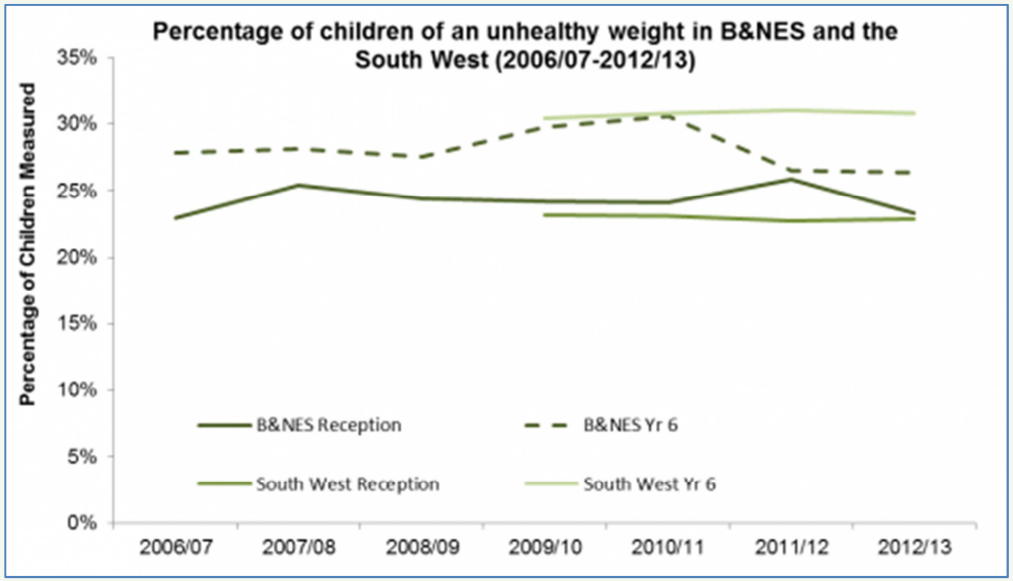
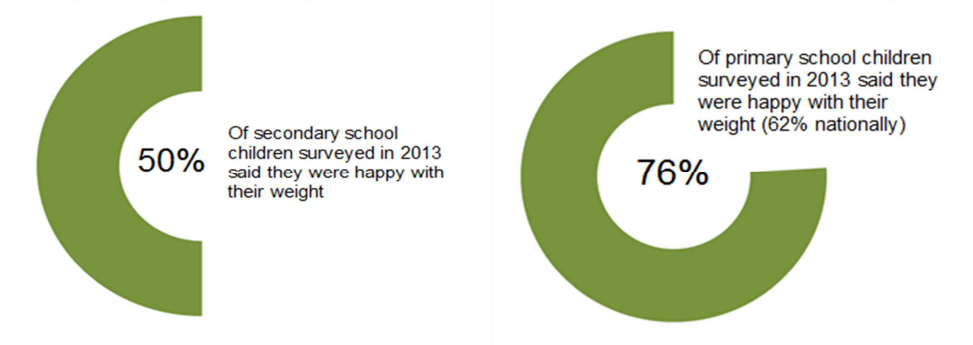
Appendix One – Joint Health and Wellbeing Strategy performance report (November 2014)

JHWS Priority	**Helping children to be a healthy weight**
Outcome	**All children are a healthy weight**
Officer lead	**Jameelah Ingram, Public Health Development and Commissioning Manager**
HWB member lead	**Cllr Dine Romero, Cabinet Member for Early Years, Children and Youth, B&NES Council**

Outcome & Indicator	**Baseline and story behind it**	**Partners**	**What works to do better locally?**
Outcome: All children are a healthy weight **Indicator:** National Child Measurement Programme (Overweight and Obesity prevalence of reception/yr. 6) Infant feeding: Breastfeeding prevalence initiation and continuation at 6-8 weeks **Local:** Overweight and obesity prevalence of pregnant women at 1st antenatal booking School Health Survey **Population:** Pregnant women, Children and young people aged under 18		Local residents Sirona – Health Visiting, School Nursing, SHINE Weight management, Cook it!, HENRY Bath University Play Services Children's Centres, private nursery and play group settings Maternity Services Schools Director of Public Health Award Parks and open spaces Sports Clubs Sports and Active Lifestyles Dieticians GPs Paediatricians Oral Health – Dentists Curo	Controlling exposure to and demand for consumption of excessive quantities of high calorific foods and drinks. Increasing opportunities for and uptake of walking, cycling, play and other PA in our daily lives, reducing sedentary behaviour. Establishing lifelong habits and skills for positive behaviour change through maternal health and early life interventions. Staffs are competent, confident and effective in delivering brief interventions and are able to signpost and refer to commissioned service with

Data issues/gaps: • Have mechanism to monitor BMI of pregnant women at 10 week booking at RUH but need to obtain data from Bristol trusts also to get B&NES resident population • Only record obesity prevalence in reception and Yr. 6 • Only measure children in B&NES schools – do not include children who study out of area • Updated NCMP maps – detailing ward areas with highest rates and with schools mapped for targeting inequalities work. • Poor physical activity data for children and young people – no national indicator • Missing – Play and active travel indicators, measuring utilisation outdoor space and facilities. • Mapping of all service provision in the area needs to be undertaken to identify gaps and areas of duplication • Linking NCMP with pupil attainment and free school meals data. • Neighbourhood profiles	**Story behind the baseline: (examples of contributory factors)** As shown in figure 1 the percentage of unhealthy children in reception year in B&NES between 2006/07 and 2012/13 has been higher than in the South West as a whole. In contrast the percentage of unhealthy children in year 6 in B&NES between 2006/07 and 2012/13 has been lower than in the South West as a whole. Further profiling data is taken from analysis conducted on the 11/12 data **14** • Children from Black ethnicities in year 6 were significantly more likely to have an unhealthy weight and children from Other White ethnicities were significantly less likely to have an unhealthy weight than the B&NES average. • There is significant variation in rates of unhealthy weight between schools, with rates ranging from 4%-50% in reception and 12%-49% in year 6. • Rates of obesity in different schools vary from 0%-31% in reception and 5%-32% in year 6. • There is considerable geographical variation by ward of residence of children in levels of obesity and unhealthy weight for reception and year 6 children. • Keynsham (particularly Keynsham South) and Midsomer Norton/Radstock areas consistently have higher levels of unhealthy weight and obesity than other areas in B&NES. • More deprived areas in B&NES have higher rates of obesity and unhealthy weight than less deprived areas, for year 6 this difference is significant for both obesity and unhealthy weight. • Children and young people with disabilities are more likely to be obese than children without disabilities and this risk increases with age (analysis of HSE 2006-2010 for children aged 2-15 with a LLTI) • Maternal obesity is a major risk factor for childhood obesity, which persists into adulthood independent of other factors. • Research shows that 3 year olds are now experiencing tooth decay – with sugary drinks being a key factor. **Infant Feeding** • 84% of babies in B&NES are breastfed at birth, higher than regionally (78%) and nationally (74%). At the 6-8 week check this rate has dropped to 65% as of Q2 2013/14, although this is still higher than regional (49%) and national (47%) rates. These rates have been relatively flat over the past few years, but seem to be rising locally.	Youth Connect Foodbanks	confidence. A holistic integrated weight management pathway which Include clear outcomes for lifestyle interventions in all relevant commissioning and procurement processes. Harnessing the contribution of existing community resources within local healthy weight pathway. Maximising on the contribution of local partnership organisations. (e.g. sports clubs, play groups etc.) Building local intelligence: of resources Auditing and evaluating existing provision to identify gaps, avoid duplication and determine contribution to outcomes. Developing the necessary mechanisms to ensure effective local signposting is in place for commissioned services.

