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 Guildhall, High Street, Bath BA1 5AW	Direct Line:	01225 394452
	Ask For:	Jack Latkovic
	E-mail:	Democratic_Services@bathnes.gov.uk
	Date:	9 September 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), Councillor Dine Romero (Bath & North East Somerset Council), Jo Farrar (Bath & North East Somerset Council), Pat Foster (Healthwatch representative), Diana Hall Hall (Healthwatch representative), John Holden (Clinical Commissioning Group lay member) and Tracey Cox (Clinical Commissioning Group)

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

Observers: Councillor John Bull and Vic Pritchard

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, 17th September, 2014** at **10.00 am** in the **Brunswick Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
Committee Administrator

NOTES:

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

2. **Public Speaking at Meetings:**
   The 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. **Recording at Meetings**:-

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

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

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

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

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, 17th September, 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

   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.

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

6. PUBLIC QUESTIONS/COMMENTS

7. MINUTES OF PREVIOUS MEETING

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

8. MENTAL HEALTH UPDATE (40 MINUTES) Steven Andrews

   This report provides an update on the mental health of people in Bath and North East Somerset, an update on commissioning and strategic progress and a request for further advice and support from the Health and Wellbeing Board.

   The Board is asked to note:
   - The progress to date across all commissioning, strategy and provision areas.

   The Board is asked for further advice and support in relation to:
   - Parity of Esteem
   - The Mental Health Crisis Concordat
   - Accommodation options for people with serious mental health problems (on CPA)

- Ways to improve the employment options for people with serious mental health problems in B&NES
- Reducing stigma about mental health and promoting wellbeing

9. BETTER CARE FUND (40 MINUTES) Jane Shayler

In early July 2014, the Department of Health (DH) announced the Government's decision to place different requirements on the use of £1bn of the £3.8bn Better Care Fund (BCF). This was followed in the last week of July with the publication of new guidance on the use of the BCF and revised templates for the submission of plans along with the timetable for submission and assurance of plans, with a deadline for submission of plans signed-off by the Health and Wellbeing Board of 19th September 2014.

Changes to the use of the BCF do not, for Bath and North East Somerset, require amendments to the Better Care Plan 2014/15-2018/19 agreed by HWB on 26th March 2014 or to the use of the BCF.

The revised guidance and templates do require clarification of the vision for integrated care and support, case for change and plan of action along with the locally agreed target for reduction in total emergency admissions (to hospital).

This report sets out: i) summary of key changes to the guidance on use of the BCF; ii) the associated timetable; iii) better care plan summary revisions (Appendix 1); and iv) summary of schemes to be funded from the BCF with revisions highlighted (Appendix 2).

The report seeks delegated authority to the Chair of the HWB and CCG's Interim Accountable Officer to sign-off submission of plans to meet the deadline of 19th September.

10. TWITTER QUESTIONS (10 MINUTES)

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

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HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Wednesday, 16th July, 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
Councillor Dine Romero	Bath & North East Somerset Council
Jo Farrar	Bath & North East Somerset Council
Diana Hall Hall	Healthwatch representative
Tracey Cox	Clinical Commissioning Group
John Holden	Clinical Commissioning Group lay member
Paul Scott	Bath & North East Somerset Council
Ronnie Wright	Healthwatch representative
Julia Davison	NHS England

23 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

24 EMERGENCY EVACUATION PROCEDURE

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

25 APOLOGIES FOR ABSENCE

Bruce Laurence and Pat Foster had sent their apologies for this meeting. Paul Scott

and Ronnie Wright were their substitutes for this meeting.

26 **DECLARATIONS OF INTEREST**

Diana Hall Hall declared a disclosable pecuniary interest under item 6 on the agenda as she is a member of the newly formed B&NES Neurological Alliance. Diana Hall Hall declared the interest as she would read a statement on behalf of the B&NES Neurological Alliance.

27 **TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR**

There was no urgent business.

28 **PUBLIC QUESTIONS/COMMENTS**

The Chairman informed everyone that a number of speakers submitted their requests to address the Board at this point of the meeting.

The Chairman said that each speaker would have up to three minutes to address the Board.

Diana Hall Hall read out the statement by introducing the newly formed group called B&NES Neurological Alliance. Diana Hall Hall, as a member of that group, also said that the B&NES Neurological Alliance (NE) had been concerned that neurology had been completely omitted from the CCG's 5 year plan. Diana Hall Hall invited Councillor Allen and Jane Shayler (Deputy Director for Adult Care, Health and Housing Strategy) to meet the Alliance and hear what they have to say in terms of neurological services.

A copy of the statement from Diana Hall Hall is available on the Minute Book in Democratic Service.

The Chairman informed the meeting that the Panel received a number of statements about Warm Water Pools in advance of the meeting.

The Chairman invited Susan Charles and Susan Smith to read out their statements. Susan Charles and Susan Smith presented their views on benefits from the Warm Water Pools provision. Speakers also asked the Board to support their suggestion for provision of the Warm Water Pools.

Lara Varga read out her statement in which she asked the Board to support provision of the Warm Water Pools.

A statement from Lara Varga is available on the Minute Book at Democratic Services.

The Chairman informed the meeting that all statements submitted to the Board would be placed on the Minute Book at Democratic Services.

The Chairman read out the following statement:

‘**Warm Water Pools – HWB Briefing Note**

‘The Health and Wellbeing Board is committed to working in partnership with sports and leisure commissioners and providers to encourage people to be active and to make sure that leisure facilities are accessible. As part of this, the Health and Wellbeing Board notes that the Council is considering a range of options (including accessible teaching pools) as it seeks to modernise its leisure facilities.

The Health and Wellbeing Board notes that the Council and the CCG will be working closely together to ensure that the new leisure contract provides the best possible service for local people and supports them to live healthy lifestyles.

It is important to clarify that the provision of warm water swimming facilities is not the same as the provision of hydrotherapy services which is a specialist health service provided from appropriately equipped, specialist facilities and funded by the CCG.

For advice and guidance on accessible sports facilities, Sport England has produced an ‘Accessible Sports Facilities Design Guidance Note.
(http://www.sportengland.org/media/30246/Accessible-Sports-Facilities-2010.pdf)

Comments on the procurement process for the new leisure contract are welcomed by the Council and the Health and Wellbeing Board recognises the important role this contract plays in helping to deliver the Joint Health and Wellbeing Strategy. The Health and Wellbeing Board will work with the Council as it develops these options through dialogue with potential contractors as part of the procurement process. The contract will be awarded in January 2015, with a contract start date of July 2015.’

29 MINUTES OF PREVIOUS MEETINGS

The minutes of the previous meetings were approved as correct records and signed by the Chair, subject to small corrections which were taken on board by Jack Latkovic (Senior Democratic Services Officer).

30 LONELINESS AND ISOLATION (40 MINUTES)

The Chairman informed the meeting that he would allow Chris Head to read out his statement before officers’ introduction of the report.

Chris Head said that there were two age groups of people that should be looked on this subject. Young people 16-25 age and over 70. Loneliness could be caused by many issues, some of which were:

- Access to transport in rural areas
- Lack of employment in some areas
- Black and Ethnic Minority
- Access to different services (Council, bank, etc)
- Advice and guidance
- Broadband and technology
- Lack of contact with relatives and neighbours

- Lack of affordable housing

The Chairman invited Andy Thomas (Group Manager for Partnership Delivery) and Ronnie Wright (Healthwatch) to introduce the report.

Andy Thomas took the Board through the report as printed.

Ronnie Wright updated the Board on outcomes of the network event where loneliness and social isolation had been discussed. Ronnie Wright explained that loneliness and social isolation were two different matters. Loneliness was a subjective feeling whilst social isolation was when people were for one reason or another isolated from other people and community.

Two questions had been raised within the discussion – how to support people through changes and how those changes were managed.

Older people should not be seen as stereotypes for loneliness.

58 people had turned up at the network event and the following had been highlighted: mental health issues; a need for consistent access to services; GP involvement; range of available services; more joined-up thinking; more support with more training for staff; availability of funding.

The Chairman commented that loneliness and social exclusion were quite complex issues. The Chairman also said that quality of interaction was a key element when looking at these issues.
The Chairman also said highlighted importance of having an advice and information strategy, something that the Council had been working lately.

Councillor Romero agreed that loneliness should not be linked only with older people. Councillor Romero also said that public transport was an issue for rural areas. The technology, mostly IT, could be seen as 'silver bullet' – people tend to stay more at home and their only communication mean was their PC/laptop/tablet. Loneliness was not only an issue for rural area – some communities in Bath had been experiencing the same.

Jo Farrar commented that the Council had been discussing Transport Strategy and Leisure Strategy, which should contribute towards interconnectivity.

Dr Ian Orpen commented on importance of distinction between loneliness and social exclusion.

John Holden said that one of the reasons for isolation had been that people were less mobile than before (due to IT, social networks, etc).

The Chairman proposed that the Board should set up a working group to look in to this issue from all aspects.

It was **RESOLVED** to note the report and for the Board to set up a working group to look into this issue.

31 **COMMISSIONING OF PRIMARY CARE (20 MINUTES)**

The Chairman invited Tracey Cox to introduce the report.

