongly on outlier practices.

Mental Health commissioning is supported by a network of mental health lead GPs who assist in the development of integrated mental health pathways of care. Co-commissioning is an opportunity to further strengthen the practical implementation of this work and achieve parity of esteem for mental health patients e.g. support the "antipsychotic prescribing pathway" work to improve primary care access to injectable antipsychotics leading to improved availability, uptake and quality of health care "pick up" of patients with mental illness. It could also be impactful in the work we are doing to introduce GP led clinics alongside mental health services to work with people with medically unexplained symptoms.

C. Scope

BaNES CCG is expressing interest on the basis of a Joint Commissioning arrangement with NHSE. The CCG anticipates that Joint Commissioning will allow the pooling of resources across the CCG and NHSE. The arrangements will allow a stronger "localisation" of discretionary budgets to align the focus of these budgets to CCG priorities. With NHSE, we will develop lean commissioning intentions and arrangements for primary care aligned to the CCG's five year plan, the development of locality arrangements and any emerging federated models of delivery which are anticipated to develop over the next five years.

The Joint Governance Arrangements which would need to be negotiated and agreed with NHSE are:

Strategic Primary Care Group– this group would meet quarterly and report to the CCG Board and to NHSE via appropriate governance arrangements. This group will set the strategic direction and will operate in a way that is consistent with the CCG's Constitution and Standards of Business Conduct Policy to ensure all conflicts of interest are managed, openly and transparently. This group would be chaired by a Lay Member of the CCG Board and would have appropriate representation from the Health and Wellbeing Board, CCG Board, Local Medical Committee and NHSE Primary Care Team. The Terms of Reference will define core membership and quoracy. The work plans and agenda will be jointly agreed between CCG and NHSE.

Primary Care Commissioning Group – this group would meet monthly and will be an operational group which will review and allocate the on-going work programme holding both CCG and NHSE Officers to account for delivery. This group would report to the Strategic Primary Care Group and would be supported by teams from NHSE and the CCG.

In addition, the elements of the work programme which are currently duplicated across NHSE and the CCG e.g. Quality, Public Patient Involvement would be supported by existing CCG mechanisms, in agreement with NHSE. Other aspects, especially the transactional elements would continue to be provided by the existing contract with NHS Shared Business Services (SBS) and would be monitored by the Strategic Primary Care Group.

I. Which aspects of commissioning fall within scope?

The "Securing Excellence in Commissioning Primary Care: Annex 2 Tasks and Functions" document (http://www.england.nhs.uk/wp-content/uploads/2012/06/task-func.pdf) sets outs the key primary care functions originally tasked to NHSE.

The CCG has mapped through the functions we would like to consider are in scope of our proposed Joint Commissioning Arrangements in Table 2. The CCG has undertaken some initial analysis and identified risks. Further work can be undertaken to inform the CCG's understanding and analysis of the potential issues. The CCG in conjunction with NHSE would also want to complete some due diligence assessment on the proposed arrangements.

Table 2: Functions in scope of Joint Commissioning and associated risks

Function	Sub functions	In scope?	Comment	Risks identified
Working with patients, public & Health & Wellbeing Boards (H&WB) to assess Joint Strategic Needs and set strategic priorities Communicating with local stakeholders as required	Primary Care Strategy	YES	Co-ordinated by the quarterly strategic group Integrate primary care commissioning into the local JSNA and H&WB strategy. Links service reviews & and proposed changes with the CCG's Patient and Stakeholders engagement mechanisms	Reputation- puts CCG at centre of commissioning a service currently under high pressure
Designing & negotiating local contracts (PMS, enhanced services)	Core GMS/ PMS QoF DES / LESs	YES	This will be co-ordinated by the monthly group Welcome opportunity for a core QoF and local QoF aligned to priorities	Need to ensure administration is proportionate
Approving discretionary payments		YES	This will be co-ordinated by the monthly group	Negative impact on CCG membership engagement
Managing financial resources and reviewing budget performance		YES	This will be co-ordinated by the monthly group. Not anticipating NHSE changing budget setting.	Financial risk
Monitoring contractual performance including quality assurance: • Negotiating quality improvement plans • dispensary services quality scheme		NO	Co-ordinated by the Area Primary Care Team. Opportunities to bring local engagement to drive change and align Quality agenda to local priorities	Negative impact on CCG membership engagement

• make referrals to NHSE performance panels as appropriate				
Applying contractual sanctions	Core GMS/ PMS QoF	NO	Co-ordinated by the Area Primary Care Team	Negative impact on CCG membership engagement
Bringing in new providers & managing procurements & deciding on practice mergers		YES	This will be co-ordinated by the quarterly strategic group	
Function	**Sub functions**	**In scope?**	**Comment**	**Risks identified**
Alignment of decisions on commissioning community pharmacy services		YES	Co-ordinated by the monthly group	
Alignment and co-ordination of Local Professional Network in BaNES including Eye Care Pathway redesign linking into NHSE		YES	This will be co-ordinated by the quarterly strategic group. The CCG is currently working on eye care pathways	
Dentistry – service reviews / needs assessments in relation to general dentistry & additional services		YES	Expect Area Primary Care Team to lead reporting to quarterly strategic group	
Maintain a list of dispensing doctors, deal with applications to dispense		NO	Expect Area Primary Care Team to lead reporting to quarterly strategic group	
Performers List and investigations around concerns about poor performance, revalidation & appraisals		NO	Medium Interest– One team leading this across NHSE is a good approach	Impact on membership engagement. Need good governance process
Workforce Planning		YES	Medium interest –Workforce is key to transforming Primary Care, strong linkage between the Joint Commissioning and Workforce	Recruitment of local professionals into Primary Care is key to successful high quality primary care. Currently GPs recruitment high risk

Estates		NO	Medium interest – opportunity to align local agenda to broader strategy about bring care closer to home	Quality of linkage with NHS Property services to align agendas
Rent reviews		NO		Negative impact on CCG membership engagement
Training & education		YES	Medium Interest - Training and education is key to transforming Primary Care, needs a strong linkage	

II. Request for capacity and resources

The CCG will need further discussion with NHSE to understand the resources available to support the Joint Commissioning arrangements. In order for co-commissioning to be successful and recognising the growth in commissioning responsibilities, it is anticipated the CCG will require some additional resources outside of its running costs allowance, particularly given our size.

Resource requirements based on the model outlined are as follows:-

- Band 7 Project Manager
- Admin support (Band 4)
- Additional GP Clinical sessions (1 session/ week to include covering attendance at Quarterly meetings, annual cluster meetings and practice visits)

The annual cost is currently estimated for this additional resource at: **£79.4k** (B7 £43.3, B4 £24.6k and £11.4k clinical sessions)

D. Nature of co-commissioning proposed – Joint commissioning arrangements

I. Overview

BaNES CCG intends through Joint Commissioning to provide complete alignment of the Primary Care Commissioning agenda to the CCG's five year plan. Joint responsibility would bring together current resources in NHSE with those in the CCG to eliminate duplication, pool resources and sharing of the work plan. BaNES CCG would wish to maximise the opportunity to put clinicians at the heart of Primary Care Commissioning.

There are some aspects of the work programme which should be absorbed into the CCG existing work programmes e.g. Quality Assurance, Public Patient Engagement, linkage with the local health community through Health and Wellbeing Board etc. Other aspects of primary care commissioning will continue to be led by NHSE relating to the contracting, payments and administration of the Primary Care. The Leadership of Primary Care Commissioning and engagement of practices would be presented to practices as a shared responsibility with the CCG and NHSE being in a "shoulder to shoulder" commissioning relationship rather a "them and us". The key benefit would be the better integration of the National Primary Care contract and the local health priorities to give locally sensitive and place based commissioning to give the best health outcome for people in BaNES.

The CCG believes that delivery of the priority work streams identified in table 1 would be enhanced as a result of the Joint Commissioning arrangements.