showing trends dietary behaviour, activity levels and unhealthy weight prevalence in maternal and child health • Measuring longer term outcomes (6/12 months for commissioned services). • Service user feedback on commissioned services.	• Within B&NES there is considerable variation in rates of breastfeeding between different areas, with 9 wards having 6-8 week rates of less than 50%, the lowest being 29%. It is difficult to distinguish the influence of geographical deprivation from age of mother from the data in B&NES as some of the most deprived areas, with the lowest rates of breastfeeding, also have the highest numbers of teenage mothers. • In 2012/13, 41.2% of people in B&NES use outdoor space to exercise for health/reasons, the highest regionally and significantly higher than the national average (1.3%) **Physical Activity** • Bath and North East Somerset is significantly lower than the national average regarding the percentage of children participating in at least 3 hours per week of high quality PE and sport at school (age 5-18 years) **4** **LISTENING TO THE PUBLIC AND SERVICE USERS** In 2013 the Child Health-Related Behaviour Survey in B&NES in 2013 results on healthy eating and activity were similar or better than the national average.  • Primary school - 83% of primary school children reported enjoying physical activity at school and in leisure time. They also reported that they are adopting healthy eating behaviours; 98% have breakfast and 32% reported eating 5 or more portions of fruit or vegetables. Approx. 1 in 5 said they would like to lose weight. Almost half of primary school children (47%) travel to school by car. • Secondary school - 1 in 10 children are skipping meals, with 11% reporting that they did not have lunch on the day before the survey. Fewer secondary school children (21%) are eating their recommended portions of 5 a day. However more secondary children are walking to school (54%) and 75% of		

	respondents are enjoying physical activity 'quite a lot or a lot. 68% (59%) of Year 10 pupils said they worried about at least one of the issues listed 'quite a lot' or 'a lot' • A focus group of young mums with preschool aged children highlighted issues around availability of good facilities and activities (including for under 3's and for parents) and crèche facilities whilst exercising • A youth focus group highlighted the need for indoor and outdoor spaces to socialise within their age group • A group of disabled people commented that transport is one of the main barriers to participating in activities as well as access issues • A survey by the University of Bath (2012) highlighted that parents have a significant effect on young people's physical activity levels with barriers including: fears of parenting skills being judged, not knowing other parents or workers, cost of services, lack of awareness of services and reacting badly to being told that their child is overweight		

Outcome Framework: All pregnant women, children and young people are a healthy weight

Current good practice in B&NES	Gaps/Needs Identified
A holistic integrated weight management pathway for the whole population which includes prevention, an ethos of taking personal responsibility for the both the health and wellbeing of the family and individuals with the offer of specialist support when needed	
Maternal Health • Health in pregnancy support service **Early Years 0-5** • Healthy Start • HENRY • Cook IT – to include food growing • Director of Public Health Award • Health Visiting: Healthy Child Programme • HENRY and HENRY Parenting • Breastfeeding & infant feeding • Peer Support for Under 26s • Nutritional Guidance in early years settings • Play inclusion Worker **5-19 Years** • SHINE weight management for 10-17 year olds	**Maternal Health** • To introduce integrated commissioning of maternal and child health to ensure a holistic approach to positive parenting, early messaging of importance of healthy lifestyles for the whole family both antenataly and postnataly. • Ensure universal early year's services such as Health Visiting/Children Centres staff are competent in raising and addressing the issue of weight and promoting breastfeeding. **Early Years 0-5** • Greater promotion of Start4IIfe social marketing campaign for • Increase the number of HENRY programmes • Incorporate healthy lifestyle messaging into all commissioned parenting programmes. **5-19 Years** • Family based weight management service for 7-10 year olds which is parental lead • More parental support and advice needed in SHINE programmes

• Healthy Child Programme • Cook it! – to include food growing and cooking skills programme (up to 17 years) • Director of Public Health Award • School nursing • National Child Measurement Programme (Proactive telephone follow up for reception • Dietetics/Paediatric support	• More work with schools in referring into weight management and having the confidence to raise the issue of weight. • Closer links with schools in supporting or referring to weight management services. • The majority of secondary schools do not provide meals that are compliant with nutritional guidelines. There is a need to improve the nutritional quality and offer of food in secondary schools. • Increase public awareness Raising the issue with parents of reception aged children • Assess the whole Early Years/school/College environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight and be physically active. • Improving the nutritional quality of food supplied in schools. • Improve link with oral health services **Across birth and childhood years** • Develop community development approach to delivering interventions which include an intergenerational approach to healthy weight – where the influence on a child's weight is from its wider community not just their main carer • A greater focus on reducing diet-related inequality is needed by focusing services on low-income residents/families with priority given to children from Black and Minority Ethnic Backgrounds, Children with a physical or learning difficulty • Continue to provide effective services for those at risk of unhealthy weights, ensuring that commissioned interventions include psychosocial aspects of being overweight. • Create opportunities for integrated commissioning of family based services. • Enable staff to have increased confidence in raising the issue of weight and the competencies to deliver/refer to weight management interventions where appropriate.
Controlling exposure to and demand for consumption of excessive quantities of high calorific foods and drinks	

• Eat out Eat Well
• 5 A Day
• Change 4 Life
• School Food Plan
	• Help families and children make healthier lifestyle choices for diet, prioritising:
	  ○ Families in low socioeconomic groups
	  ○ Children with disabilities and/or who have parents with a disability
	  ○ BME children
	  ○ NEETS
	• Link in with national Change4Life programme to deliver key messaging on the dangers of sugary and caffeinated drinks and portion sizes/over snacking locally.
	• Work with street trading team to reduce the number of outlets which offer unhealthy snack and drink in areas close to educational settings and family

	leisure facilities. • Reduce the number of new fast food outlets near educational settings. • Increase the availability of affordable fruit and vegetables in neighbourhoods of high need.
Increasing opportunities for and uptake of walking, cycling, play and other PA in our daily lives, reducing sedentary behaviour	