The Board supported the approach and also the issue around the governance. Members of the Board felt that the new approach would open doors to joined-up ways of working.

Tracey Cox welcomed comments from the Board and added that some frameworks were yet to be put in place, as well as some safeguards in terms of the joined-up arrangements between the NHS England and the CCG.

It was **RESOLVED** to note report and to receive further on governance arrangements within the commissioning of primary care at one of Board's future meetings.

32 **HEALTHWATCH B&NES ANNUAL REPORT (20 MINUTES)**

The Chairman invited Ronnie Wright to give a presentation to the Board.

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

Diana Hall Hall thanked the Care Forum for being a host organisation to the Healthwatch. Diana Hall hall also said that the Healthwatch had been in discussion with the Council around contractual requirements, such as percentage of people engaged via social media.

Dr Ian Orpen had said that he was delighted with the Healthwatch, whose representatives had been attending every meeting of the CCG Board.

Tracey Cox said it was helpful to see the plan and invited Healthwatch to meet with her and Jane Shayler to talk about future workplans.

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

33 **SPECIAL EDUCATIONAL NEEDS AND DISABILITY REFORM UPDATE (30 MINUTES)**

The Chairman invited Charlie Moat (Child and families Group manager) to give a presentation to the Panel.

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

The Chairman said that children with Special Educational Needs (SEN) should have access to education like every child.

Charlie Moat said that SEN Reform would put strong duties on school to identify SEN and meet those needs.

Jo Farrar commented that she would be happy, on behalf of the Council, to help with

the project.

Tracey Cox commented that it was important to raise awareness of personalisation. Tracey Cox also said that possible dialogues with a range of providers, across the whole system, could contribute towards more commitment, on this subject, across the whole system.

The Chairman suggested that the Board should receive a further update on this matter, at one of future meetings.

It was **RESOLVED** to note the report and to receive a further update at one of future meetings.

34 **TWITTER QUESTIONS**

The Chairman read out a question from twitter to which he provided an answer.

The meeting ended at 12.10 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**17/09/2014**
TYPE	**An open public item**

Report summary table	
Report title	Mental Health Update
Report author	Andrea Morland, Senior Commissioning Manager (01225 831513) Paul Scott, Deputy Director, Public Health Mary Kearney-Knowles, Senior Commisioning Manager
List of attachments	None
Background papers	• No Health without Mental Health • Children and Young People's Emotional Health and Wellbeing Strategy • Children and Young People's Plan 2014-2017 • Closing the Gap – Priorities for Essential Change (25 priorities for change) • Mental Health Crisis Concordat • Joint Commissioning Panel for Mental Health Guidance • Dementia Strategy • Outcomes frameworks – Public Health, Social Care, NHS • Talking Therapies – A Four Year Plan • A Commissioners Guide to Primary Care Mental Health • Parity of Esteem
Summary	This report provides an update on the mental health of people in Bath and North East Somerset, an update on commissioning and strategic progress and a request for further advice and support from the Health and Wellbeing Board.
Recommendations	The Board is asked to note: • The progress to date across all commissioning, strategy and provision areas. The Board is asked for further advice and support in relation to: • Parity of Esteem • The Mental Health Crisis Concordat • Accommodation options for people with serious mental

	health problems (on CPA) • Ways to improve the employment options for people with serious mental health problems in B&NES • Reducing stigma about mental health and promoting wellbeing
Rationale for recommendations	The work taking place is in line with the Health and Wellbeing Board's strategic priorities for mental health, long term conditions and dementia: **Theme 1 – Helping People Stay Healthy** Healthy and Sustainable places (Accommodation, Community services) **Theme 2 – Improving the Quality of People's Lives** Improved support for people with long term conditions (e.g. Wellbeing College, MindFull, parity of esteem) Reduced rates of mental ill health (e.g. suicide and self harm, wellbeing) Enhanced quality of life for people with dementia (e.g. in-patient provision) **Theme 3 – Creating Fairer Life Chances** • Increase resilience of people and communities including action on loneliness (e.g. Community services review) • Improve skills, education and employment (e.g. Wellbeing College, employment services) • Reduce health and wellbeing consequences of domestic violence (social prescribing)
Resource implications	Continuing re-design of mental health community and social care support services is taking place, in the context of the overarching savings requirements of the Council, as part of the Supporting People and Communities programme. Following sector reviews the final proposals for 2014-16 saw re-investment of monies into re-designed mental health services in line with members' requests. The longer term financial revenue (CCG) and capital (AWP) implications of improving specialist acute mental health in-patient facilities will be quantified and assessed as part of an options appraisal and impact assessment process. Implementation of service changes and improvements that relate to wellbeing, crisis concordat work and parity of esteem involve investment proposals that will need to be considered in light of overarching pressures on all health social care and related public sector finances.

Statutory considerations and basis for proposal	Statutory duties of the NHS and Council for the provision of Health and social services. Equality impact assessments relating to the options for in-patient redesign will be included as part of the engagement and impact assessment processes to be presented to the Policy Development and Scrutiny panel in the Autumn of 2014. This is in order to meet our duties under the Equalities Act.
Consultation	All mental health community service developments are taking place in conjunction with the Mental Health Wellbeing Forum, service users and carers. AWP and commissioners will engage with HealthWatch, Your Health, Your Voice (CCG participation group) stakeholders, clinicians, staff, service users and carers regarding in patient provision in line with their public duty requirements to involve the community under Section S244 of the NHS Act 2006 (as amended). No specific consultation has been undertaken on the contents of this update.
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. What do we know about mental health?

- Mental health problems are common (around 1 in 6 people affected at any one time), often start in childhood and are a leading cause of disability.
- Intervening early for children with mental health problems has been shown not only to reduce health costs but also realise larger savings such as improved educational outcomes, reduced unemployment and less crime.
- Prevalence of depression in B&NES is similar to the national average, with almost 9000 adults in B&NES recorded as having depression by their GP.
- Emergency hospital admissions due to self-harm in B&NES are significantly higher than national average. This may be due to different thresholds for admission compared to other areas. The highest admission rates are amongst teenage girls and young women. Admission rates show a close relationship with deprivation levels around the district.
- The number of suicides fell slightly during the mid-2000s but has returned to previous levels. It is similar to the national rate, but lower than the South West rate.
- 66% of adults on the Care Programme Approach (CPA) are in settled accommodation which is higher than the national average but has fallen over the last 18 months.
- 14% of adults on the Care Programme Approach (CPA) are in employment, which is double the national average.

- The proportion of mental health related social care clients receiving home care is higher than the national average. The proportion receiving day care services is lower than the national average.
- The number of carers of adult mental health clients whose needs were assessed during the year is lower than the national rate.
- B&NES has good performance compared to national averages across a range of service activities. Attendances at the emergency department and days spent in hospital beds for mental health issues are both lower than national average. Emergency admissions for people with schizophrenia are much lower than the national rate.
- Detentions under the mental health act are double the national rate.
- Hospital admissions for deliberate and unintentional injuries amongst people aged 0-24 years are higher than the national average.
- 47% of people completing primary care psychological therapies treatment are rated as moving towards recovery, which is similar to the national rate.
- In 2012/13 B&NES spent less per head of population on mental health specialist services than the national average.

2. Commissioning and strategic updates for wellbeing, self-harm and suicide prevention.

2.1 Wellbeing

Public Health England is publishing a national approach to improving wellbeing in October 2014 and we will use this national work to review local work in B&NES.

A variety of actions to support the wellbeing of young people are being coordinated via the Children and Young People's Emotional Health and Wellbeing Strategy. Recent NICE guidance identified a range of actions local authorities should be taking to promote the wellbeing of young people and the strategy is currently being benchmarked against this guidance.

Early identification and intervention with children displaying emotional distress is vital. Schools (particularly Primary Schools) have accessed specialist training and support to become Attachment Aware Schools and several Primary Schools staff have undertaken training in Nurture and Theraplay to enhance their understanding of children with high levels of social and emotional needs who may later be at risk of exclusion.

A new Nurture Outreach Service has been commissioned to support school staff to manage challenging behaviour where a nurturing approach is best to meet the needs of the child. From September Place2Be will be providing a counselling service in selected Primary Schools and Brighter Futures will run the Nurture Outreach Service for targeted children from all primary schools.

A "Get Set" programme is now offered through the Education Psychology Service for those children who have been identified as needing more support for starting school. This programme allows school staff to be released to regularly visit children in their pre-school settings and Early Years staff to subsequently visit the child in their schools.

For older children and young people, a pilot of MindFull - an online information, peer-support and online counselling service - has been commissioned jointly by B&NES CCG and Public Health and will commence in September. Its online nature makes it accessible and is the preferred medium for some young people. The counselling provides support for young people to self-refer for milder mental health problems which may not meet the criteria of specialist mental health services.

There are also exploratory conversations with Oxford Health regarding young people aged 16-18 being able to self-refer to their services. This may help address “reluctant “ young people being referred from other services who subsequently do not engage with treatment.

The Director of Public Health Award is given to those schools that improve the school setting to promote wellbeing and demonstrate change within their pupils. Mental wellbeing has been added to the criteria used for reviewing schools working towards the award.