II. Managing Primary Care Budgets

Currently the CCG understands that the financial envelope for GP Primary Care excluding GP IT and running costs is approximately £23.1 million. This includes items which are deemed as Public Health expenditure, so would need to be

excluded. Under the current proposal, the CCG would anticipate working with NHSE to manage this budget jointly, recognising that currently the statutory responsibility still remains with NHSE. The expectation would be that the monthly operational group would have a financial role to monitor performance against budget.

III. The Future

The CCG would view this proposed Joint Commissioning Arrangement as an initial step in a developing relationship of co-commissioning between the CCG and NHSE. The CCG through the Strategic Primary Care group would keep under review the nature and outcomes of the developing co-commissioning relationship, to identify further opportunities to strengthen and develop arrangements, devolving some management to the CCG. This incremental approach for a CCG with a relatively small infrastructure would be a safe way of developing the co-commissioning agenda, whilst minimising risks to service delivery.

E. Timescales

The CCG would be keen to develop the infrastructure and processes in 14/15, with a plan to move to full shadow form during 14/15 with a fully developed work programme. The CCG would expect that the co-commissioning model would be fully operational from 1st April 15.

F. Governance

The CCG has appropriate governance arrangements in place for managing conflicts of interest. These arrangements are articulated clearly in the CCG's Constitution (Section 8: Standards of Business Conduct and Managing Conflicts of Interest).

These arrangements can be reviewed with NHSE to determine if they need to be strengthened further, or clarified to reflect the governance arrangements which will need to be satisfied for NHSE. The arrangements for every significant decision would be considered individually, as they are now, and appropriate arrangements made. Significant decisions such as: applying contractual sanctions, confirming practice mergers, discretionary payments of a certain value (as defined by our standing financial instructions) would remain the responsibility of the CCG Board and would not be delegated.

In the first year of existence, the CCG has had some experience in managing conflicts of interest related to the commissioning of services. The first involved the tendering of our new Urgent Care Centre which incorporated out of hour's services and the GP led Health Centre. The Board also made a decision regarding commissioning Primary Care to provide an Enhanced Community Service for nursing home patients. In both cases the governance process worked well. The Board was quorate and able to make decisions without the conflicted members being present or participating in the decision. The Board decision making was strengthened by the inclusion of the Medical Director from NHSE, the secondary care doctor from Wiltshire CCG and the Chair of the Health and Wellbeing Board from the Local Authority although these additional representatives were not voting members.

G. Engagement –CCG members and stakeholders

I. How has the CCG engaged its GP Members in its proposals?

There has been focused and formal engagement with some key opinion leaders: including the five GP CCG cluster leads, the CEO of our local GP provider organisation and our LMC. In addition, GP members have received a verbal briefing at a recent GP Forum in June. The expression of interest has been discussed and supported at both a CCG Operational Leadership Team meeting (May) and a CCG Board meeting (June). Responses are set out in Table 3.

II. Proposals for future engagement of GP members

The CCG are intending to have a dedicated session at GP Forum which we will jointly host with NHSE to explore in more detail GP member views on the Joint Commissioning proposals. Our expectation would be to run this session with GP members when a formal full response from NHSE is available.

III. How has the CCG engaged Local Stakeholders?

There has been key focused formal engagement with some key local stakeholders: the CEO of Community Health and Social Care provider, the CEO of our local Acute Provider, the CEO of our local Mental Health Trust, Healthwatch and the Director of People and Communities at the Local Authority. A summary of responses are set out in Table 3.

IV. Future plans of engagement of local Stakeholders

The CCG is intending to have a dedicated engagement workshop which we will jointly host with the NHSE Area to explore the Joint Commissioning proposals with local stakeholders in more detail. Our expectation would be to run this session when a formal full response from NHSE is available.

V. How has the CCG engaged patients and the public?

A “SurveyMonkey” questionnaire was sent to our 42 Public & Patient Associates. The questionnaire had a 28.6% response rate. A summary of responses are set out in Table 3. The expectation is that the CCG will use the various communication channels that are developing with this group to craft a strategy to engage patients and the public in this important initiative.

VI. How has the CCG engaged with NHSE?

The CCG has been keen to engage with both the Area Team at BGSW (BaNES, Gloucester, Swindon & Wiltshire) and the other CCGs in pulling together this expression of interest. The CCGs have been keen to work together jointly risk assessing the options and utilising the Commissioning Support Unit to inform their expressions of interest.

With the NHSE there has been:

- A meeting with the Director of Primary Care (27/5/14)
- NHSE wide CCG telephone conference call (30/5/14)
- NHSE Conference (10/6/14)
- A draft of the Co-commissioning Expression of Interest Document was shared and comments incorporated into this final document (16/6/14)

H. Monitoring and evaluation

The CCG will fully engage with any NHSE national and Area Team level evaluations for comparisons across different health communities.
In addition the CGG intends to review:

- The co-commissioning processes established
- The performance of the work programmes and the health outcomes.

With respect to the Co-commissioning processes the CCG will work with relevant Audit Committees, its internal auditors to include Primary Care on relevant work programmes and to include early review of the effectiveness of any new arrangements set up and agreed.
The Primary Care work programme would be aligned into the CCG performance assurance and management systems with regular reporting to the CCG Board against key performance measures.

The CCG will link any evaluation of Primary Care Commissioning to the broader evaluation of the Health and Wellbeing Strategy and the Joint Strategic Needs Assessment. The CCG has had initial conversation with the Local Authority based Public Health team to explore this.

Table 3: Summary Feedback from Stakeholders

Summary Key issues raised by GP members • Co-commissioning feels like a positive step for CCGs and GPs are broadly supportive • There are some significant concerns
Positives identified by GP members High Gains: Better localism, freedom from higher system pressure to make decisions around pathways, care and systems; Will be able to make real change to systems Medium Gains : Advance the integration agenda
Challenges identified by GP members High Concerns: CCG capacity (Human and financial), Conflict of interest- the governance arrangements need to be robust to meet outside scrutiny, GP Practices will be sceptical Medium Concerns: Will NHSE be able to step back?, CCG engagement with members practices, will localism affect the National GP contract and lead to a non-universal service, puts GPs centre stage when the system is feeling precarious
Summary Key issues raised by Local Stakeholders LMC, Community Provider, Healthwatch, Local Authority & Acute Provider • Support CCGs Interest for Joint Commissioning and alignment of strategy and resources • Concern about CCG Capacity
Positives identified by Local Stakeholders LMC: Integrate commissioning of services from CCGs, NHS E and Social Care, people making decisions who understand local issues Community Provider: Potential conflict of interest manageable –providing: good governance, a willingness to be transparent and a clear role for external scrutiny Healthwatch: Welcome opportunity to share patient stories about their primary health services
Challenges identified by Local Stakeholders LMC: More organisation change –will not be helpful, capacity of CCG not appropriate, conflicts of interest , need to be out of scope: performance procedures for individual practitioners and practices Community Provider: Capacity within CCG to undertake the work Acute Provider: Capacity within CCG to undertake the work
Summary Key issues raised by Patients & Public 58% in favour, 17% against, 25% do not know • Some real advantages as a logical next step and helping the integration of services • Recognition that GPs are in touch with patients and local communities • There are some significant concerns related to managing conflicts of interest • There is a request for more information is required to make an informed view
Positives identified by Patients & Public

Service tailored to local needs, and accountable to local demands, better integrated services, better utilisation of primary care premises
Challenges identified by Patients & Public Some individuals will dominate, divisive for CCG, management of conflicts of interest, worry about postcode health service

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MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**16/07/2014**
TYPE	**An open public item**

Report summary table	
Report title	Healthwatch Bath and North East Somerset Annual Report 2013/14
Report author	Pat Foster Tel: 0117 9659640
List of attachments	• Appendix One: Healthwatch B&NES Annual Report 2013/14
Background papers	n/a
Summary	Healthwatch Bath and North East Somerset presents the Annual Report
Recommendations	The Board is being shown the Annual Report for information
Rationale for recommendations	Healthwatch Bath and North East Somerset has sent the annual report to the Secretary of State, the annual report is also with the CQC, Healthwatch England, the Local Authority. As Healthwatch has a statutory place on the Health and Wellbeing Board we are sharing our year 1 report
Resource implications	n/a
Statutory considerations and basis for proposal	n/a
Consultation	n/a
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

1. Summary

This paper provides an update for members on the progress of Healthwatch Bath and North East Somerset which was commissioned by Bath and North East Somerset Council in April 2013.