• **Maternal Health**
***Currently no specific commissioned services available antenataly**
• Moving on Up – Postnatal exercise group (Sirona)
• Healthy Lifestyle Service
 	
Early Years 0-5 years
• HENRY 2 day core training for Health visitors and children's centre staff
• Play inclusion workers and community play teams
• Triactivate - cycling for pre-schoolers
• Director of Public Health Award (nurseries, child-minders and children's centres)
• Cycle training for pre-schoolers
 	
5-19 years
• Bike it!
• Dance research
• Wheels for All
• Everyday Activity in schools
• Triactivate
• Director of Public Health Award (schools and colleges)
	• Investment into leisure facilities to modernise them and make them more attractive to young people and families.
	• Work across sectors to increase everyday activity and opportunities for play in children, young people and families. Prioritise:
	  ○ Develop a physical activity offer for pregnant women
	  ○ Families in low socioeconomic groups
	  ○ Children with disabilities and/or who have parents with a disability and
	  ○ BME children
	  ○ Girls aged 12 upwards
	  ○ NEETS
	• Assess the whole Early Years/school/College environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight and be physically active.
	• Work with Leisure and Tourism, parks and allotments and open spaces to create opportunities for spontaneous play and maximising opportunities for physical activity.
	• Ensure development of the transport plan includes opportunities for families to travel sustainably and contributing to climate change and traffic calming agenda
	• Strengthen partnership with Planning Department to influence the need for families to be physically active as a routine part of their daily life on new planning applications.
	• Invest in training for planners (urban, rural and transport), architects and designers on the health implications of local plans.
	• Increase the opportunities for active travel for families – considering key transition points – such as starting preschool/school/college/university.
	• Introduce walking buses to and from educational settings
	• Playing out schemes which residential roads are closed to cars from 3pm to 5:30pm to enable children to play safely close to their home
	• Introduce new scheme which increase the number of opportunities for families to walk to school. For example, introducing car free zones within ½ mile radius of local preschool and primary schools.
	• Mapping of free/ discounted exercise opportunities for young people.
	• Explore opportunities for co-locating health, leisure and NHS services to offer a holistic approach to supporting families.

	• Remove the cost of venue hire for commissioned services operating in public sector venues to enable more families to access services.
Increasing responsibilities of organisations for the health and wellbeing of their employees working in children's services.	
• Workplace Wellbeing Charter • Incentives • Eat Out Eat Well • NHS Health Checks • Healthy Lifestyles Service offer as part of Healthy Workplaces Award (includes slimming on referral) • Passport2health • Exercise on referral • Lifestyles advisors • Active travel incentives: workshops, cycle training	• Upskill local public sector workforce so that they are healthier in themselves, reducing sickness absence and improving productivity.

Key Priorities 14/15

- Refresh of Healthy Weight Strategy
- Development of Partnerships and implementation plans for interrelated strategies, Play, Food, Fit for Life
- Maximise on opportunities to promote Change4Life campaigns with partnership organisations focussing on highlighting the dangers of sugar and raising awareness of portion size.
- Integrated commissioning for children's services (health visiting and school nursing), incorporating maternal health
- School food plan - Improving the nutritional quality of food provided in secondary schools.
- Improve access to a healthy and affordable diet prioritising families in low income groups. (Food Strategy)
- Seek opportunities for the development of food skills (i.e.) cooking and growing to be incorporated into numerous service delivery programmes.
- Enhance the uptake, use and awareness of food-welfare schemes by eligible families
- Leisure facilities procurement – ensuring a targeted and family based offer for increasing physical activity and weight management.
- Delivery of Healthy Child Programme – 0-19s, through health visiting and school nursing
- Development and implementation of the Fit for Life Strategy and Food Strategy
- Roll out making every contact counts for professionals working in children's services
- Improve the data quality of local indicators to measure outcomes
- Prioritise physical activity opportunities for pregnant women, girls aged 11-19 and activities for families which preschool aged children.
- Develop an agreement with NHS and Local Authority to offer free venues for public sector commissioned lifestyle activities.
- Ensure all organisations represented at Health and Wellbeing Board delivers Making Every Contact to frontline staff.

Progress Report - October 2014

NCMP Performance against outcome measures:
Please note that the following figures are provisional and produced by our local analytical team. We are awaiting the national report which is due out in December 2014.

- Participation levels remain higher than the national average. Both reception and Year 6 participation rates are slightly lower than the previous year. For Year 6

coverage rates, the School Nursing Team are reporting that the increase in Pupil Opt-Outs is because the young people want to be measured but do not give their consent to the data being published as part of the surveillance programme.

Reception

	Number of children measured	Number of children eligible for NCMP	Children measured as % of those eligible for NCMP	Parent Opt-Out	Pupil Opt-Out
2012-13	1739	1757	98.88%	10	1
2013-14	1776	1800	98.67%	13	1

Year 6

	Number of children measured	Number of children eligible for NCMP	Children measured as % of those eligible for NCMP	Parent Opt-Out	Pupil Opt-Out
2012-13	1608	1654	97.22%	24	8
2013-14	1557	1616	96.35%	32	24

Reception Year

- Very overweight (obese) **increased** from 8.5% in 2012/13 to 8.9% in 2013/14.
- Overweight from **fell** from 14.7% in 2012/13 to 14.2% in 2013/14.
- Results in a **very small difference** in unhealthy weight (overweight and obesity) – from 23.2% in 2012/13 to 23.1% in 2013/14.
- Underweight remains unchanged at 0.3%.

Year 6

- Very overweight (obese) **increased** from 14.7% in 2012/13 to 15.8% in 2013/14.
- Overweight from **increased** from 11.7% in 2012/13 to 13.4% in 2013/14.
- Results in an **increase** in unhealthy weight (overweight and obesity) – from 26.4% in 2012/13 to 29.2% in 2013/14.
- Underweight has increased very slightly from 1.1% to 1.2%.

Conclusion: Year 6 pupils are 'heavier' than last year and the year before, thus reversing the recent falling trend.

Performance against action plans

- The current Shaping Up! Strategy is due to expire in December 2014. Priority has been given to strategic leadership and development of this theme. There is now a Healthy Weight Strategy Group, which is leading on the refresh of the existing Shaping Up strategy. This group is partner between Health, Local Authority and the voluntary sector, it has an adopted set of Terms of Reference and has now met twice and will continue to meet quarterly.