The key development to promote wellbeing amongst adults at high risk of poor mental health is the commissioning of a Wellbeing College. This is a joint development between B&NES CCG, Adult Care and Public Health starting in September 2014. Work is underway to provide courses which help people manage their long term conditions and mental health, develop a healthy lifestyle, manage key social issues such as housing, employment and debt and achieve wellbeing through learning new skills and pursuing interests. The work of the College will be integrated with mainstream community activities and education in its broadest sense and will provide an umbrella concept for the delivery of many of our existing groups etc.

Through a "college" approach a range of educational courses and access to resources can be made available for people to understand their conditions, share their experiences, learn ways to manage their conditions, build their skills, support one another and take control. The college is informed by national evidence of effectiveness in mental health recovery collages and Expert Patient/peer facilitation programmes and designed around the principles drawn from the peer-led Bridging the Gap research in B&NES.

A joint approach to improving the physical health of people with severe mental illness is also being implemented. This will require more systematic checks of key lifestyle risk factors amongst people using the services of Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). People with severe mental illness have a very much reduced life expectancy compared to the general population. Smoking and other lifestyle risk factors often account for a significant proportion of this gap.

Somer Valley FM have been piloting an information campaign to promote the Five Ways to Wellbeing amongst local people. These are a range of evidence based actions to improve wellbeing, including: Connect, Be Active, Take Notice, Keep Learning, Give.
Sirona Care and Health’s Healthy Lifestyle Service are also incorporating mental health in to their overall workplace wellbeing programme which works with local employers to make changes that support the health of their staff and productivity of their business. ***Further***

advice and support from the Health and Wellbeing Board on reducing stigma about mental health and promoting wellbeing is welcome

2.2 Self-harm

A new programme of support for people who attend the RUH emergency department following self-harm starts in September 2014. We expect to see a reduction in the number of people who are readmitted in the future. This is jointly commissioned by B&NES CCG, B&NES Public Health and Wiltshire Public Health. As part of this commission a self-harm register is now helping us have better insight in to people attending for self-harm, their key risk factors and the quality of the care they receive. Examples of recent focus have been people using high fatality methods and also older people who are at higher future risk of suicide than younger people but are less likely to receive psychosocial assessment.

2.3 Suicide prevention

In addition to the above actions to promote wellbeing and reduce self-harm, we are working closely with specialist mental health services for young people and adults to ensure that key national recommendations for reducing suicide risk are being implemented locally.

The feasibility of setting up a bereavement support group for people affected by the death of a family member or friend is being explored, which is a current gap in the West of England area.

Three training sessions on suicide were provided during the Spring of 2014 to around 150 front line staff across B&NES. These staff were largely non-clinical coming from a range of organisations such as schools, housing providers, teachers, employment advisers, drug treatment staff, etc. The rationale being that most clinical staff already receive opportunities for training and the majority of people taking their life in B&NES are not in touch with mental health services.

We are working closely with colleagues across the West of England, Bristol University and AWP to develop a joint system for monitoring suicide data from the Avon Coroner. This would provide more timely and insightful data than has been available previously.

3. Mental Health services update

3.1 Primary Care and Community Services

During 2013-14, local commissioners and providers built upon our previous successes and re-emphasised our commitment to deliver more personalised, recovery focused mental health community services, with people able to improve their health through self-management of conditions and peer support and education.

Our aspirations above will be further realised during the next two years through the model of care and associated services outlined below:

- A continued increase in the development of peer support and service user/carer led activities through the Building Brides to Wellbeing and Creative Arts projects as well as maintaining funding into Quartet grants.

- An increase in the self-management of long-term health and mental health conditions through piloting a Wellbeing College.
- Fully develop a Single Point of Entry Primary Care Mental Health service combining the Primary Care Talking Therapies and Liaison teams in order to expand the range and types of intervention available and meet the national target of 15% of the prevalent population accessing services by the end of 2014-15.
- The provision of an episode of mental health reablement normally for up to 6-8 weeks (or up to 12 weeks in a smaller number of cases) at the beginning of a pathway of care providing intensive support to resolve acute social care related issues that may be undermining mental wellbeing.
- The development of a short stay Respite facility attached to the reablement team for those who would benefit from short periods in a different environment.
- A remodelling of Sirona Care and Health floating support services, to staff an expanded reablement service and a Community Links service (previously Community Options).
- Supporting service users who have received long term support from Sirona Care and Health to access an alternative provider of floating support by October 2014 (or by January 2015 in exceptional circumstances).
- The establishment of a social prescribing service across B&NES to link with new domestic violence initiatives.
- The re-design of the vocational and job retention employment service in the context of low levels of employment compared to the rest of the population. ***Further advice and support from the health and wellbeing Board ion this issue is welcome.***

3.2 Specialist Acute Mental Health services

Following reorganisation of services by the Avon and Wiltshire Specialist Mental Health Trust we now have a locality management team working alongside commissioners and other providers in a more focused way to:

- Improve the local integration of specialist mental health services into all the pathways of care as described above. AWP are key to ensuring the success of many of the initiatives above through information and signposting as well as shared delivery of service where appropriate.
- Enable mainstream health and public sector services to realise their roles in attending to the physical healthcare needs of people with mental health problems as well as the mental health needs of people with physical health problems (Parity of Esteem - national agenda). Developments in this area are evidenced in AWP's excellent mental health liaison services into the RUH, care homes and community hospitals as well as commissioners' plans to transform the pathways of care for people with long term conditions to, for example, include psychological and wellbeing support with training and service support from AWP. ***Further advice from the Health and Wellbeing Board about how to embed this approach in B&NES is welcome.***
- Facilitate appropriate responses to people in a mental health crisis or requiring urgent care in B&NES in line with National Crisis Concordat work. This work is not restricted to implementation by and investment into mental health services but requires a whole public sector system response. E.g. it is planned to pilot the ambulance service having internal mental health clinical hubs for advice to front line staff. ***Further advice from***

the Health and Wellbeing Board about how to embed this approach in B&NES is welcome.

- Continue to address the falling levels of people with mental health problems on CPA living independently in what is known as settled accommodation. On review of the data which covers people who are 18-69 (not 65) the predominant numbers of people who are home owners are between 65-69 with younger people being in supported accommodation or having tenancies. Of these tenancies the number that are through private landlords is lower that through housing associations. We are continuing to investigate these trends as AWP provide the data but not service in this area in order to understand what effects any benefit changes may be having on a our younger and more vulnerable clients. ***Further discussion with the Health and Wellbeing Board about ways to improve accommodation options for people with mental health problems is welcome*.**
- Work with commissioners to improve the quality of local in-patient facilities. The current configuration of wards means B&NES has two stand-alone specialist acute Mental Health assessment units (Sycamore and Ward 4) so, whilst it is imperative to address the immediate environmental concerns on Sycamore Ward in Hillview Lodge (following serious concerns from staff and CQC about the environment on the ward) we also need to "future proof" capacity and provision to ensure we deliver high quality, skilled in-patient care to both our functional and dementia patients.

Initial ideas for moving forward have been discussed with clinical and managerial staff as well as stakeholders at the:

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

Soundings from these early discussions are that doing nothing is not an option, that having new purpose built facilities is a positive opportunity and that commissioners and AWP should:

- Continue to investigate options for a rebuild/new build that includes the dementia assessment beds being on the same site as the acute functional mental health beds
- Investigate the option to retain a presence on the RUH site but in another part of the site and maximise benefits of linking mental health with physical health facilities
- Explore an option of decanting, demolishing and rebuilding Hillview to accommodate extended in-patient (wider than B&NES basis) services and community teams
- Pursue a purpose built option, whether on the RUH or another site, as this offers the potential for developing new partnerships with other providers of complementary services
- Consider whether new / remodelled accommodation in the B&NES locality could also include the potential for an "all age"Section 136 suite

4. Conclusion

A great deal of work is taking place to support mental health and wellbeing in B&NES in line with the Health and Wellbeing Strategy's themes and crossing cutting principles. Based on these principles further advice and support from the Health and Wellbeing Board is sought on:

- Embedding the notion of Parity of Esteem for physical and mental health
- Embedding support for people in a mental health crisis across all sectors
- Ways to improve accommodation options for people with serious mental health problems in B&NES
- Ways to improve the employment options for people with serious mental health problems in B&NES
- Reducing stigma about mental health and promoting wellbeing.

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MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**17/09/2014**
TYPE	**An open public item**

Report summary table	
Report title	**Better Care Fund**
Report author	Jane Shayler, Telephone: 01225 396120
List of attachments	Appendix 1: Better Care Plan Summary Revisions Appendix 2: Summary of schemes to be funded from the Better Care Fund
Background papers	Report to Health and Wellbeing Board (HWB), 26th March 2014, *"5-Year Strategic Plan 2014/15-2018/19, Better Care Plan and Operational Plan 2014-16"*
Summary	In early July 2014, the Department of Health (DH) announced the Government's decision to place different requirements on the use of £1bn of the £3.8bn Better Care Fund (BCF). This was followed in the last week of July with the publication of new guidance on the use of the BCF and revised templates for the submission of plans along with the timetable for submission and assurance of plans, with a deadline for submission of plans signed-off by the Health and Wellbeing Board of 19th September 2014. Changes to the use of the BCF do not, for Bath and North East Somerset, require amendments to the Better Care Plan 2014/15-2018/19 agreed by HWB on 26th March 2014 or to the use of the BCF. The revised guidance and templates do require clarification of the vision for integrated care and support, case for change and plan of action along with the locally agreed target for reduction in total emergency admissions (to hospital). This report sets out: i) summary of key changes to the guidance on use of the BCF; ii) the associated timetable; iii) better care plan summary revisions (Appendix 1); and iv) summary of schemes to be funded from the BCF with revisions highlighted (Appendix 2). The report seeks delegated authority to the Chair of the HWB and CCG's Interim Accountable Officer to sign-off submission of plans to meet the deadline of 19th September.