During the last 12 months (to the end of March 2014) operational systems have been set up. New staff have been appointed and the first cohort of volunteers (16) have been inducted and trained. Volunteers have been selected to sit on the Healthwatch Advisory group with 2 volunteers still to be found to complete the group on Equality and Children and Young People.

The governance of Healthwatch Bath and North East Somerset has been devised and agreed.

The project has been working with Healthwatch England to set up good communication and branding. Healthwatch Bath and North East Somerset has used the Bath and North East Somerset Council website supplied to us and branded this as Healthwatch in the Healthwatch England corporate colours. Social media has been set up and is working well, leaflets have been distributed across the area and awareness raising at public events now use the Healthwatch banners. Healthwatch Bath and North East Somerset joined the Healthwatch England Advisory Group to look into how the complaints system have been working to meet the needs of the public and found confusingly that nationally there are 75 different agencies working with public complaints.

A database (Well Aware) of resources relevant to the health and social care needs of people living in Bath and North East Somerset is being used as the information and signposting function of Healthwatch. Well Aware now offers a signposting service to Freephone telephone callers enquiring about services in Bath and North East Somerset. During the first 6 months, a total of 66 calls were made to the service.

The first annual work plan for Healthwatch Bath and North East Somerset has been drawn up using the Joint Health and Wellbeing Strategy, the NHS England and CCG commissioning plans and the JSNA data on health inequalities. The work plan was adopted by the Advisory Group at its December 2013 meeting.

The project has been receiving and recording public concerns relating to health and social care services during the year and there have been 95 to the end of March 2014 (63 of these were recorded in Quarter 4).

Healthwatch Bath and North East Somerset is contributing to the Joint Health and Wellbeing Strategy challenge. Healthwatch contributes to

- Integrated primary, community and mental health services
- Long term conditions
- Urgent Care
- Older People

- Engaging people in decision making about the services they use

2. Issues for consideration / recommendations

Healthwatch has a small staff team and needs the recruitment of volunteers to ensure that Healthwatch is focused on achieving its outcomes. Volunteers in the first cohort have expressed an interest in representing the following groups within the Healthwatch Bath and North East Somerset Advisory Group:

- Older people
- Children and young people
- People with long term conditions
- Carers
- Urgent care
- Transport – particularly in rural areas

A selection of volunteers to the Advisory group is expected to be completed by the end of September 2014 with a view to the volunteers serving as a member of the group for a period of 12 months.

However no one has expressed an interest to date in leading the work on Children and Young People and Equalities.

3. Background

Bath and North East Somerset Council commissioned the Care Forum as a corporate body to provide the Healthwatch service for Bath and North East Somerset using volunteers to carry out the work. There are 3 strands within the Healthwatch contract including**:**

- Receiving and representing the views and opinions of the public in Bath and North East Somerset about Health and Social Care Services
- Signposting people to Health and Social Care provision in Bath and North East Somerset
- Provision of the NHS Complaints advocacy which in Bath and North East Somerset is provided through referral to SEAP (Support Empower Advocate and Protect)

4. Implications

Progress towards the creation of a body of volunteers enables the project to begin some of the practical work to be carried out. To date volunteers have been requested for the following:

- Bath and North East Somerset Health and Wellbeing Board
- BSWG Quality Surveillance Group
- Health Overview and Scrutiny
- Bath and North East Somerset CCG Quality Group
- Volunteers have also taken part in PLACE inspections at the RUH and have replied to the NHS Trust Quality Accounts

Please contact the report author if you need to access this report in an alternative format

healthwatch
Bath and North East
Somerset

Healthwatch Bath & North East Somerset Annual Report 2013/14

Any enquiries regarding this publication should be sent to us at info@healthwatchbathnes.co.uk

You can download this publication from www.healthwatchbathnes.co.uk

Contents

Introduction

Healthwatch Bath and North East Somerset is pleased to report on our first year of activity.

Healthwatch Bath and North East Somerset started on 1 April 2013. Healthwatch has been set up to hear what children, young people and adults have to say about their health and social care services.

Bath and North East Somerset has a population of 177,643 with 23% of the population under 20 years of age, due to a large student population.

12% of children and young people live in poverty in areas that include Twerton, Southdown and Radstock. Bath and North East Somerset has a mixed ethnic community with over 6000 people from Black Minority Ethnic (BME) origins, 9% of children and young people come from BME communities.

1 in 10 people in Bath and North East Somerset provides unpaid care and there are 155 known young carers.

Bath and North East Somerset has large rural areas including the Chew Valley and 22% of households have no car.

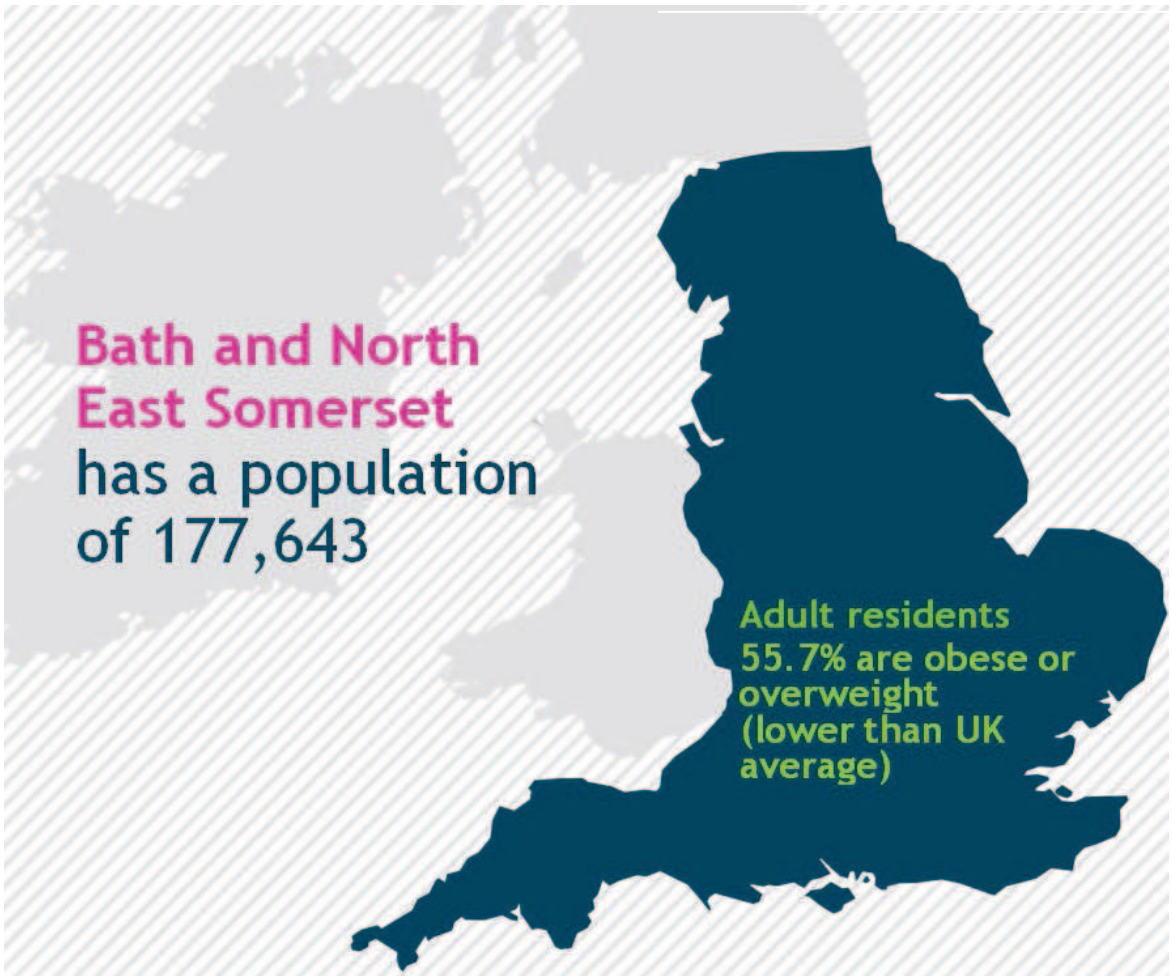
50% of the homelessness applications are from people aged under 25 years.