- The first draft of the refreshed Shaping Up strategy is currently being consulted on with Healthy Weight Strategy Group members. It is anticipated that the final draft will be presented at Health and Wellbeing Board in March 2014. It has been designed using the outcomes based accountability model.
- The school food plan is currently delivered across B&NES with all key stage 1 children now being offered a free school meal. From January 2015, it will be a statutory requirement for maintained schools and new academies to comply with new food based standards. The Food in Educational Settings programme is currently working with new academies to ensure they meet the new standards. However, there is concern around the lack of engagement from Academies who are *not* new who are not required to comply with the standards
- The Local Food Strategy will be completed by November 19th and an implementation plan developed accordingly. A stakeholder/action planning event will be held in late January 2015.
- The council now has adopted a cross cutting physical activity strategy 'Fit for Life', an executive board has been established to oversee the implementation of the strategy with the support of a Fit For Life Partnership who will lead on the development of the implementation plan.
- The local authority is currently undertaking a leisure facilities procurement, which is now mid-point in progress. The procurement panel are shortlisting in October 2014 with a view to award a contract in December 2014.

Request / recommendation to the HWB

- For each Board member to champion the 'making every contact count' brief advice training in their organisation and develop a plan for cascading out to employees so that it becomes a mandated part of staff induction
- For Health and Wellbeing Board members to sign an agreement that all public sector commissioned lifestyle services will not be charged venue hire if they deliver in a public sector venues (e.g. hospitals, doctors, children centres)
- Support the implementation of local food planning policy: to ensure the protection of growing spaces and allotments, protect markets and restrict number of fast food outlets in close proximity of schools as well as ensuring new developments have adequate cooking and dining space for residents.
- Support the development of a refreshed play strategy for B&NES
- Support for the board to develop a stronger partnership with leisure, transport and education to promote and deliver outside learning programmes for both preschool and school aged children. (Targeting children who are disabled/learning difficulty and young girls)
- Increase level of investment in promoting active travel to families (improving links with the Local Sustainable Transport Fund, Highways and Education)

JHWS Priority	**Improve outcomes for families with complex needs**
Outcomes required as at March 2015	**All 215 families to have been allocated a key worker, and worked with. 100% of the attachment fee's claimed 100% of the payment by results claimed; improved outcomes for families linked to and reduced under 18 crime and ASB, Families into work training, children and young people attending well at school. As linked to the troubled families financial framework.**
Officer lead	**Paula Bromley, Connecting Families Manager**
HWB member lead	**John Holden, BaNES CCG lay member**

THE BIG PICTURE

Key facts

- The government has estimated that there are 210-220 families experiencing multiple problems
- In 2013/14 the local Council's 'Connecting Families' team was in contact with 43 of these families
- Out of work benefit claims and education absence represented the most common needs of the Connecting Families caseload

Multiple disadvantage ('Troubled families')

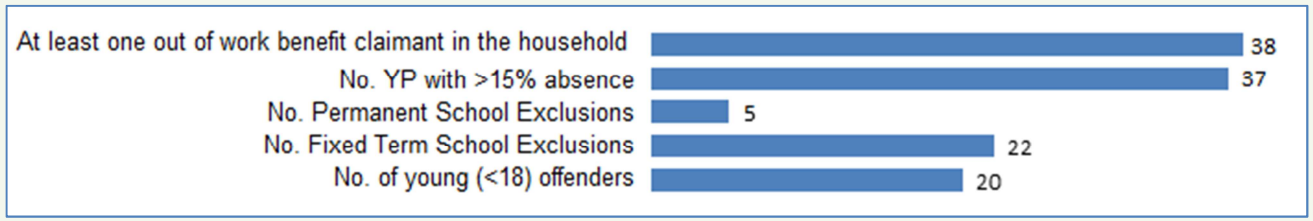
- In 2012, the government estimated that there are 120,000 families living with multiple disadvantages in England. Of these, it was estimated that 210-220 lived in Bath and North East Somerset

Are we meeting the needs

In April 2013, the council's Connecting Families team was working with 43 families, composed of 112 children and young people and 74 adults.

- Adults in the caseload were 53%/43% female/male, whereas children and young people were 48%/42% female/male. 33 families were single parents, of which the majority were single mothers
- 58 (52%) children and young people on the caseload had identified Special Educational Needs or were on a school action plan
- The Ethnicity profile of the cohort largely matches that of the population as a whole
- There is quite a broad geographical variation of the location of families, with only Twerton and Southdown local government wards having >5 families resident
- Fig 1 identifies the breakdown of specific nationally defined criteria by the caseload and demonstrates that out of work benefit claims and education absence are the most common criteria experienced in Bath and North East Somerset

Figure 1 - Connecting Families Caseload (Feb 14) by national criteria



Health inequality

See item above that details special educational needs details within the team. As part of phase 2, the Government have requested that we add a new area of criteria; parents and children with a range of health problems – and there will be a range of outcomes linked to these.

DELIVERING THE PRIORITY

Aims of the services

- To support these families to make positive change and live full active lives. The staff team (called family key workers) work alongside these families, helping them to achieve their aspirations and with parents to give their children an enjoyable, successful childhood and preparing them for adult life
- By working in a co-ordinated way, staff will support the whole family including children and young people with school / college to get the best from educational opportunities and through positive activities to engage with the wider community
- Co-ordinating the right services at the right time to meet the family's needs, improve outcomes and reduce the impact of crime, lack of education, worklessness, and physical and mental ill health amongst the most disadvantaged families

Successes and challenges

- Key successes to date have included:
    - Results linked to Payment by results to meet the Governments requirements
    - Outstanding work with families delivered by the core teams family workers
    - Progress made by families to date
    - Positive feedback from the Government Troubled Families Unit
    - Positive feedback from the family members via family feedback
- Challenges to date:
    - Sustaining positive parenting
    - Obtaining flexible curriculum opportunities

THE PATIENT AND PUBLIC VOICE

"Well from my point of view I am 100% happy with the help I was provided and if I ran into any problem with my family or with finances I was always helped. I just can't thank you all enough for what you have done for me and my family. I will never forget your help, kindness and understanding. I would not be where I am now if it was not for your project"

"I would still be unemployed and my confidence wouldn't be as good as it is as they helped me build my confidence and other skills."

"My keyworker's down to earth approach, she makes me feel relaxed and comfortable, does not judge. My son has taken to our worker, he doesn't take to many"

"We would not be in the positive place we are now. My eldest son has a job and the other is working towards getting a job. My youngest has had excellent help with problems at school. Good support with dealing with my marriage breakdown."

ASSESSING PERFORMANCE

Connecting Families criteria
The family would need to meet 3 of the national criteria or 2 national and 1 local criteria

- National criteria
  - School Attendance - exclusion, in a Pupil Referral Unit or 15% unauthorised absences across the last 3 consecutive terms.
  - Crime / Anti-Social Behaviour – under 18 year old with a proven offence in the last 12 months; anti-social behaviour order, anti-social behaviour injunction, anti-social behaviour contract, or subject to a housing-related anti-social behaviour intervention in the last 12 months
  - Out of Work and Claiming Benefits - households which has an adult on DWP out of work benefits (Employment and Support Allowance, Incapacity Benefit, Carer's Allowance, Income Support, Jobseekers Allowance or Severe Disablement Allowance
- Local criteria
  - Domestic Violence
  - Mental ill health
  - Children on the edge of care
  - Substance abuse

The next page sets out the B&NES Council Connecting Families Team Dashboard for 2014.