Recommendations	The Board is asked to agree: • The summary of schemes to be funded from the Better Care Fund as revised from that approved by March 2014 HWB (Appendix 2); and • Delegation to the Chair of the Health and Wellbeing Board and the CCG's Interim Accountable Officer of sign-off of BaNES BCF submission in the required revised format on 19th September 2014.
Rationale for recommendations	Health and Wellbeing Board in March 2014 approved and endorsed BaNES's Better Care Plan 2014/15-2018/19 and the associated schemes to be funded from the Better Care Fund in the context of the local vision for and delivery of integrated care and support. This local vision is aligned with and makes a significant contribution to delivery of the outcomes in the Joint Health and Wellbeing Strategy as follows: Theme One - Helping people to stay healthy: • Reduced rates of alcohol misuse; • Creating healthy and sustainable places. Theme Two – Improving the quality of people's lives: • Improved support for people with long term health conditions; • Reduced rates of mental ill-health; • Enhanced quality of life for people with dementia; • Improved services for older people which support and encourage independent living and dying well. Theme Three – Creating fairer life chances: • Improve skills, education and employment; • Reduce the health and wellbeing consequences of domestic abuse; • Increase the resilience of people and communities including action on loneliness. Timescales for revised BCF submission, following publication of revised guidance at the end of July 14 are extremely challenging and adjustments to the detailed submission in the required template(s) are likely, therefore, to be made right up to the deadline for submission on 19th September. It is, therefore, necessary to seek delegation of sign-off of this detailed submission.
Resource implications	Proposed use of BCF funding in 2014/15 and 2015/16 is set out in Appendix 2. The most significant revision from the use of BCF funding agreed by HWB in March is provision for additional financial burdens arising from the Care Act, which establishes a number of new duties for local authorities, from April 2015. The Government is indicating that an element of the BCF should be used to meet the additional costs arising from the new Care Act. However, the indicative amount falls significantly short of the current estimated cost of the new financial burdens for B&NES.

	As well as having wider implications for the Council's financial planning for 2015/16 and beyond, the additional financial burdens associated with the Care Act and use of the BCF to meet an element of these costs could become an increasing issue that would place a strain on the other objectives of the BCF. On an annual basis and in accordance with each organisation's financial planning processes and decision making, adjustments are likely to be made to BCF funded schemes; model(s) of service; and/or capacity. Revisions will take account of i) evidence of the outcomes delivered by the schemes; ii) the principles and conditions of use of the BCF, including any future revisions; iii) any changes in the statutory obligations of either or both of the organisations; and iv) best value. The overarching aim of BCF funding is to act as a key enabler of the delivery of integrated services that support and safeguard older and vulnerable people to remain independent through timely interventions that contain, stabilise, decrease and/or de-escalate risks, care and support needs. Also, to continue to reduce unnecessary and unplanned admissions. This requires a shift in focus and of resources to the "front end" of the pathway/system to place greater emphasis on prevention and early intervention. This strategy is critical to responding in a sustainable way to the increasing volume, complexity and acuity of older people and those with long term conditions whilst also achieving the best possible outcomes for individuals. In the longer term this strategic shift of resources is likely to require a reduction in the proportion of funding to acute and specialist health in order to fund sufficient capacity and capability in community services.
Statutory considerations and basis for proposal	This report responds to the national technical and planning guidance on the Better Care Fund published on 25th July 2014. In order to draw down the maximum BaNES' BCF allocation, it is necessary for BCF plans and proposals to comply with this guidance.
Consultation	Key contributors to this report are: • Council Section 151 Officer; • CCG Chief Finance Officer; • Strategic Business Partner – Joint Commissioning (Council & CCG); • CCG Interim Accountable Officer; • Senior Commissioning Managers (Council & CCG); The local vision for integrated care and support and associated plans have been developed and endorsed by a broad range of partners, including representatives from: provider organisations; primary care; VCSE (Voluntary, Community and Social Enterprise) sector organisations; Healthwatch BaNES; the HWB; the CCG and Council, including Public Health; and NHS England. Specific consultation and engagement has been undertaken with

	key health and social care providers. Also with relevant Cabinet Members and Council Officers.
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 BCF submission includes a Risk Log with mitigating actions.

THE REPORT

Better Care Fund Revised Guidance (25th July 2014) - Policy Changes in Summary

1.1 The substantive change in policy is that, of the £1.9bn additional NHS contribution to the BCF, £1bn will remain within the BCF but will now be either commissioned by the NHS on out-of-hospital services or be linked to a reduction in total emergency admissions. The intention of this policy change is to ensure that the risk of failure for the NHS in reducing emergency admissions is mitigated, and CCGs are effectively compensated for unplanned non elective activity.

1.2 The following bullet points summarise the changes to policy agreed by Ministers.

- The £1bn proportion of the BCF will replace what was originally the 'pay for performance' fund linked to the production of a plan and delivery against national and local metrics. No payment will now be linked to these metrics, although Health and Wellbeing Boards will be expected to continue to set levels of ambition for these within their plans. Further detail on requirements for these metrics is included in the technical guidance. Total emergency admissions replaces the original metric of avoidable emergency admissions.

- Health and Wellbeing Boards are invited to agree a target reduction in total emergency admissions. The funding corresponding to any reduction forms one element of the pay for performance fund. The outstanding balance will be spent by CCGs on 'NHS commissioned out-of-hospital services' as part of the BCF plan.

- For the proportion of the £1bn funds linked to a reduction in total emergency admissions, money will be released from the CCG into the pooled budget on a quarterly basis, depending on performance. These payments start in May 2015 based on Quarter 4 performance in 2013/14. The remaining proportion of the £1bn will be released to the CCG upfront in Quarter 1 in 2015/16.

- If the locally set target is achieved then all of the funding linked to performance will be released to the Health and Wellbeing Board to spend on BCF activities. If the target is not achieved, then the CCG will retain the money proportional to performance, to be spent by the CCG in consultation with the Health and Wellbeing Board.

- The expected minimum target reduction in total emergency admissions will be 3.5% for all Health and Wellbeing Board areas, unless an area can make a credible case as to why it should be lower. All areas can set more ambitious

targets should they wish, and the amount of funding linked to performance will increase accordingly.

- The local target and resulting funding linked to total emergency admissions will be based on the total figure for the whole Health and Wellbeing Board area, not just to the portion resulting from BCF schemes.

- All plans will be expected to clarify the level of protection of social care from the £1.9bn NHS additional contribution to the BCF, including that at least £135m has been identified for implementation of the Care Act

- Every Health and Wellbeing Board is asked to sign off and resubmit their Better Care Fund Plan by 19 September. Up to and after this date there will be a support and assurance process so that the Chief Executive of NHS England (as the accounting officer of the BCF) and Ministers can be confident that the plans are affordable and deliverable in 2015/16.

1.3 **Timetable**

Date	Process
25 July	Guidance and templates issued
28 July – 19 September	• Support to local areas to strengthen plans • Checkpoints for regional support and assurance on 8 August, 29 August, 12 September
19 September	• Revised BCF plans submitted to bettercarefund@dh.gsi.gov.uk and copied to Area Teams and local government regional peers by 12pm
22 September – 3 October	• Desktop review of plans
10 October	• Moderation exercise complete
17 October	• Final presentation and recommendations to Sir Bob Kerslake, Simon Stevens and Ministers

1.4 These key national policy changes along with the associated template documents (parts one and two), planning and technical guidance have resulted in the revisions to the better care plan (summarised in Appendix 1) and to the schemes to be funded from the Better Care Fund (summarised in Appendix 2). Detailed Scheme Descriptions will be Annexed to BaNES' submission (Template One) as required.

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Bath & North East Somerset

Better Care Plan 2014/15 – 2018/19

Summary Revisions September 2014

Contents

Chapter 1 Our Vision

Our vision is to provide care and support to the people of Bath & North East Somerset (B&NES), in their homes and in their communities, with services that support people to take control of their lives and reach their potential and are characterised by:

- Empowered individuals, carers and communities who are supported, confident and able to:
  - take increasing responsibility for their own health and wellbeing;
  - manage their long term conditions;
  - be part of designing health and social care services that work for the people that use them.