14% of the population are dispersed across villages and the wider rural areas, the rural populations have experienced the greatest proportion of population ageing.

Bath and North East Somerset has a population of 21,540 students at the University of Bath, Bath Spa University and the City of Bath College.

Health is generally better than the England average and deprivation is lower than average although 3,800 children are living in poverty.
14% of children are classified as obese.

Happiness Index ONS
84% of residents reported high levels of satisfaction



Figures from the Office of National Statistics and Bath & North East Somerset JSNA

"Healthwatch is being heard by Commissioners and we are beginning to make a difference"

Diana Hall Hall, Healthwatch representative for the Health and Wellbeing Board

healthwatch Bath and North East Somerset

Vision

Communities and people in all their diversity in Bath and North East Somerset can maintain their health and wellbeing, and care for themselves and each other.

Healthwatch Bath and North East Somerset Mission:

Healthwatch Bath and North East Somerset involves local people to help improve health and wellbeing services

Healthwatch Bath and North East Somerset held a successful launch event on 23 Sept 2013 which was well attended by stakeholders and commissioners. The launch gave Healthwatch the opportunity to update on the first six months progress in setting up and beginning to hear what local people have to say about their health and social care services. Claire Pimm from Healthwatch England gave a presentation on how they will hear from each of the local Healthwatch organisations across England to build a national picture of health and social care services.

The Care Forum trustees are responsible for the Healthwatch contract and a Healthwatch Advisory Group has been set up with Advisory Group members reflecting a range of necessary knowledge and skills.

Terms of Reference set out the operating procedures and the size of the Advisory Group to reflect governance and to give the opportunity for the Advisory Group membership to change over time to reflect the Healthwatch direction and future vision.

Healthwatch volunteers are clear about the respective roles of Advisory Group members and senior staff and work to the Nolan Principles of standards in public life.

Healthwatch Bath and North East Somerset has been working closely with the Clinical Commissioning Group (CCG) responsible for commissioning emergency and urgent care and healthcare services including community health, hospital, maternity and children's, mental health and learning disabilities services. The CCG works closely with other agencies such as Bath & North East Somerset Council to improve health and social care services.

Healthwatch has a volunteer representative on the CCG Quality Group to share information. Healthwatch has recently met with the lay member for Patient and Public Involvement, Suzie Power, to discuss the community engagement information gained from working with seldom heard groups and patient story information collected and collated for the Healthwatch quarterly reporting.

Advisory Group

At present the Advisory Group is made up of:

- The Care Forum General Manager -Healthwatch
- Healthwatch Development Officer
- Representatives from the voluntary sector – Age UK Bath and Connecting Capacity
- A representative from advocacy – SEAP hold the contract in Bath and North East Somerset
- CCG Lay Representative for Patient and Public Involvement
- Volunteer lead representative on the Health and Wellbeing Board
- Volunteer lead representative on Quality
- Volunteer lead representative on Equality (vacant)
- Volunteer lead representative on Children and Young people (vacant)
- Volunteer lead representative on Enter and View

During 2013/14 the group agreed:

- Terms of Reference to ensure roles for five volunteer champions to take lead Healthwatch representative roles and the opportunity for these volunteers to take an active role in governance
- Strategy for Healthwatch community engagement and an action plan
- Strategy for Healthwatch communication and the use of a wide range of communication tools
- Work plan devised from the Health and Wellbeing Strategy, the Joint Strategic Needs Assessment, CCG priorities, NHS England priorities and health inequalities. The work plan remains fluid to maintain capacity for the Advisory Group to take forward health and social care issues coming from the public. It is important for Healthwatch to demonstrate how local people's views have influenced decision making, prioritisation and recommendations.

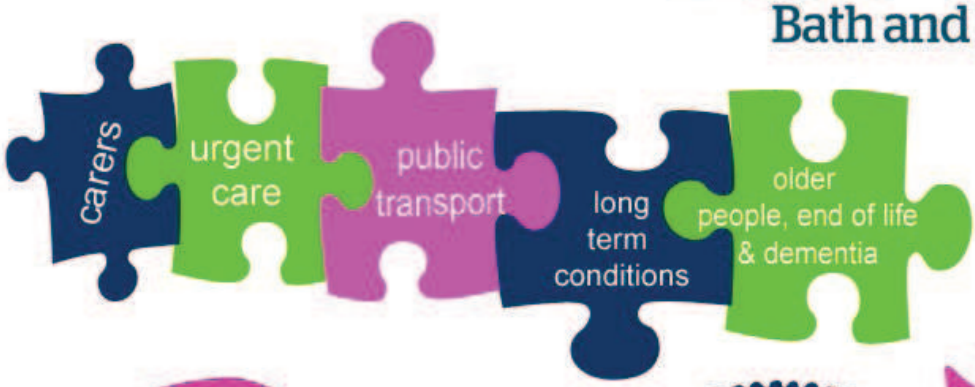
This year has seen the development of the Healthwatch governance structure to allow Healthwatch to demonstrate the highest standards of transparency, involvement and use of evidence in its decision making. Healthwatch Bath and North East Somerset now has a form and structure that allows it to operate effectively and Healthwatch Advisory Group members understand their duties and powers.

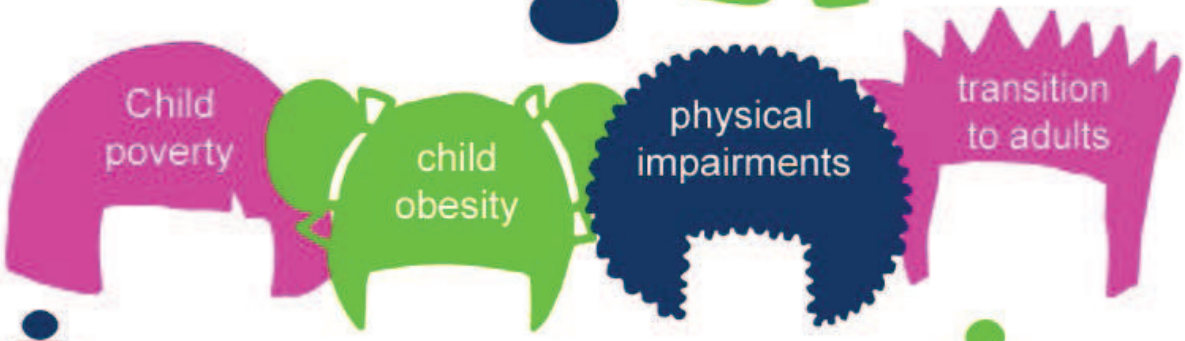
The Healthwatch Advisory Group meetings are held monthly in a range of venues across Bath and North East Somerset. The meetings are meetings in public and mechanisms are in place for discussions with the public through a public submission slot on the agenda.

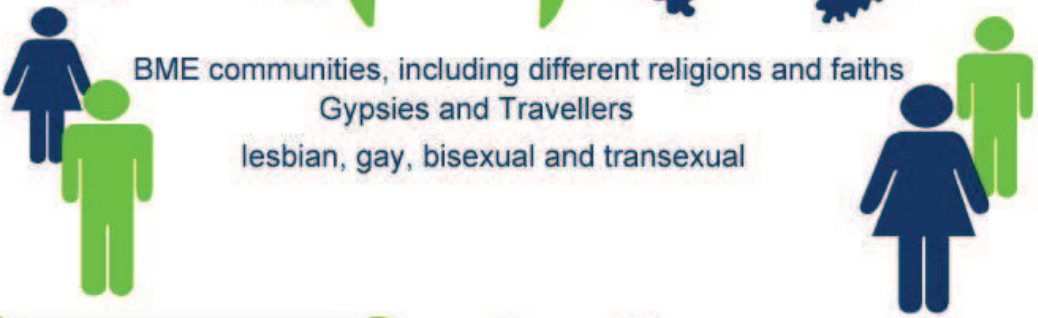
Healthwatch Advisory Group meetings are advertised through the Healthwatch communication channels and minutes and papers are available on the website.