Bath & North East Somerset Council

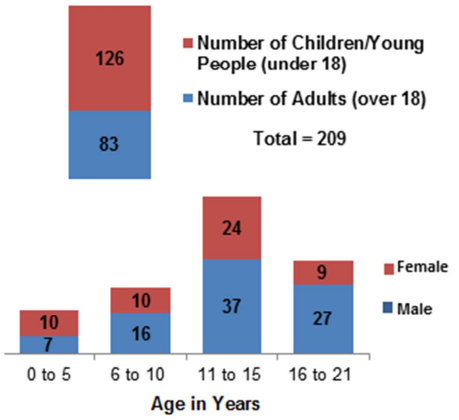
Bath and North East Somerset Council: Connecting Families Team Dashboard

Profiles of Families allocated to the Core Team

Total Number of Families: 50

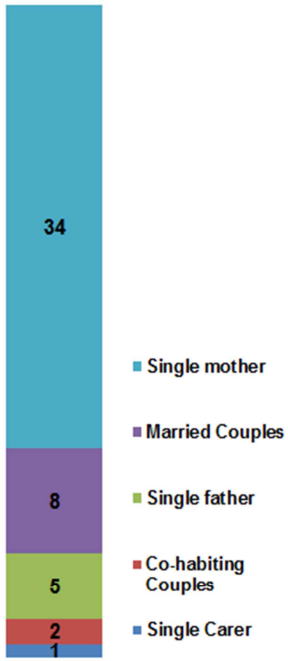
Connecting Families

Age / Gender Profile



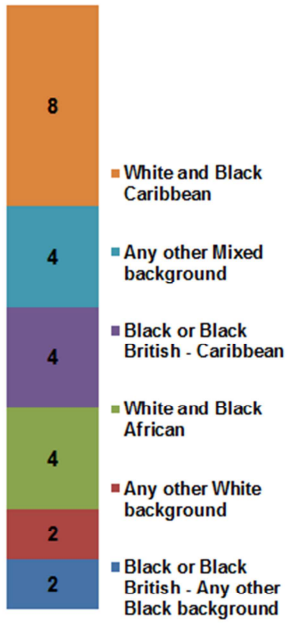
Gender

Relationship Profile



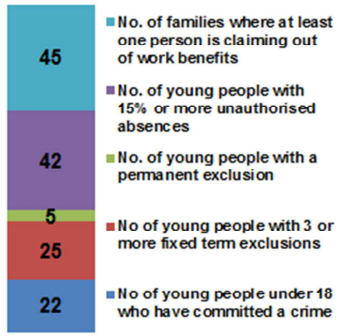
Ethnicity Profile

White British = 185

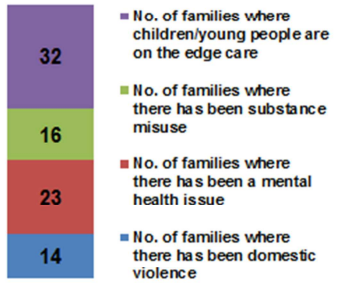


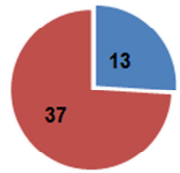
Criteria Profile

National Criteria



Local Criteria

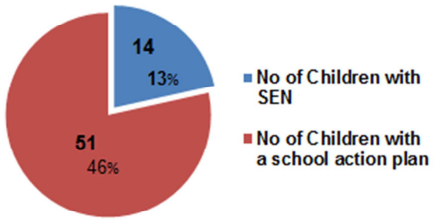




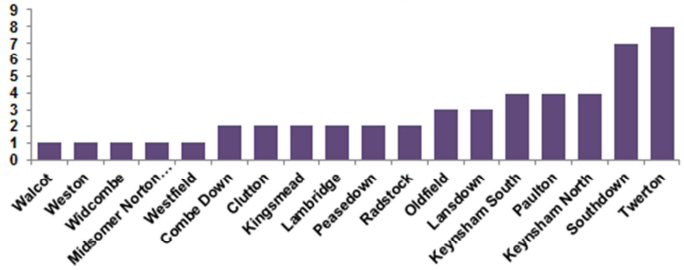
No of families matching 3 national criteria

No of families matching 2 national criteria

Education Details

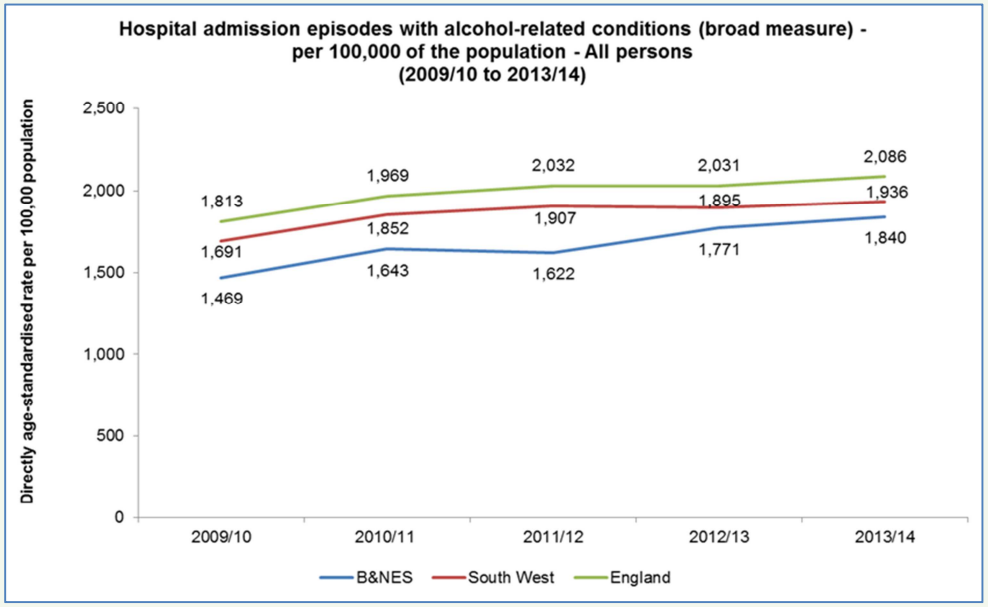


No. of Families by Wards



JHWS Priority	**Recued rates of alcohol misuse**
Outcomes	**Safe, healthy and responsible drinking amongst the B&NES population**
Officer lead	**Cathy McMahon, Public Health Development and Commissioning Manager**
HWB member lead	**Ashley Ayre, Strategic Director – People and Communities, B&NES Council**

THE BIG PICTURE



- The hospital admission episodes with alcohol-related conditions (broad measure) – rate per 100,000 of the Bath and North East Somerset population has increased by 25% between 2009/10 and 2013/14. This is a greater increase than that of the South West and England (15%) but has constantly been lower than regional and national rate. During this period there has been a 23% increase in the rate of these admissions for men and a 30% increase for women.
- People living in the most deprived areas of Bath and North East Somerset are significantly more likely to be admitted for an alcohol related condition than those living in the least deprived areas.
- Bath and North East Somerset has significantly higher rates of under 18's admitted to hospital for alcohol specific conditions than nationally.