- Enhanced and integrated primary, community and mental health services, support and expertise working 24/7 with clusters of populations in order to respond to health and wellbeing needs close to home and ensure that hospital admissions are driven by the need for specialist and emergency treatments

- Innovative and widely integrated and utilised pathways of care understood for each long term condition and including self-management, transition, urgent and contingency planning elements as routine

- A focus on the most vulnerable, at risk, frail or excluded citizens as a matter of priority regardless of age

- Local people of all ages who have worked with clinicians and practitioners to design, inform and then have access to information that enables them to be confident in the quality and safety of services and, where they are not confident, to voice and raise concerns easily

- Integrated information and care record systems that facilitate the delivery of integrated health and care services

- Services that represent excellent value for money, measure by quality and effectiveness of outcomes as experienced by the people who use them.

This vision has been drawn from a variety of engagement processes including engagement with members of the public and key stakeholders on the Joint Health & Wellbeing Strategy for B&NES and the recent development of the CCG's 5 year Strategic plan.

These changes are aimed at supporting the increasing local demographic pressures in the B&NES population with our older population. By 2021 we will see a 27% increase in the number of patients aged 75-79 and a 38% increase in those aged over 90. The wider health and social care community needs to continue to develop a comprehensive range of responsive services to meet the needs of this growing population with a high level of need.

Our overarching aim is to further develop integrated, sustainable models of care that will deliver a greater proportion of care and support to people in their own homes and communities with services that:

- Co-ordinate around individuals, providing person centred care and support that is experienced as seamless by those individuals;
- Maximise independence and community inclusion through an increased focus on early intervention, prevention, self-care and peer support; and
- Empower people to remain in control of their own lives by extending self-directed support and ensuring access to information, advice and advocacy.

Our Joint Objectives are:

- Proactively identify people who are at most risk of loss of independence or hospital admission and put in place an integrated, Personalised Care Plan, including intensive community support.

- Integrated services that support and safeguard older and vulnerable people to remain independent though timely interventions that contain, stabilise, decrease and/or de-escalate emerging risks, care and support needs.

- Maximised use of health and social care resources through an integrated approach that responds in a sustainable way to the increasing volume, complexity and acuity of older people and those with long-term conditions.

- Further development and embedding of our integrated commissioning and provision to encompass not only mental health, physical health, social care, public health and housing but also further alignment of the resources, services and partners that influence the wider determinants of health and wellbeing.

- A Transformation Programme that responds to the wider strategic landscape of the Better Care Plan, Joint Health & Wellbeing Strategy, the Care Act, the Council and CCG's wider strategic priorities (especially reducing avoidable admissions and facilitating discharges and reliance on acute care), and the NHS *"A Call to Action".*

The Better Care Fund will support a number of initiatives that contribute to our joint programme of enhanced service provision and transformation. Services will be provided by a range of providers including voluntary and third sector partners. Over this period the provision of community health and social care services is due to be re-tendered and therefore the mix of provider provision may change.

The intended patient outcomes are illustrated through two service user stories set out below.

End State Objective: - *Enhanced and integrated primary, community and mental health services, support and expertise working 24/7 with clusters of populations in order to respond to health and wellbeing needs close to home and ensure that hospital admissions are driven by the need for specialist and emergency treatments*

Stephen was terminally ill and with the support of his GP agreed his preference was to die at home. Even when very ill, Stephen had remained independent, walking to the pharmacist to collect his medication and cleaning the car on Sundays. He wanted to remain at home to die with his family around him. However, he deteriorated more quickly than was expected and his family knew him to be in great pain. In the early hours they called 999 for him to be taken to hospital. A carefully documented care plan, appropriate support from community services and strong competent decision making between the paramedics and the GP supported Stephen and his family in these difficult circumstances enabling him to be cared for and to die at home as planned.

End State Objective: - A *focus on the most vulnerable, at risk, frail or excluded citizens as a matter of priority regardless of age*

Mrs. S developed a pressure ulcer on her sacrum. This was noticed when Mrs. S was admitted to hospital after a fall. During admission to hospital, Mrs. S was assessed by a specialist nurse who advised the ward nurses which equipment to use and which dressing to apply to her pressure ulcer. This made the healing process quicker and the ulcer was almost healed by the time Mrs. S went back to the care home.

As a result of a greater focus on meeting the needs of frail older people, local GPs and nurses will have the resources and time to work proactively with care homes to assess and treat patients who are frail, preventing the development of pressure ulcers and the exacerbation of other conditions. Admissions to hospitals from residential homes are prevented as a result of such changes.

Both these case studies illustrate that the further development of integrated support in the community and enhanced services for carers will help mitigate against avoidable admissions to the acute sector.

The Better Care Fund is a key enabler supporting the CCG's and Council's plans for whole system integration. It is ambitious and groundbreaking, reflecting and building on the established integration of commissioning and provision. Our plans encompass not only mental health, physical health, social care, public health and housing but also further alignment of the resources, services and partners that influence the wider determinants of health and wellbeing. We aim to look beyond service and organisational boundaries to ensure community connectivity, mutual learning and support.

To this end, we will maintain a focus on developing patterns of behaviour in our communities that promote active aging, positive reablement and strong, empowered citizens.

The BCF plan in B&NES: -

- Consolidates funding and allows for expansion of some existing initiatives
- Supports projects that have been funded on a temporary basis or are being piloted to test their impact
- Contributes to the protection of adults social care provision in B&NES
- Allows for the expansion of 7 day service provision in key priority areas
- Support Integrated Reablement & Hospital Discharge & Admission Avoidance
- Supports our aproach to Early Intervention & Prevention

We have already begun to make progress on our programme of change. During 2013/14 the CCG and Council have made two significant changes to local service provision. These include the development of Community Cluster Teams and a re-designed social care pathway: -

Community Cluster Team Model

This model delivers an integrated approach from virtual teams which are aligned with the five practice clusters in B&NES in order to respond in a sustainable way to the increasing volume, complexity and acuity of older people and those with long term conditions. The key objectives are to:

- Provide better coordinated services giving GPs and community staff more time to provide face to face care for those with greater need
- Increase focus on early intervention to prevent people's health and social circumstances deteriorating
- Utilize the risk stratification tool proactively to identify people who are at most risk of loss of independence or hospital admission
- Develop a sustainable model of care that responds to the growing pressure of more and sicker people being cared for in the community
- Prevent hospital admission and admission to long term institutional care as well as facilitating timely and safe discharges from acute and community hospitals
- Support patients with long term conditions to self-care and feel self-empowered in the management of their condition

Social Care Pathway Redesign

The overarching aim is to deliver an integrated service that will support and safeguard older and vulnerable people to remain independent through timely interventions that contain, stabilise, decrease and/or de-escalate emerging risks, care and support needs. This will involve a shift in focus and of resources to the 'front end' of the social care pathway to place greater emphasis on prevention and early intervention.

For those who appear to be in need of social care services, within the current eligibility framework, a short-term, intensive period of integrated reablement to reduce or delay the need for a long term package of care and support will be offered. This significant expansion of the reablement service is being funded from the Better Care Fund pooled budget, with early implementation, from July 2014, funded from Council reserves.

For those with the most complex needs the model will focus on in depth assessment, support planning and regular review to avoid the need for hospital/residential admission or escalation of need.

In facilitating these fundamental changes in the adult social care pathway, the key objectives are to:

- Enhance opportunities for co-producing solutions with potential service users and carers
- Be explicit about the intended outcomes of interventions, placing a stronger emphasis on the achievement of independence
- Prioritise the development of enabling approaches, in the broadest sense, as well as specific service interventions to support recovery

- Challenge the assumption that services will always continue at the same level for relatively long periods of time
- Promote a culture within adult social care that engenders independence and community inclusion
- Empower people to remain in control of their own lives by extending self-directed support and direct payments

There is a high degree of inter-operability between the community cluster model and social care pathway redesign, which includes increased Social Work capacity funded from the Better Care Fund ensuring input into integrated, personal care plans and multi-disciplinary planning.

Looking to the future we are aiming to further develop and frame our approach to whole system integration in the context of an emerging "House of Care" model for B&NES. This is based on the Kings Fund Report 'Delivering Better Services for people with Long-term conditions – Building the House of Care'.

This approach sets out four interdependent components, which, if delivered together, will achieve patient centered, co-ordinated care for people living with long-term conditions and their carers.