Work Plan

healthwatch
Bath and North East Somerset







Twerton
Twerton West
Whiteway
Whiteway West
Fox Hill North
Radstock
Chew Valley (rural access)

monthy e-bulletins
quarterly newsletter
website updates
informative posters and leaflets
patient story leaflets

Volunteers

Time has been spent ensuring that robust procedures and policies are in place to support and involve volunteers in helping Healthwatch Bath and North East Somerset achieve its mission and vision.
This has meant producing a clear volunteer pathway demonstrating how volunteers can get involved in Healthwatch Bath and North East Somerset, the recruitment/ selection process and how they will be supported during their involvement. Role descriptions for the three key roles: Champion, Representative and Enter and View authorised representative have been developed along with branded application packs.

Volunteer Champions represent their community/constituent group so that Healthwatch can reflect a range of views and not just the loudest voices. Volunteers can further commit and become a Volunteer Representative becoming a two way flow of communication between boards and service deliverers. Volunteers can take up the opportunity to be trained and join the pool of 'Enter and View' volunteers needed for the Healthwatch statutory role to observe services.

To help promote the volunteer roles, marketing materials such as flyers and posters have been designed to help us target potential volunteers from the local community.

A core training package has been designed to develop the knowledge and skills of volunteers to enable them to carry out their role. The production of our Healthwatch Bath and North East Somerset volunteer handbook has meant volunteers can take away the key messages from training and have them available to them at all times.

This time spent preparing has enabled us to recruit, train and support volunteers to become part of their local Healthwatch.

Recruitment and training

Across the year 2013/2014 Healthwatch Bath & North East Somerset has recruited 16 volunteers in total:

- 13 are Champions, acting as a point of contact between Healthwatch and their group
- 4 are Representatives, sitting on health and social care boards, feeding in and feeding back to Healthwatch
- 6 are Enter and View authorised representatives
- 3 are members of the Advisory Group

Throughout the year the volunteer support team has delivered training to meet the needs of volunteers and their chosen roles. These have been held at various community venues and have been continually developed in response to training evaluation given by volunteers

- Introduction to Healthwatch
- Representing Healthwatch
- Enter and View training

In support of these roles volunteers have also been offered Safeguarding training with Sirona Care and Health and equalities training delivered by Voscur.

Representatives have taken part in a training and a thank you event alongside representatives from other voluntary sector boards.

Enter and View

Enter and View volunteers have taken part in a 'practice' Enter and View at Emerson's Green Treatment Centre. This provides practical experience of what is involved in planning and reporting on an Enter and View visit as well as the realities of approaching and speaking with members of the public.

All volunteers have been offered the opportunity to undertake Carers Awareness training.

Support

Group support sessions have been held at St Luke's Church and Bath Central Library. These have given the opportunity to meet volunteers from other training cohorts and share experiences. They have included a demonstration on the Well Aware database and an information share from Avon and Wiltshire Mental Health Mental Health Partnership NHS Trust respectively. As part of The Care Forum, Healthwatch volunteers were invited to attend our AGM and Christmas lunch.

Volunteers have been kept informed with the Healthwatch Bath and North East Somerset e-bulletin, The Care Forum's In Contact newsletter and our staff/volunteer newsletter. They have also been consulted about their area of interest within health and social care and added to mailing lists accordingly.

Christine Teller, Citizens Assembly of the South West Clinical Senate Representative

The volunteer support team has also been able to support volunteers with their access and transport needs to ensure equal access to involvement. This has included providing training materials in audio, in a chosen font size or paper colour; and with financial support to buy computer translation equipment and software. Taxis have been booked to support volunteers with transport needs.

Activities

Healthwatch Bath & North East Somerset Enter and View volunteers have convened a planning group to arrange forthcoming Enter and View visits.

Individual volunteers have been involved in various events on behalf of Healthwatch Bath & North East Somerset such as:

- Children's Trust Board stakeholder event
- Your Health Your Voice consultation
- Adults with physical disabilities and/or sensory impairments consultation
- Proposed changes to vascular services consultation

A Healthwatch Bath & North East Somerset volunteer sits on the Citizens Assembly of the South West Clinical Senate.

NHS Quality Accounts

Healthwatch gave a standard reply to the NHS Trust Quality Accounts for 2012/13 as these requests came very early into the set up of Healthwatch. Having a lead volunteer now for Quality on the Advisory Group, has given Healthwatch the opportunity to comment on the NHS Quality Accounts for 2013/14 and to ask the NHS Trusts to supply accessible audio versions to allow the volunteer to take part.

NHS Equality Delivery System

At present the volunteer lead position on the Healthwatch Advisory Group is vacant, so staff have ensured that the Healthwatch Advisory Group has had information on the Equality Delivery System and the Healthwatch role to comment.

Wellbeing Policy Development Scrutiny Panel

Healthwatch Bath and North East Somerset has built a relationship with the Wellbeing Policy Development Scrutiny Panel and has explained its role in helping Healthwatch hear from commissioners if questions we ask have not been answered within the allocated 20 days or 30 days for any joint commissioning questions. It was agreed that Healthwatch would report progress at quarterly meetings.

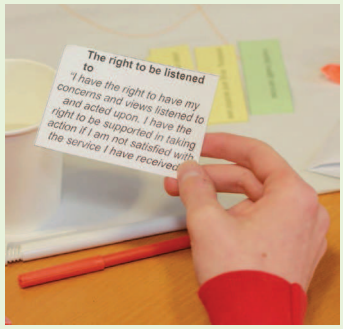
Quality Surveillance Group

Healthwatch Bath and North East Somerset has been building a relationship with the NHS England Quality Surveillance Group for Bath, Swindon, Gloucestershire and Wiltshire. The purpose of the Quality Surveillance Group is to bring together systematically different parts of the system to share information and intelligence that can provide an early warning mechanism of risk about poor quality and the opportunity to co-ordinate actions to drive improvement in services.

Healthwatch England

Healthwatch attended the Healthwatch England event on 29 January 2014 where the Healthwatch England rights were discussed.

1. The right to essential services
2. The right to access
3. The right to a safe, dignified and quality service
4. The right to information and education
5. The right to choose
6. The right to be listened to
7. The right to be involved
8. The right to live in a healthy environment



Healthwatch attended the Healthwatch England 'Strengthening Healthwatch in a changing system bringing outcomes and impact alive' event on 23 March 2014. The meeting discussed the use of the Healthwatch England outcomes and impact development tool and 360 degree evaluation being piloted in the north of England.

Well Aware

www.wellaware.org.uk is the information and signposting service for Healthwatch Bath and North East Somerset.

In our first year there were 505,634 page views on the site which covers Bath and North East Somerset, Bristol, South Gloucestershire and Somerset.

The top ten searches on Well Aware between April 2013 and March 2014 were:

- Befriending
- Mental Health
- Dementia
- Counselling
- Supported Living
- Learning Difficulties
- Gardening Services
- Gardening
- Carers' Support
- Older People

Community Engagement

A community engagement strategy was co-produced with members of the Healthwatch Advisory Group and an action plan sets out how Healthwatch will reach out to priority neighbourhoods and seldom heard communities and individuals. During April to September 2013 the Project Co-ordinator Claire Littlejohn undertook awareness raising across the Bath and North East Somerset area with stakeholders and commissioners. Community groups, including Bath Area Play Project, helped us reach children and young people and Bath Parent Carers were visited. On 12 September Healthwatch attended a round table meeting with the minister Norman Lamb.