Health inequality

- There are more alcohol related hospital admissions amongst men than women and more men in treatment and estimated to be dependent on alcohol in B&NES than women.
- Those living in more deprived areas of Bath and North East Somerset are four times more likely to be admitted to hospital for an alcohol related cause than those living in less deprived areas.
- 16% of people in alcohol treatment services in B&NES also have a severe mental illness.
- Problematic drug and alcohol use and mental health problems are key factors in the lives of people who have recently slept rough (St Mungo's June 2013 report)
- Alcohol specific hospital admissions amongst under 18's in B&NES are more frequent amongst girls than boys and girls are more likely to be receiving treatment for alcohol misuse than boys.
- There is a significant difference in self-reported exposure to alcohol (drinking in the last week) for primary school pupils who qualify for free school meals compared to those who do not qualify for free school meals.

DELIVERING THE PRIORITY

- The B&NES Alcohol Harm Reduction Strategy 2012 has been refreshed to reflect national policy and local priorities.

- A full children and young people's substance misuse needs assessment in underway and due to report by March 2015. This process will update and broaden the 2010 needs assessment and will cover prevention, early intervention, treatment and harm reduction in relation to smoking, alcohol, illegal drugs and novel psychoactive substances and the relationship with risk taking behaviour.
- B&NES Council Statement of Licensing Policy has been reviewed over the last 6 months. The Review has enabled recognition of new powers such as Early Morning Restriction Orders and recommends the retention of the Cumulative Impact Policy for Bath City Centre. It also acknowledges the wider public health agenda and health as a Responsible Authority and has led to the development of a voluntary code for licensed premises to promote responsible retailing of alcohol.
- Project 28, the young people's drug and alcohol treatment service provider for B&NES, has recently been successful in securing funding from Children in Need for an additional 2 years' delivery of the Drink Think Alcohol project. The service has also been successful in attracting National Institute for Health Research (NIHR) funding to evaluate the impact of its Drink Think Alcohol Screening Tool in reducing alcohol misuse amongst young people.
- Systematic screening for alcohol misuse is now included in the NHS Health Check and as part of the inpatient and community mental health services contract for 14/15. The RUH Alcohol Liaison Service will begin systematic screening for alcohol misuse in the Emergency Department this autumn.
- The Substance Misuse commissioner is working with treatment providers to support increased capacity for alcohol clients. There is also increased focus on mutual aid as a key step in the recovery journey for example working with AA, SMART and peer mentoring approaches to increase successful outcomes.
- Additional community detoxification capacity has been created in Burlington Street Dry House for RUH patients. This facility is contributing to the substantial bed day savings that have been made as a result of intervention by the Alcohol Liaison Service in the RUH.
- The Blue Light Treatment Resistant Drinkers project with Alcohol Concern has produced a range of resources to support local strategy for this client group, including a local needs assessment. It is estimated there are approximately 200 people that meet the definition in B&NES, costing local services around £10 million pounds. A working group has been set up to develop a local action plan.

THE PUBLIC AND PATIENT VOICE

- Girls self-report higher levels of drinking and are over represented in treatment services for alcohol misuse and also in alcohol related hospital admissions. Qualitative feedback from young people using treatment services (Project 28) is consistently positive and satisfaction is high
- When asked in 2012 about drunk and rowdy behaviour in public places in their local area, 21% of voice box survey respondents believed it was either a very big problem, or a fairly big problem.

ASSESSING PERFORMANCE

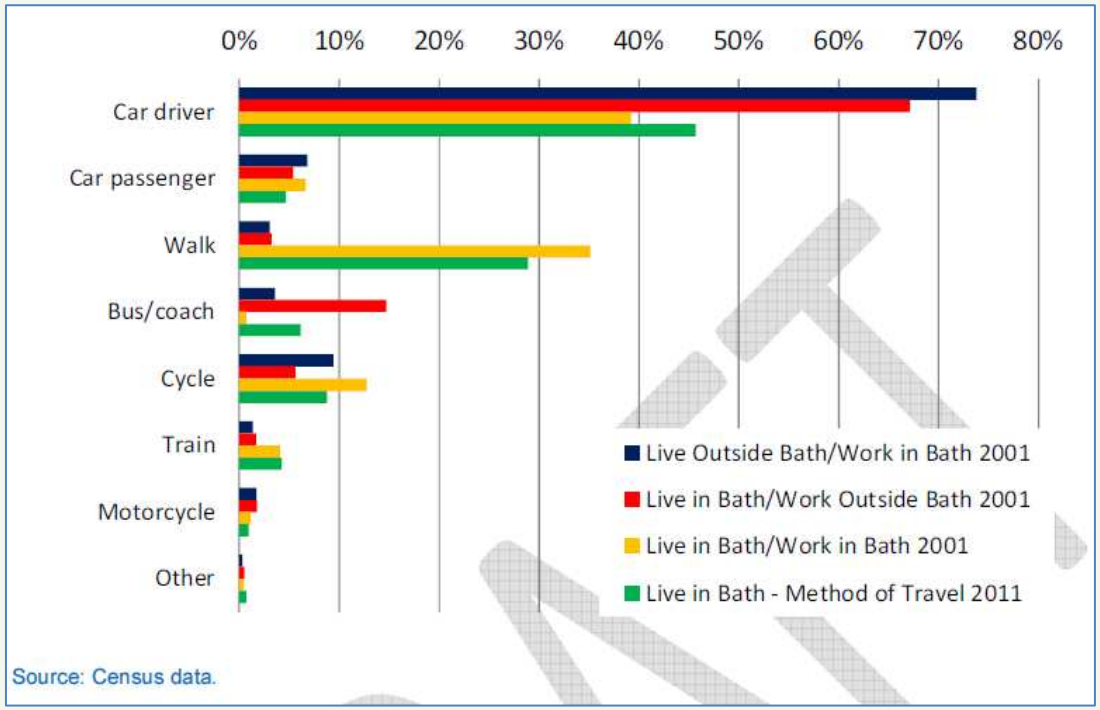
Indicator	Performance	Trend	Comment
U18's Alcohol Specific Hospital admissions	B&NES rate (69 per 100,000 pop.) is the highest in the South West and significantly higher than national rate (45 per 100,000 pop.)	The rate of admissions is on a downward trajectory, in line with national trends.	A working group has been set up to better understand this issue.
Alcohol related hospital admissions (18+)	B&NES rate lower than national and regional rate	25% increase between 09/10 and 13/14, higher than regional and national increase of 15%	There was a 4.4% drop in alcohol specific hospital admissions in 13/14 compared to 12/13. The introduction of the Alcohol Liaison Service at the Royal United Hospital is thought to have contributed significantly to this reduction.