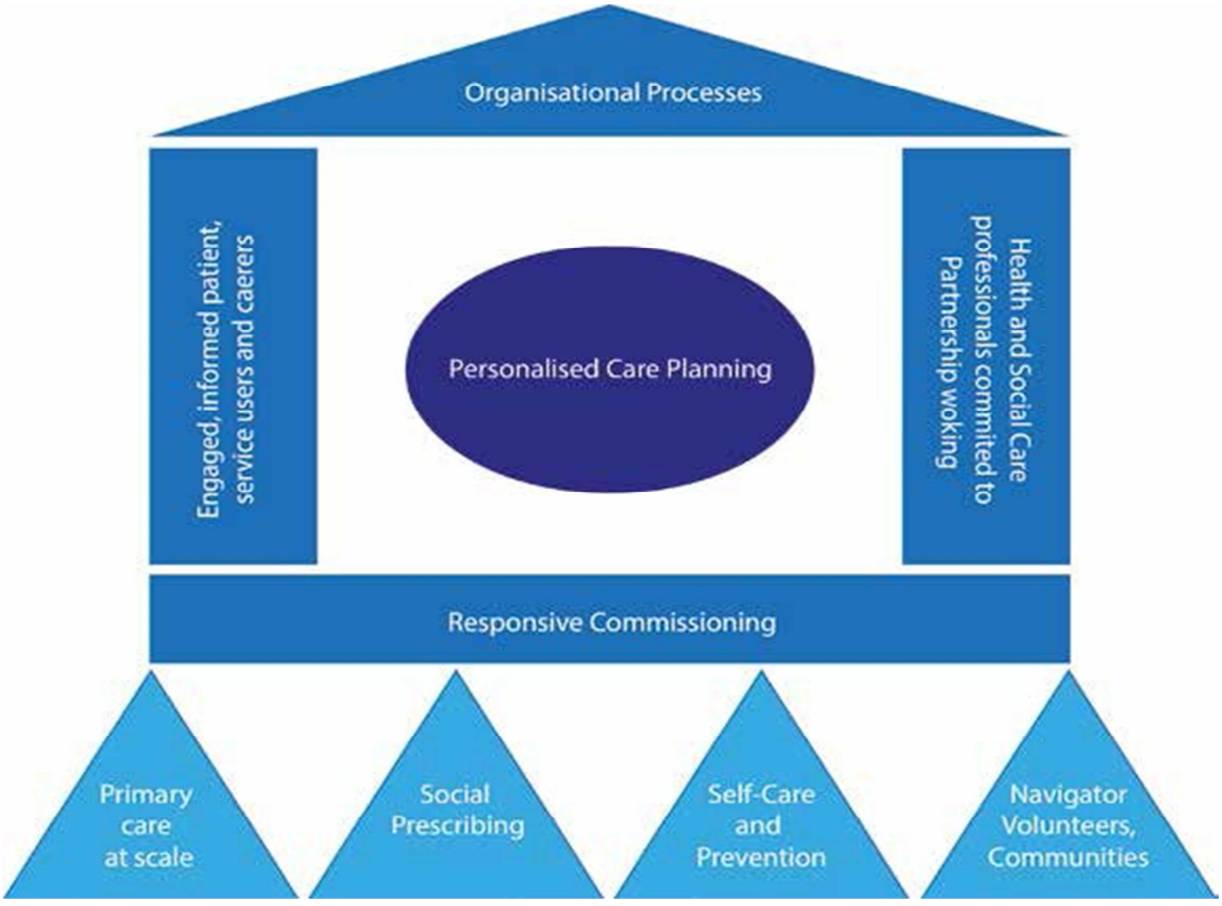


Figure 1: The House of Care Model in BaNES

Whilst this work is at its formative stages, we will utilise the Better Care Fund as a key enabler to develop and enhance integrated services. Linked to this approach is our vision for the development of integrated community services based around the

individual shown in the diagram below. Building on the Community Cluster model further services in BaNES will be grouped into five clusters that centre around GP practices with patients, service users and carers at the centre.

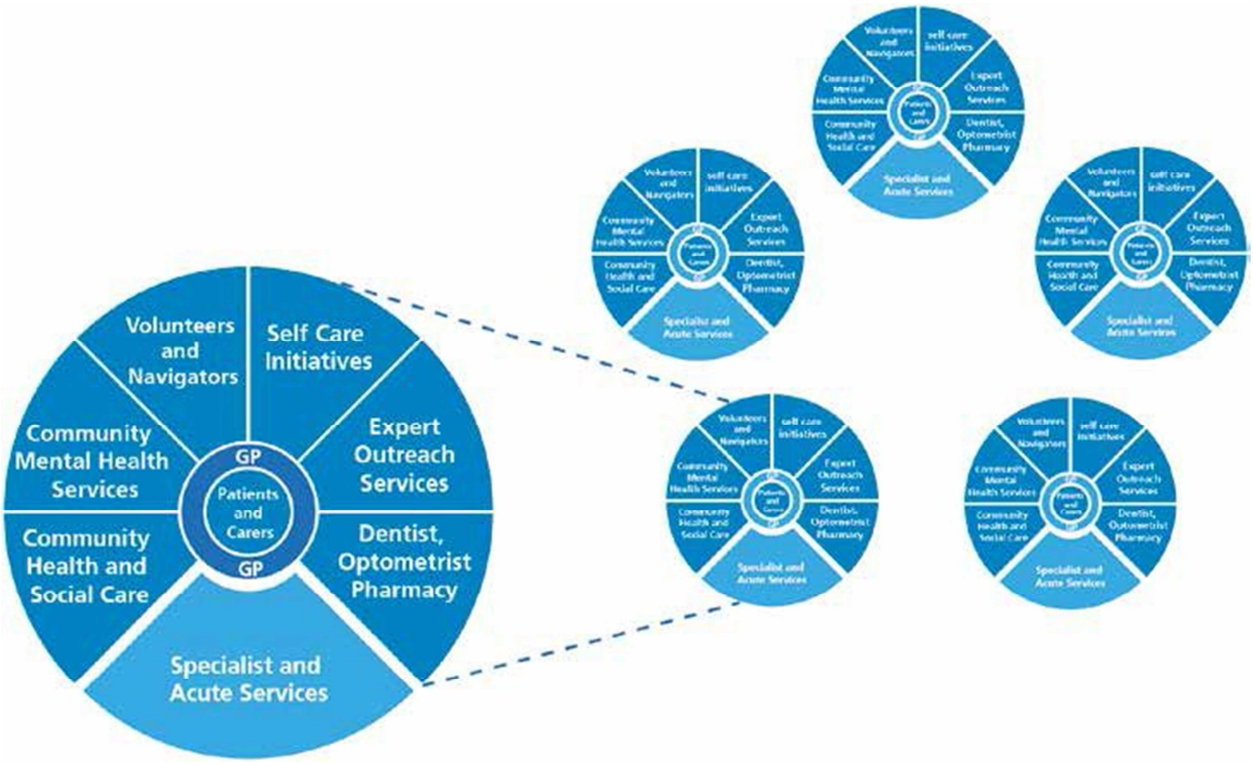


Figure 2: Building and integrating Services in Clusters

The BCF will support a number of components of our integrated system and safeguard key services including: -

- 7 Day working
- Protection of Social Care
- Increased capacity in Approved Mental Health Practitioner and DOLS
- Increased capacity in the Learning Disabilities Social Work Service
- Support for Integrated reablement
- Social care pathway redesign
- Expansion of Social prescribing
- Mental health reablement beds pilot
- Hospital discharge initiatives
    - Intensive home from hospital support
    - Step down accommodation
- Support for carers
- Disabled Facilities Grants

These schemes support our approach to bring care closer to home, Enhancing integrated primary, community and mental health services and empowering individuals, carers and communities to be supported, confident and able to take increasing responsibility for their own health and wellbeing.

Chapter 2 The Case for Change

The Council and CCG have established a range of integrated arrangements (teams, systems, processes and budgets) already and have evidence of their successful contribution to value for money and quality improvements in health and wellbeing services for the population of B&NES. The Better Care Fund is, for us, an opportunity to build on this to meet the challenges of an increasing population with increasing needs (frail elderly people, people with long term conditions, multi-morbidity, more acute and complex care needs falling on less carers) and to continue to address areas for improvement in the current system (ease of navigation, person-centred care).

Our focus, therefore, is on consolidating and expanding successful schemes, arrangements and relationships and implementing additional schemes to enhance care in key areas and for key target groups, ensuring that we retain the full alignment and coherence with wider CCG and Council plans which has in the past delivered significant benefits to both organisations and, more importantly to our population.

The case for change is grounded in analytical evidence of population trends; of those groups within our population who have most need of care; of the costs associated with rising demand for care at increasingly complex levels; and of the expected impact of planned interventions. Our sources of evidence include the Joint Strategic Needs Assessment (JSNA); public health analysis; cost and activity trend analysis and modelling; risk stratification; and performance monitoring of existing integrated schemes.

Chapter 3 Delivering Our Vision

Delivering our Vision – Our Plan for Change

Our plans for transformational change are designed to build on the high levels of integrated care and support already in place and well embedded. Since agreeing our Better Care Plan 2014/15-2018/19 in March 2014, we have already acted on our plans with the Council, for example, funding early implementation of the expanded, integrated reablement service and the redesigned adult social care pathway, which went live on the 1st July 2014. This early action will enable us to learn from this first year of operation, evaluate and make the best possible case for our model of integrated, personalised care.

The BCF Plan has interdependencies with the CCG's 5 Year Strategy and the re-design and re-commissioning of community health and social care services.

The CCG's 5 Year strategy has six priority work programmes: -

- Increasing the focus on prevention, self-care and personal responsibility.
- Improving the coordination of holistic, multi-disciplinary Long Term Condition management (focusing initially on Diabetes).
- Creating a stable and sustainable Urgent Care System that can respond to changes in demand.
- Commissioning safe, compassionate and integrated care for frail older people.
- Re-designing musculo-skeletal services to improve their efficiency.
- Ensuring the interoperability of IT systems across the health and care system

The table over the page sets out the key **milestones** for the BCF and related projects, highlighting key interdependencies.