From October 2013 Jan Perry was employed as Project Co-ordinator and began working with the West of England Rural Network and the Village Agents to reach people in the Chew Valley area. Events have been held at Chew Magna, Chew Stoke and West Harptree to hear people's stories. Events attended included the Market Place and Spinning World conference. Contact was made with service providers including Sirona, Avon and Wiltshire Mental Health Partnership NHS Trust, the South Western Ambulance NHS Foundation Trust and the Royal United Hospital.
Jan attended Bath & North East Somerset Carers Centre and reported carers' concerns, and worked with Chew Valley School on a Positive Mental Health Awareness Day and heard the issues of young people on stress and depression.
The Healthwatch Advisory Group has identified Black and Minority Ethnic communities including other faiths and religions, Gypsies and Travellers and Lesbian, Gay, Bisexual and Transgender people as seldom heard. Priority areas include: Twerton, Whiteway, Fox Hill, Radstock and Chew Valley.

The Bath & North East Somerset Health and Wellbeing Network

Over the year we ran three Health and Wellbeing Network meetings. These discussed: the local Placemaking Plan – places development and wellbeing; Working and Wellbeing – skills, education and employment; Reducing the Health and Wellbeing Consequences of Domestic Abuse. Over 120 people came to the meetings. Notes and a summary of the findings of the meeting were presented to the Health and Wellbeing Board. Initially the Health and Wellbeing Network immediately preceded the Board meetings, however this schedule changed over the year. Now the schedule for meetings is becoming more established with Network held the week preceding the Health and Wellbeing Board and six meetings are scheduled for this year. The topics for the Network meetings are usually driven by agenda items for the Health and Wellbeing Board, to ensure the Network remains topical, relevant and influential. The meetings are evaluated and general feedback is that the networks are welcomed and are useful. Comments include:

I hate workshop sessions BUT this way of working was much more user-friendly!

It was all very informative - well organised and I got a lot out of it.

Joined up conversation across different organisations and disciplines relevant to health and social care. Networking.

Ronnie Wright, Project Co-ordinator TCF presents the What Works Conference Report to the Bath & North East Somerset Health and Wellbeing Board March 2014

Healthwatch Bath and North East Somerset has been building a relationship with the Health and Wellbeing Board. Until a volunteer representative was inducted and trained Pat Foster The Care Forum manager with responsibility for Healthwatch, has stood in. Healthwatch has two places on the Health and Wellbeing Board and the volunteer representative Diana Hall Hall has taken up the second Healthwatch statutory place on the Health and Wellbeing Board.

Healthwatch is a service for all communities and in particular works to ensure the voice of those not normally heard is gathered. The views and priorities of children and young people are a key focus for us and is fully integrated within the work we do. Within the Bath and North East Somerset area we have made links with existing children and young people networks, inputted into the development and consultation on the Children's Trust children and young peoples Plan for 2014-2017.

We have undertaken engagement work with several youth clubs such as Southside and Riverside youth hubs talking to the young people about Healthwatch and hearing their issues and concerns.

The young people were asked about their experiences of visiting doctors and whether they were happy to go alone and what the top priorities were for them. Most did take a parent/adult with them to appointments as they needed a lift and also adults felt they would understand what was said better than themselves.

Top priorities for young people have been identified as child poverty, child obesity, transition to adult services and physical impairments. Mental health services, in particular, issues surrounding stress and anxiety have also been identified through engagement work.

Our website contains information about us, news and Tell Us Your Story online forms where people can leave feedback on their experiences of local health and social care services. There is also an advice section on how to make a complaint relating to health and social care; links to Well Aware the Healthwatch Bath and North East Somerset information and signposting service; volunteering and how to get involved with us; interactive polls; social media feeds and videos.

We have added Browse aloud to the website which reads out the text making the website accessible to visually impaired users.

Social media has enabled us to reach many people, especially local communities. Healthwatch Bath and North East Somerset is also on Facebook where we share local health and social care news and events.

We have produced monthly e-bulletins that contain news from the Bath and North East Somerset Health and Wellbeing Network with local and national news and events relating to health and social care, plus a regular Healthwatch update. In our first year our e-bulletins were opened 12,307 times and 4,321 of these were from Twitter.

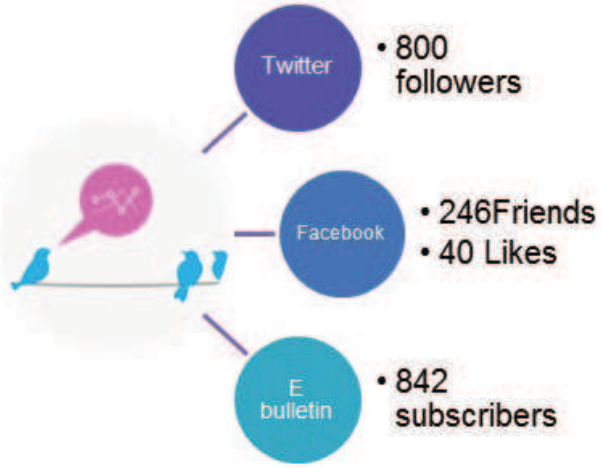
We have also recently set up a text service where people can text feedback on their health and social care to us. Over the year we heard from young people and the deaf community that being able to text to us would be a great way of getting in touch.

We have created a screen advert which will be displayed in the Royal United Hospital Bath every 15 minutes for a year. We have also developed a screen advert for GP surgeries in Bath and North East Somerset and are hoping that these will be used across the area over the next year.

www.healthwatchbathnes.co.uk

Website engagement

Social media engagment between April 2013 and March 2014:



This year we have advertised in the Essential GP Health guide available at GP practices in the area, the Friends of the Royal United Hospital Guide 2014, Now Bath website, Bath Mums website has featured us as have the Bath and North East Somerset CCG Prospectus and the Bath Council Connect Magazine which goes out to 76,000 households in Bath and North East Somerset.

As well as leaflets that explain what we do we have also produced “Tell Us Your Story” leaflets that we take out into the community to gather feedback of people’s experiences of local services. We have also created postcards that people can leave feedback on and we now have ballot boxes that people can post these into at events such as the Village Agent Roadshow and Bath City Conference.

Healthwatch England provided the trademark that is shown on all communication tools.

We have developed a wide range of promotional materials pens, pencils, lip gloss, banners, balloons and trolley coins to take to events with us.

Issues and concerns

Healthwatch Bath and North East Somerset has heard 95 issues and concerns from health and social care service users, carers, family members, and service providers since April 2013.

Methods

Healthwatch Bath and North East Somerset has captured data submitted via the channels listed in Graph 1, and coded them according to the categories in the Healthwatch England Info Bank. This has been done to facilitate sharing and triangulation between Healthwatch Bath and North East Somerset, other Local Healthwatch and Healthwatch England.

The coded data form an evidence base of issues, concerns and compliments about health and social care in Bath and North East Somerset, which can be interrogated for patterns or 'themes'.

In Year one, the most commonly used method of capturing service users' feedback was through a presence at meetings. The Healthwatch Project Coordinator, a Healthwatch Representative or Healthwatch Champion notes down any issues and concerns expressed by meeting attendees, and with the commentator's consent, submits them for inclusion in the Healthwatch Bath and North East Somerset database.

The second most utilised method of communicating issues and concerns was by email, and the third was within online forums aimed at specific community groups, for example on the Bath Mums website. www.bathmums.co.uk

Other methods used include correspondence (letter writing), telephone, and 'Tell Us Your Story' leaflets, which are available in public places throughout Bath and North East Somerset and at relevant public events and meetings.