Crimes linked to the Night Time Economy	There has been a 26% reduction in the number of crimes linked to the Night Time Economy in B&NES between 2008 and 2013. From 2,504 recorded crimes (Q4 07/08 – Q3 08/09) to 1,841 crimes (Q4 11/12-Q3 12/13)	Downward trend in violent crime at both national and local level	Nationally violent crime has been reducing since 2001
Numbers in alcohol treatment % successfully leaving treatment and not returning within 6 months	In 13/14 there were 467 people in alcohol treatment with 302 of these starting their treatment in 13/14 40% of people leaving alcohol treatment in B&NES during 13/14 left successfully with no return within 6 months. 63% of young people left Project 28 drug free in 2013/14, 32% left as 'occasional' users (In total 55 young people left treatment last year)	This reflects a year on year increase in the numbers of people accessing alcohol treatment. This is better than national average performance of 36% and improving 11% more young people leaving drug free than 12/13.	With rising numbers of people accessing alcohol treatment year on year there are potential capacity issues in meeting future demand Increase could be related to the introduction of '28 day challenge' where young people are challenged to spend 28 days without using drugs or alcohol but sample size is small

JHWS Priority	**Create healthy and sustainable places**
Outcome	**The built and natural environment in B&NES enables all people in our communities to lead healthy and sustainable lives**
Officer lead	**Paul Scott, Assistant Director of Public Health, B&NES Council**
HWB member lead	**Jo Farrar, Chief Executive, B&NES Council**

THE BIG PICTURE

- 27% of Bath and North East Somerset population undertake 30 minutes of moderate intensity exercise on 3 or more days a week (22.3% national, South West 22.9%). This rate is higher among men than women both locally and nationally and there is no difference by ethnicity. (Source: The Active people survey 2011-12)
- Only 30% of 65-74 year-olds and less than 15% of adults aged 75 and over reported any exercise lasting at least ten minutes during four weeks (Health Survey for England, 2008).
- There is evidence of health inequalities as several of our most deprived wards in B&NES also have the lowest levels of physical activity and higher than average levels of obesity.
- 41.2% of people in B&NES are using outdoor space for exercise/health reasons compared to the England average of 15.3%. B&NES has the highest figure in England. (Adults aged 16+ years, Feb 2012 to March 2013, Source: PHOF). Nonetheless, it would be helpful to understand who the 59% of the population are that are not using outdoor space for exercise/health reasons and whether they have worse physical and mental health outcomes which could benefit from greater access and use.



- In B&NES there are 197 leisure facilities per 100,000 population. This is one of the highest rates in the country - as a comparison, South Gloucestershire has 120 per 100,000 and 86 per 100,000 for Oxfordshire (Source: B&NES JSNA).
- 9.5% of households are considered as being in fuel poverty, compared to 10.4% across England (2012, Source: PHOF)
- During the winter of 2013 B&NES experienced rainfall and flooding in a pattern consistent with the findings projected by local climate change impacts research. Over the same period, the area has experienced subsidence problems for buildings and roads, again in line with the projected research.
- The figure overleaf from 'Getting around Bath' shows that the majority of all journeys to work are made by car, particularly for people living outside of Bath where few journeys are made by bike, bus or train. The recent transport plan for Bath aims to shift this proportion towards active travel modes.

DELIVERING THE PRIORITY

A working group has been set up to progress this priority, with representation from all three council directorates (Place, People and Communities and Resources). The group's aim is that:

- The built and natural environment in B&NES enables all people in our communities to lead healthy and sustainable lives.

By working with key colleagues our ambitions are to:

- Increase active travel
- Improve access to high quality open and green spaces
- Improve local food environments (shops, markets, growing, culture)
- Improve the number of energy-efficient, safe and affordable homes
- Mitigate the impacts of climate change and environmental hazards
- Integrate these issues in to the local planning system

A key principle will be to ensure these things are possible for areas or communities currently experiencing higher levels of deprivation or worse health outcomes than the general population. Otherwise, there is the risk of widening inequalities across the district rather than narrowing them.

The approach of the group is to work with partners across the council and elsewhere:

- to make the most of the health and sustainability opportunities arising in key plans which may otherwise be missed
- to provide colleagues with the technical or strategic support to enable this to happen.

Key areas that working group members have been contributing to, influencing or developing over the recent period include:

- Fit4Life - an active living strategy for B&NES has been published. The working themes for this include leisure, travel and active environments and we are working with colleagues involved to support the development of this in a coordinated way.
- Working with regeneration colleagues so that wellbeing and sustainability are now included as cross-cutting themes of the refreshed Economic Strategy for B&NES.
- Working with planning colleagues to ensure that Objective 6 of the Core Strategy (which is to plan for development that promotes health and wellbeing) is sufficiently reflected in the current Placemaking Plan Options which are to be agreed and consulted on shortly.
- At a more detailed level, we have carried out a health impact assessment and contributed to wider sustainability appraisal of the Bath enterprise area master plan.
- A local food strategy has been published and consulted on with very positive engagement from a wide variety of external organisations.
- Adaptation to climate change has been agreed in the Council's Strategic Review as a project area needing further development which will be led by members of this group. To support this work, it has been agreed to update the Local Climate Impact Profile (LCLIP) study.
- A report was produced for the council leadership to help understand what we know about the health impacts of air pollution in B&NES and potential recommendations arising from that. These are being taken forward with public protection and transport colleagues.

THE PUBLIC AND PATIENT VOICE

Public voice is being captured through consultations on a number of key plans at present, including Fit for Life, Getting around Bath and so on. The working group

needs to more proactively capture views of the public arising in these consultations that relate to healthy and sustainable places views.

ASSESSING PERFORMANCE

Although a number of population indicators have been set out in the 'big picture' section at the start of this report, our aim is to use local indicators arising from the various plans indicated above. Although the economic, leisure, placemaking and travel plans will have a wide variety of actions, we propose to agree a small number of indicators from each which relate specifically to our ambition and can be used to track progress as part of their delivery, rather than being outside and unrelated. The indictors have not yet been agreed yet as the various plans are all still new.