Better Care Fund Key Milestones

Task	Inter-dependencies	Year 1 2013/14				Year 2 2014/15				Year 3 2015/16				Year 4 2016/17			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Community Cluster Team Model Goes Live					Feb-14												
Roll out of personal care planning & risk stratification						Apr-14											
Care Pathway & Expansion of Integrated Reablement Service							Jul-14										
Wellbeing College Pilot launched								Oct-14									
Start re-commission of social prescribing							Aug-14										
Extended Social Care Prescribing Service in Place									Jan-15								
Approved Mental Health Practitioner/DOLS Assessment Capacity in place				Sep-14													
LD Social Work Capacity in place				Sep-14													
Mental Health Pre-crisis/Respite Beds goes live				Dec-14													
Utilisation of £5 per head monies in Primary Care	X							Nov-14									
TLB Mobilised to oversee CCG Strategic Priorities	X							Dec-14									
Care Act Implementation										Apr-15							
Complete Option Appraisal of Inter-operability										Jun-15							
Re-procurement of Social Care IT System				Oct-14													
New IT System in Place													Feb-16				
Community Services Re-procurement	X										Jul-15						
Health and Well-being Board Review of BCF										Jun-15				Jun-16			
Adapt Community Cluster & Reablement models										Apr-15							

Governance

Integrated health and social care structures have been in place in BaNES since 2009, with commissioning arrangements implemented in that year and provider arrangements consolidated by the creation of an integrated health and social care provider in 2011. The commissioning arrangements were reviewed and redesigned in 2013 in response to the creation of the CCG and the reaffirmation of the commitment by both CCG and Council to joint working and to the integrated commissioning and provision of services.

Integrated arrangements are overseen by the Health and Wellbeing Board (HWB), which was developed from a previously existing Health and Wellbeing Partnership Board which oversaw joint working arrangements between the Council and the PCT. This has created an embedded recognition of the contribution of joint working in delivering optimal outcomes at best value, within the wider remit of the HWB. The HWB has also created a sub-group (the

Strategic Advisory Group) of large providers, whose remit includes collaboration on whole system solutions for care and support.

The operation of joint working arrangements, including the operation of pooled funds and the exercise of functions by either body on behalf of the partner body, is overseen by a Joint Committee for the Oversight of Joint Working. This is constituted as a joint committee of the CCG and Council with membership at elected member/Board member level and reports to the HWB, Council and CCG.

The governance and operational structures are underpinned by a Joint Working Framework, adopted by both the CCG and the Council, which sets out the commitment, aims and practical supporting arrangements for joint working, and is underpinned by legal agreements as follows:

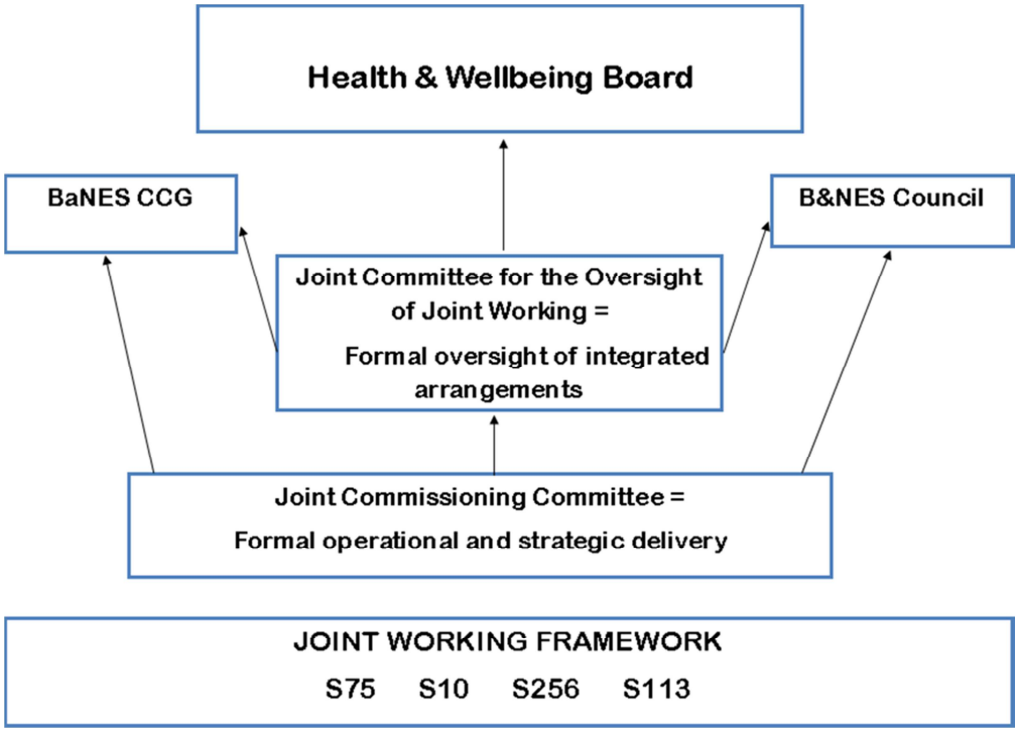
- S113 agreements allowing managers with joint responsibility employed by either body to perform functions for and be accountable to the other body within an agreed HR framework and within the Schemes of Delegation of each organisation

- S75 and s10 pooled budget agreements to allow pooling of resources managed by joint commissioners to support integrated commissioning and provision

- S256 agreements (both nationally required and local) to support expenditure on social care which has a benefit for health services

A further arrangement agreed by the CCG and the Council and due to be implemented from October 2014 is the creation of a Joint Commissioning Committee, replacing the previous structure of two separate and one joint committee. The CCG's Constitution and the People and Communities governance structure have been amended to allow this. The new Committee will have a formal governance and operational leadership role across health, social care and public health commissioning in respect of strategic planning, performance management and decision-making. The Committee is a formal Committee of the CCG Governing Body and is accountable to Cabinet Members within the Council, and has a reporting line to the Joint Committee for the Oversight of Joint Working.

The diagram below whos the governance structure in full.



Management and Oversight of Delivery

Within its 5 Year Strategic Plan, and with the support of partner organisations, the CCG has established a full programme management structure which will oversee and support delivery of the priority workstreams identified in the Strategic Plan. A clear rationale was identified for including the Better Care Fund as one of the priority workstreams alongside the CCG's six transformational change areas. This took into account efficiency of structure and process; equity of importance and contribution to delivery of the Plan; and level of interdependency between the Better Care Fund and other workstreams.

The CCG has established a project management structure for each workstream with accountability for delivery to a project board. These structures vary dependent on the nature of the individual project and the opportunities for efficient use of existing arrangements. For the Better Care Fund, the Joint Commissioning Committee which becomes operational in October 2014 will act as the project board. Given the operational leadership role across health, social care and public health commissioning in respect of strategic planning, performance management and decision-making which this Committee holds, it is well placed to oversee delivery of the Better Care Plan and to direct any remedial actions required should the plans go off track.

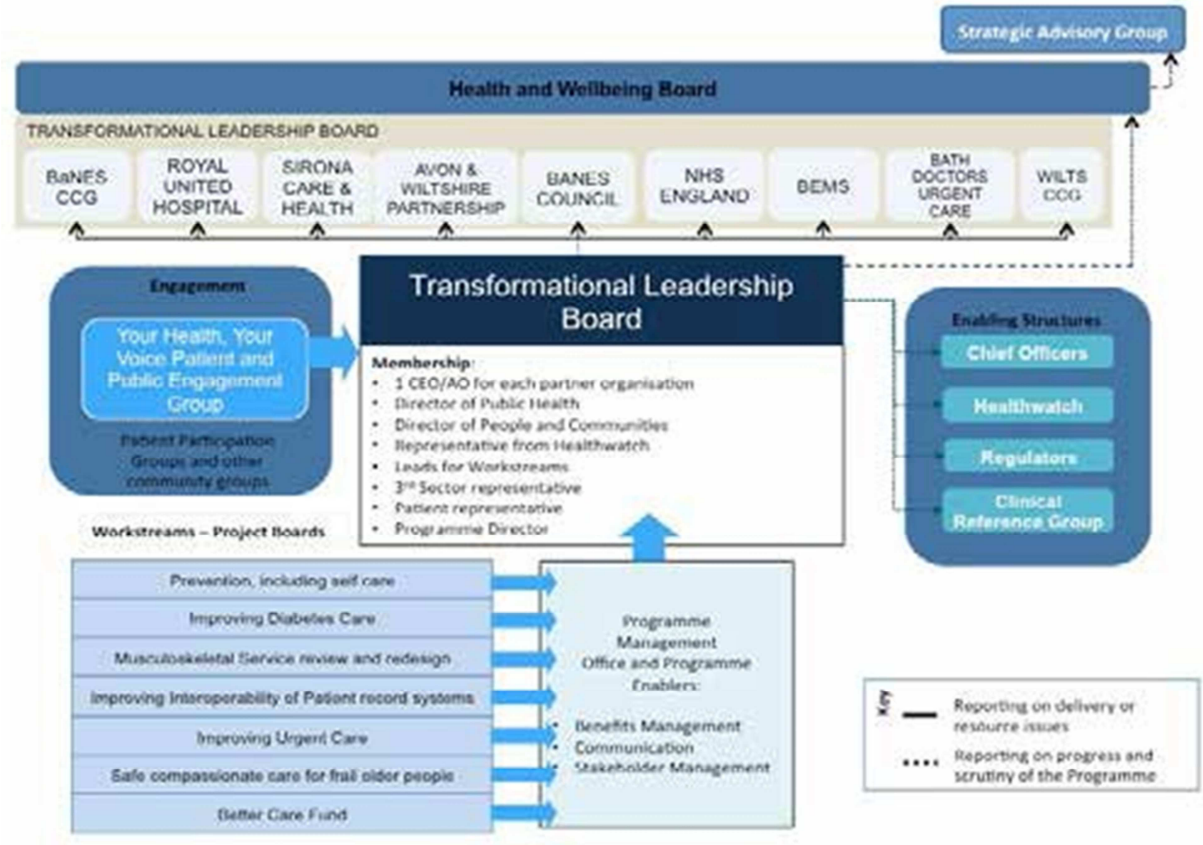
Each project within the overall Better Care Fund workstream has a named senior commissioner as lead, with overall project leadership and the Senior Responsible Officer role provided by the Deputy Director Adult Care and Health Strategy and Commissioning, a joint postholder who is a member of the Joint Commissioning Committee.