Sentiment of comments

The sentiments of the service feedback heard by Healthwatch Bath and North East Somerset are shown in Table 1. Some of the comments contained mixed feedback, which is why more than 95 'sentiments' are reported:

Table 1: Sentiments for all Issues and Concerns Y1

Positive	**3**
Mixed	**6**
Negative	**106**
Neutral/Unclear	**32**

Table 2: Types of Issues and Concerns Y1

Access to a Service	11	Fit for purpose/meeting needs	2
Access to Information	21	Housing	1
Admissions	1	Involvement and Engagement	7
Appointment booking service	1	Medicines Management	1
Appointments	5	Patient Transport	1
Building and Facilities	1	Quality of treatment	22
Car Parking	4	Records Management	4
Change of Service	1	Referrals	1
Choice of service provider	2	Safety of Care and Treatment	1
Cleanliness of environment	1	Staff attitudes	18
Complaints Management	3	Staff Training and Development	5
Confidentiality/privacy	1	Staffing Levels	1
Coordination of Services	7	Suitability of environment	1
Diagnostics	1	Suitability of Provider/Organisation	6
Equality	3	Suitability of Staff	1
Equipment	2	Transparency of Fees	1
Finance/cost	1	Waiting Times/access to a service	2
Financial Viability	2	Waiting times/access within a service	4

Comment types

The three most often heard types of issue and concern in Year one related to:

- **Quality of treatment** (22 in total: 1 positive, 18 negative and 1 neutral)
- **Access to information** (21 in total: 1 positive, 13 negative, 6 neutral and 1 unclear)
- **Staff attitudes** (18 in total: 7 negative, 11 unclear)

The positively reported types of experience fed back related to suitability of provider organisation (1 positive issue heard), quality of treatment (1 positive issue heard) and access to information (1 positive issue heard).

The most negatively reported type of experience fed back related to quality of treatment (18 negative issues/concerns heard).

The types of issues and concerns heard by Healthwatch Bath and North East Somerset in Year one can be categorised as shown in Table 2.

Service types

The three most common services referred to in issues and concerns heard in year one are:

- Primary Care/GPs (26 in total: 23 negative and 3 neutral)
- Hospitals (8 in total: 7 negative, 1 neutral)
- Care at Home (8 in total: 5 negative, 2 mixed and 1 neutral)

The positively reported types of service were physiotherapy (1 positive issue heard), support groups (1 positive issue heard) and youth clubs (1 positive issue heard).

The most negatively reported type of service was Primary Care/GPs as detailed above (23 negative issues/concerns heard).
The services people in Bath and North East Somerset told Healthwatch about in Y1 can be categorised as shown in Table 3.

Table 3: Issues and Concerns in Y1 by service type

Accident and Emergency	1	Learning Disabilities and Autism	1
Ambulance Services	4	Maternity	1
Assisted Living	1	Mental Health	5
Cancer Services	2	Out of Hours	1
Care Assessments	3	Outpatients	2
Care at Home	8	Paediatrics	1
Carers Services	3	Parking	6
CCG/Council	3	Patient Transport	4
Child and Adolescent Mental Health Services (Hospital Services)			5
Child and Adolescent Mental Health Services (Other Services)			1
Personal budgets/Direct payments			1
Physiotherapy	1	Church	1
Primary Care/GPs	26		
Community Mental Health Team (CMHT)	5		
Radiography	1	Community Nursing	1
Residential Care Home	1	Dementia	1
Shobmobility	1	Dentistry	1
Suicide and Self Harm	1	Healthwatch	1
Support Group	2	Hospital	8
Urology	1	Inpatient Care	3

Themes

From this analysis, it has been possible to identify themes from the issues and concerns heard by Healthwatch Bath and North East Somerset. As of the end of year one, these themes are as follows:

- Healthcare professionals' communication with children and young people in primary and secondary care: children and young people are accessing primary care services with their parents so they can help them understand what is being discussed. There is also an emerging theme of children and young people feeling that staff in secondary care settings address their parent(s), rather than them directly.

- Care at Home: commentators in Bath and North East Somerset have reported a poor quality of care, as a result of what they perceive to be contract constraints e.g. targets. Specifically, service users have commented on a lack of continuity in the care staff who come to their homes, and the difficulties/stress this can cause in having to re-explain their personal circumstances repeatedly.

- Ambulance service: this is an emerging theme, with commentators identifying potential training needs of ambulance staff who have been reported as not communicating or responding to situations as efficiently as service users would wish.

- Information about care: several commentators have reported a lack of easily accessible information on care options and carers' issues. They have identified a lack of signposting to this information, and reported difficulties in having to navigate the system to find out about, and gain clarity on, their options.

Healthwatch Bath and North East Somerset will take this information to their partners, and to their Advisory Group, who will advise on any further work to be undertaken to investigate these themes further.

Individual issues that have been 'acute' or ongoing at the time they were fed back to Healthwatch Bath and North East Somerset, have been considered by the Project Coordinator, and remedial action taken where appropriate.

The Healthwatch Bath and North East Somerset Advisory Group

For financial year 2013/14, Healthwatch Bath & North East Somerset received £82,000.

Costs included in each heading:

Staff expenditure costs are staff salaries including national insurance and pension contributions, travel, training and recruitment costs. This figure also includes a contribution to the management, administrative, finance and IT staff at The Care Forum.

Volunteer expenditure includes volunteers' expenses, recruitment and training costs.

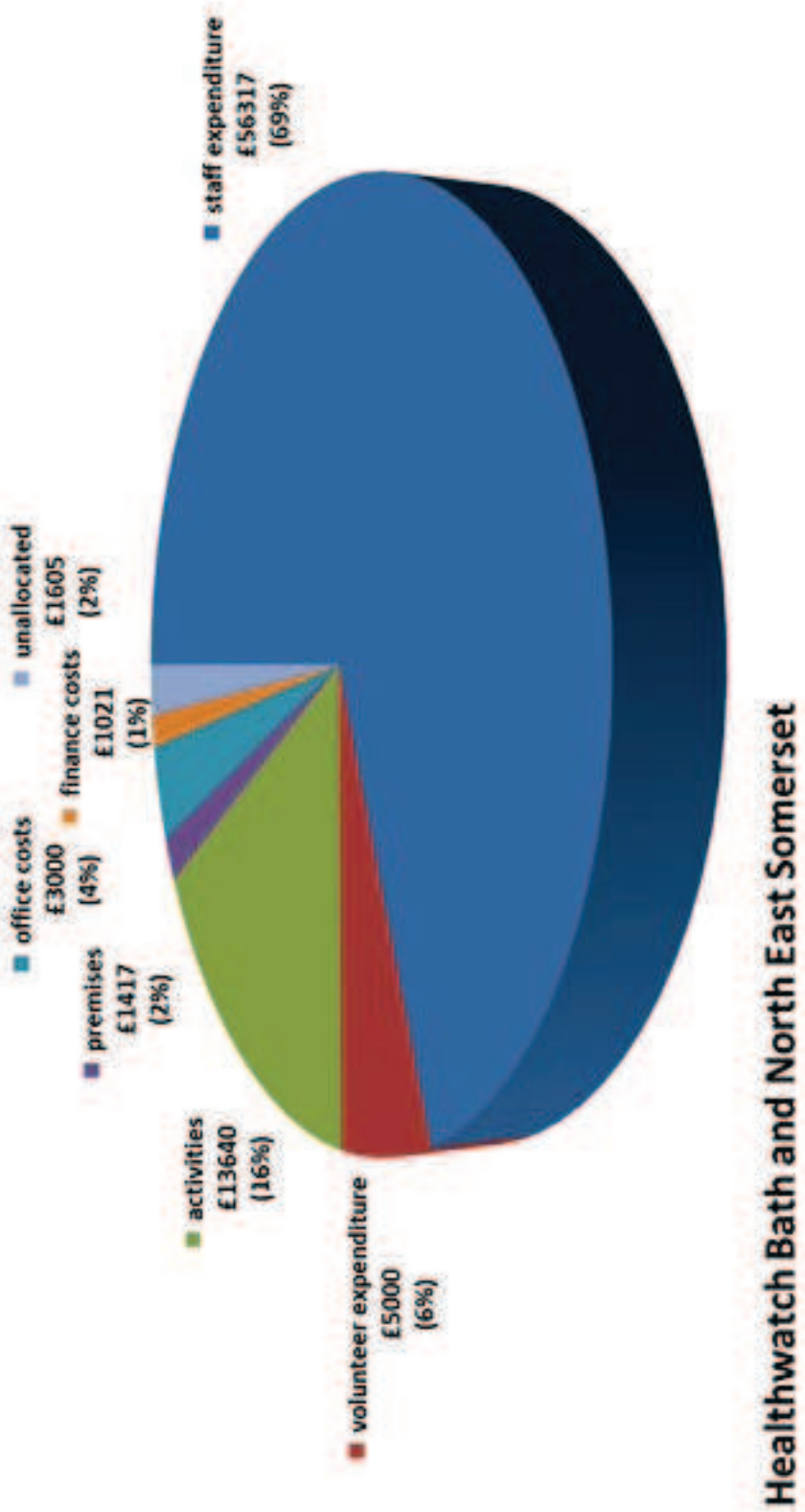
Activities costs are meeting costs, such as hiring rooms, consultation and engagement costs. Also included is a contribution to the costs of maintaining the Healthwatch website and the Well Aware website which provides the information and signposting service.

Premises costs include a contribution to the charges The Care Forum has to pay such as rent, rates, service charge, electricity, etc. In addition, there is a payment to DHI (Developing Health Independence) for use of their hubs across Bath and North East Somerset.

Office costs include postage, stationery, telephone, printing, publicity, photocopying, and setting staff up with equipment such as computers and mobile telephones.

Finance costs include a contribution to the cost of the annual financial audit of The Care Forum's finances and the cost of any Disclosure and Barring Service (DBS) checks that may be required.

Unallocated is a small amount in case of any unforeseen costs. As this was not used in 2013/14, it will be carried forward into 2014/15 and added into the budget for activities to support consultation and engagement work.


staff expenditure £56317 (69%)
unallocated £1605 (2%)
finance costs £1021 (1%)
office costs £3000 (4%)
premises £1417 (2%)
activities £13640 (16%)
volunteer expenditure £5000 (6%)
Healthwatch Bath and North East Somerset

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Facebook: Healthwatch Banes

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**16/07/2014**
TYPE	**An open public item**

Report summary table	
Report title	SEND reform implementation update
Report author	Charlie Moat, 01225 477663, charlie_moat@bathnes.gov.uk
List of attachments	• Appendix One: PowerPoint presentation to Health & Wellbeing Board
Background papers	**Report to Health & Wellbeing Board** (January 2014) - http://democracy.bathnes.gov.uk/documents/s28994/SEND%20reform.pdf, http://democracy.bathnes.gov.uk/documents/s28995/Appendix%201%20Implications%20of%20SEND%20reform%20for%20HWB.pdf, webcast http://www.bathnes.public-i.tv/core/portal/webcast_interactive/124732/start_time/1419000. **Consultation paper on SEND reform implementation in B&NES** (May 2014) - http://www.bathnes.gov.uk/sites/default/files/send_reform_consultation_paper.pdf **SEND Code of Practice** (statutory guidance published June 2014) - http://www.bathnes.gov.uk/sites/default/files/code_of_practice-final-10june2014.pdf.
Summary	Update on work to implement SEND reform in B&NES to date, key issues and proposed approaches to take this work forward.
Recommendations	The Board is asked to consider the following questions: 1. Do Board Members support the approaches proposed? 2. How can Members help with the challenges? 3. What challenges or suggestions do Members have for the continuing SEND reform project?
Rationale for recommendations	The legal framework for local authorities, clinical commissioning groups, education settings and other partners to provide support for disabled children & young people, those with special educational needs (SEN) and their parent carers is changing from 1st September 2014. The Children & Families Act 2014 part 3 and associated regulations and statutory guidance require broad-ranging and profound changes to the way special educational needs & disability (SEND) support for people aged 0-25 is commissioned and delivered.

	An implementation project was established in B&NES in summer 2013. Health & Wellbeing Board was briefed about the reform in January 2014 and agreed to support work to ensure we meet our statutory duties and take a leading role in developing the B&NES 'local offer' of SEND support. The SEND reform contributes to achieving all three of the Health & Wellbeing Strategy themes for disabled children & young people and those with SEN – staying healthy, improving quality of life and creating fairer life chances.
Resource implications	There are no direct resource implications of this report or the update presentation that will be made. SEND reform itself has significant resource implications which will be addressed in the update to the Board.
Statutory considerations and basis for proposal	SEND reform bears in particular on equalities, human rights and children (& young people up to 25). There are new statutory duties set out in the Children & Families Act 2014, associated regulations and statutory guidance.
Consultation	SEND reform steering group, implementation project working groups, workshops, consultation events, Health & Wellbeing Board (Jan 2014), Policy Development & Scrutiny panel (Nov 2013), and Children's Trust Board (Dec 2013). A consultation paper on implementing SEND reform in B&NES has been widely circulated and comments received. This work has involved a wide range of stakeholders across services, parents, young people, education settings and others.
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

1.1 A PowerPoint presentation updating on SEND reform in B&NES will be made to the Board. Slides are available as Appendix One for information.

Please contact the report author if you need to access this report in an alternative format

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SEND reform update July 2014

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SEND reform national update

- Children & Families Act 2014 given royal assent
- Final code of practice 10th June 2014
- Draft transitional arrangements guidance 10th June – statements transfer to EHC plans over 3.5 years
- Implementation grant & 'new burdens' grants to March 2016
- Implement from not for 1st Sept – Sept 2014 is a milestone or a beginning, not the end of implementation of the whole reform

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B&NES local update

» Progress since January
» Work currently underway
» Work to come
» Challenges

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Engagement

- Multi-channel communication in place with a wide range of stakeholders
- Parents involved in all workstreams
- Work underway to engage young people
- Briefings for parents in education settings summer and autumn 2014

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SEND support

- Estimate 8000+ YP 0-25 with level of SEND
- Early support pathways developed building on existing integrated working practices – early years settings engaged
- Work underway with schools/SENCOs and FE sector on SEND support in each phase
- Independent support – B&NES Parent Partnership Service won 'evidence & build' bid to shape IS nationally
- Additional advocacy for young people to March 2016

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EHC planning

- 700 – 800 YP with high needs SEN – currently statements of SEN – will be EHC plans
- Pilot EHC assessments now completed
- Model for delivery, EHC Plan template out for consultation (May 2014)
- SEND lead practitioner role established (from August 2014)
- New way of working takes more time – additional posts being recruited

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Local offer

- Local offer template now being rolled out – schools, settings, services drawing up their SEN arrangements/offers
- Rainbow Resource software platform being readied to populate with data for Sept
- SEND reform consultation paper published May 2014 – initial area-wide local offer to build on this
- Elements of co-production – work towards full co-production

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Joint commissioning & personal budgets

- SEND panel now has health & care rep.s – integrated decision making on statements & EHC plans
- Developing initial personal budget policy with parents
- Develop more integrated comprehensive personal budget offer over time – involve young people
- Personal budgets and co-production of local offer will both drive changes to how we commission – greater integration & scope for personalisation

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Workforce development

- Series of pilot EHCP workshops for those involved in pilots run through the spring
- Introduction to SEND reform training now underway – training parents alongside practitioners
- Training and practice workshops for EHC planning to be developed for the autumn
- Person centred thinking training programme getting underway

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Next phase of work

- EHCP process goes live 1st Sept – continue to refine
- Transitional arrangements – draft transfer plan shortly – 700-800 transfer reviews over 3.5 years to April 2018
- Establish partnership to keep local offer under review, work towards full co-production with parents & young people over 3-5 years
- Develop personal budget offer over 2-3 years
- Build whole system approach to SEND support

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Whole system approach

- SEND is everyone's business
- Personalisation – person centred, outcome focused, holistic working – can benefit all children, young people, adults, families and underpins inclusion for those with SEND
- Across whole system and within each service/setting/school

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Challenges

- Capacity – resourcing – currently to March 2016 – what then?
- Ownership of SEND support – establishing whole system/school/setting approach with all partners
- Personalisation – culture change – person centred thinking, outcome focus, holistic/integrated working
- Ambition/aspiration – expectations often too low
- Achieving true co-production with parents, young people

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Issues/questions for HWB

» Do Board Members support the approaches proposed?

» How can Members help with the challenges?

» What challenges or suggestions do Members have for the continuing SEND reform project?

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