The programme is overseen by a Transformational Leadership Board (TLB), to which each of the project boards is accountable for delivery. The TLB will comprise a multidisciplinary group of Directors and Clinical Leaders from the constituent organisations of the health and social care community. The TLB is accountable to the participating organisations' governing bodies and will also report to the Health and Wellbeing Board.

Delivery of the programme will be supported by a Programme Management Office (PMO) led by a programme director. The PMO will ensure that progress and benefits of the work streams are tracked and variances, risks, dependencies and issues are identified and addressed.

An integrated performance and delivery monitoring dashboard for the Better Care Plan is in development .

The diagram below sets out the overall programme structure, showing how the Better Care Fund workstream sits within it.



Chapter 4 Engagement

Our vision and plan for whole system integration has drawn from a variety of engagement process, including patients, service-users and the public, representative groups and partner organisations, including: The Care Forum, host of Healthwatch B&NES; the Royal United Hospital (RUH) Bath; Dorothy House Hospice; Sirona Care & Health CIC; Curo Housing Group; Age UK B&NES; Avon & Wiltshire Mental Health Partnership NHS Trust (AWP); B&NES Council and BaNES Clinical Commissioning Group.

Patient, Service User and Public Engagement

Our vision for whole system integrated care is based on what people have told us is most important to them.

The Joint Health and Wellbeing Strategy, which was agreed in September 2013, was informed and shaped by a formal consultation period, which launched on 30 April and ran until 7 June 2013. Consultation responses were received from a range of stakeholders including health and social care providers and VCSE (Voluntary, Community and Social Enterprise) sector organisations, members of the public and service users. Our Better Care Plan wholly reflects the aims and intentions of the Health and Wellbeing Strategy.

Key schemes described in this submission and supporting documentation, including the Community Cluster Team Model, Wellbeing College, Social Prescribing Initiative and integrated intensive Reablement Service were informed, developed and, in some instances, co-designed through embedded models of service user, carer and patient feedback, including networks and groups supported by the Care Forum, partnered with HealthWatch, and the Carers Centre as well as specific events, for example the What Works Mental Health Conference, which took place in October 2013.

Specific patient, service user and public engagement on our Better Care Fund plan has been aligned with consultation on the CCG's Operational and Strategic Plan, in the context of our long-established Joint Working Agreement and integrated commissioning and provision. Engagement events held with representatives of the public, the Health & Wellbeing Board (HWB) and other key stakeholders including Healthwatch were held between October 2013 and March 2013 to share and test our understanding of the case for change and gather support from across the health and care community. A Health & Wellbeing Board Network event in May 2014 created an opportunity to focus in more detail on two of the priority areas identified – Prevention and Self Care; and Care for Frail Older People.

On-going engagement with patients, service users and the public will be through the Health & Wellbeing Board Network, the embedded models of feedback described earlier in this section, the newly established, Patient and Public Involvement Group. "Your Health, Your Voice".

Health and Care Provider Engagement

Specific provider engagement on our Better Care Fund plan has been aligned with consultation on the CCG's Operational and Strategic Plan, in the context of our long-established Joint Working Agreement and integrated commissioning and provision. Engagement events held with providers, including the RUH, AWP, BaNES Emergency Medical Services (BEMS) and Bath Doctors Urgent Care (BDUC), Sirona Care & Health, and other key stakeholders were held between October 2013 and March 2013 to share and test our understanding of the case for change and gather support from across the health and care community.

Engagement on the BCF with BaNES System Resilience Group (SRG), which includes senior representation from the RUH, AWP and Sirona in August 2014 helped inform its further development and, also, to ensure alignment with both individual organisational plans and, also, BaNES' system-wide operational resilience and capacity planning for 2014/15 and future years.

Chapter 5 Risk & Contingency

The total value of funding designated by the revised BCF guidance as either ringfenced or performance related is £3.2m, with £0.938m designated as a performance related payment linked with a successful target reduction in emergency admissions. The guidance requires this funding to be withheld by the CCG if target reductions are not met, and to be spent as determined by the CCG in consultation with the HWB. The implication is that the first call on such funds may be to fund the costs of emergency admissions above target levels.

The Better Care plan is required to identify which elements will be 'at risk' if performance related payments are not secured, with the agreed approach endorsed by the HWB. It is proposed that the performance related payments are linked with the NHS commissioned element of the social care pathway re-design, which offers health and social care benefits through an integrated approach to reablement.

The approach to risk management is informed by the Council's and CCG's commitment to supporting effective integrated working, in that both parties would wish to continue funding this initiative, providing it is proving successful, even if the specific target relating to reduced emergency admissions is not being achieved. The proposal is therefore that the risk of any funding shortfall is borne equally; that is, 50% each by Council and CCG.

This will be mitigated by an agreement with the provider of the social care pathway to review the success of the model as a whole and to adjust financial contributions if delivery of the range of desired outcomes were not demonstrated.

Contingency funding for the management of financial risk, including the specific risk associated with non-achievement of the target reduction in emergency admissions, is included in both CCG and Council financial plans, based on assumptions consistent with those in the Better Care Plan.

Appendix 2: Summary of schemes to be funded from the Better Care Fund

Scheme Category	BCF Schemes	2014/15 £000	2015/16 £000	Commentary
7 Day Working	7 day working	350	350	Service developments including adjustments to the Sirona contract
7 Day Working	Hospital discharge	327	342	Handyperson, Step Down & Intensive home from hospital
7 Day Working	Integrated re-ablement and hospital discharge	209	209	7 day working - Hospital SW & Core re-ablement
Care Act & Data Sharing	Care Bill Implementation	654	481	Funding 14/15 implementation pressures and new burdens in 15/16.
NHS Commissioned out-of-hospital services	Integrated Care & Support		2,008	Funding the health element of existing Section 75 pooled budget arrangements
Intermediate Care / Re-ablement	Admission avoidance	208	208	Targeted rural domiciliary care service aimed at admission avoidance
Intermediate Care / Re-ablement	Integrated re-ablement	500	500	Sirona - Re-ablement & Rehab
Intermediate Care / Re-ablement	Prevention and early intervention	100	100	OP Independent Living Service
Intermediate Care / Re-ablement – (Joint Commissioned Health & Social Care)	Social Care Pathway Redesign	1,425	2,000	Pathway re-design reducing and / or delaying the need for more complex health and social care interventions
Intermediate Care / Re-ablement	Social Prescribing	100	100	Social Prescribing to enable clinicians and health workers redirect suitable patients away from the NHS and towards opportunities in their local community
Protection of Social Care	Protection for adult social care services	1,613	1,575	Sirona demographics, safeguarding & employment inclusion
Mental Health	Increased capacity in the Approved Mental Health Practitioner Service & DOLS	150	150	Strengthening Councils duty to fulfil its requirements for Deprivation of Liberty Safeguards
Learning Disabilities	Increased capacity in the Learning Disabilities Social Work Service	168	168	Building capacity to carry out reviews and safeguarding
Mental Health	Mental Health Re-ablement Beds	100	100	Providing a 3-bedded Adult of working age pre-crisis/respite facility
Protection of Social Care	Adult Social Care demographic change & Preventative Services		2,566	Funding demographic pressures to protect the level of Social Care services provided whilst ensuring successful client outcomes will be achieved
Disabled Facilities Grant	Disabled Facilities Grant		552	Essential adaptations to give disabled people better access to essential facilities within the home
Social care capital	Social care capital		406	Capital funding to contribute towards social care community projects
Support for Carers	Support for Carers		234	Support those with caring responsibilities to identify themselves as carers at an early stage
Community Cluster Model	Community Cluster Model			BaNES CCG funded in 2013/14
Total		**5,904**	**12,049**	

Key Changes:

Presentational – Addition of scheme category descriptions to align with overarching schemes and national conditions

Financial – Provision made for Care Act revenue pressures in 2015/16 from additional assessments, carers costs and implementation requirements.

Reduction to Adult Social Care demographic change & preventative services to fund Care Act pressures.

Adjusted amount for 2014/15 Social Care Pathway re-design in line with current commitments.