JHWS Priority	**Improved support for people with long term health conditions**
Outcome	**Improving the quality of people's lives**
Officer lead	**Laura Marsh, Commissioning Manager for Long Term Conditions (NHS BaNES CCG)**
HWB member lead	**Julia Davison, Bath, Gloucestershire, Swindon and Wiltshire Area Team representative**

THE BIG PICTURE

- Nationally, people with long term conditions account for:
  - 50% of all GP appointments
  - 64% of outpatient appointments
  - 70% of all inpatient bed days
  - In total around 70% of the total health and care spend in England (£7 out of every £10) is attributed to caring for people with LTCs
  - This means that 30% of the population account for 70% of the spend
- The number of people with long term health conditions is projected to be relatively stable over the next 10 years but the number of people with multiple long term conditions is set to increase by approximately 50%.
- Age is a major factor for the prevalence of long term conditions and 14% of those aged under 40 report having a long term condition compared to 58% of those aged over 60. Age is also an indicator for prevalence of multiple long term conditions with 35% of over 60s having two or more.
- In 2011, 7% of the B&NES population (12,267 residents) reported that their daily activities were limited through a long term illness or disability.
- Diabetes has the fastest rising prevalence of any long term condition and local prevalence is increasing by 5% a year. There are increasing numbers of people aged 45 and under being diagnosed with type 2 diabetes and up to 20% of all inpatients in the RUH now have diabetes. Therefore diabetes is currently the main LTC area of focus for BaNES CCG.

Health inequality

- There is a 60% higher prevalence of long term conditions in people from the lowest socio-economic group to those in the highest.
- People with at least one LTC are also more likely to have risky health behaviours and are more likely to have high blood pressure and be obese, though it is unclear the direction of causation.
- Older people are much more likely to have a long term condition (58% of those aged 60+ compared to 14% of those aged under 40)
- People with a limiting long term condition are half as likely to have a job than those with a non-limiting LTC or with no LTC

DELIVERING THE PRIORITY

<u>Current Service Provision</u>
People with long term conditions typically come into contact with the whole health care system – GPs, acute hospitals, community clinics, specialist care centres, community pharmacy and more. Care pathways for long term conditions therefore need to transcend the organisational boundaries of social, primary, community and secondary care.

As an example we created a new clinically led and patient centred approach to delivering heart failure care. Heart failure is one of the most common causes of

readmission to the RUH and patients can be admitted many times over the course of their illness and particularly towards the end of their life. In the previous pathway, providers addressed specific aspects of care but often in isolation from each other and in a way that left patients feeling unsupported so we formed a heart failure stakeholder group to map the pathway and develop a patient owned 'Heart Failure Passport'. The passport includes all the key information about a patient's condition including their treatment plans, all medications and end of life planning where appropriate. So, if a patient sees a healthcare professional who isn't part of the heart failure team all their vital information is easily available. In addition to this, our multidisciplinary team invested in telehealth technology so that patients can monitor their weight so as to better monitor their heart condition, supported by their heart failure nurse as necessary. Since redesigning the pathway, community heart failure nurses have been supported by direct access to a consultant cardiologist with regular multidisciplinary team meetings. Meeting in this way enabled the team to share valuable lessons and experiences which enhanced the continuity of care with clear improved patient outcomes and a particular emphasis was placed on end of life planning supported by the palliative care team.

To better understand the whole patient experience, a new friends and family test (FFT) specifically designed around the heart failure pathway was introduced. It surveyed patients along a pathway of care at different touch points, rather in a single care setting and over three months, more than 2000 patients responded giving their feedback on services from their GP, their heart failure nurse, cardiology inpatient and outpatient services at RUH, as well as patients from A&E at RUH. Overall 94% of respondents were either likely or extremely likely to recommend their provider, and services received in the community rated highest for treating patients kindly, as well as listening and explaining.

Successes with Current Service Provision

The Long Term Conditions Work programme covers numerous projects and this year the CCG has:

- Expanded the IMPACT service (community COPD service) to six days per week
- Commissioned a Dementia Support Worker service
- Implemented the new Community Cluster Team Model including the Active Ageing Service
- Commissioned a redesigned community bladder and bowel service
- Expanded specialist neurology nursing provision
- Expanded the Parkinson's Disease Multi-Disciplinary Team at the Clara Cross Rehab Unit
- Expanded the Early Supported Discharge service for Stroke patients

Challenges with Current Service Provision

There have been several difficulties in maintaining and improving current services, including:

- Difficulty maintaining good stroke performance. However, a revised action plan is now being developed.
- Difficulty developing the clinical model for supporting patients with non-cystic fibrosis bronchiectasis in the community
- Difficulty improving dementia diagnosis rates despite significantly increased activity at the RICE memory clinics and introduction of the Dementia Support Worker service

Next Steps for Service Provision

- Diabetes is a strategic priority for the CCG so the Long Term Conditions Work Programme is now going to focus on the redesign of diabetes services. This is essential in order to manage the increasing numbers of people with type 2 diabetes.

THE PUBLIC AND PATIENT VOICE

65 people with long term conditions were surveyed in 2011. Nearly half (47%) of respondents indicated that they were not very or not at all confident about managing their condition. More detailed patient feedback is sought as part of the commissioning cycle and recently, surveys have focussed on diabetes as this is a priority area for the CCG and also continence as the community bladder and bowel service has recently been redesigned.

Diabetes

In September 2012, NHS B&NES in partnership with Diabetes UK requested feedback on diabetes services from all Diabetes UK members who live within Bath and North East Somerset. 310 questionnaires were sent out in September 2012 and 163 were returned – a response rate of 53%. The key findings can be summarised as follows:

- 78% of all respondents said that the healthcare professional they see most often always explains things clearly to them.
- Only 13% of all respondents had been offered a written copy of their care plan.
- Only 60% of all respondents said that the information they received about diabetes was always easy to understand.
- 80% of all respondents rated communication between the healthcare professionals involved in their diabetes care as good or excellent.
- 86% of all respondents have not needed to repeat important information they had already told the healthcare professional.
- Almost three quarters of all respondents said they were always able to contact their healthcare professional and a further 18% said they could sometimes make contact.
- 64% of all respondents always understood their test results. However, 28% said they only sometimes understand them and 6% said they never understand them.
- 40% of all respondents were not given the opportunity to discuss their physical activity levels and/or diet. Of the respondents who did talk about these issues, 72% said the discussions supported them to make lifestyle changes.

More recently, the 'Your Health Your Voice' patient group has been consulted on the proposed new diabetes pathway and to help us better understand what people need to help them better manage their diabetes, a further survey for patients with type 2 diabetes is planned for the coming months.

Continence

Patient feedback was sought from patients attending a first appointment for incontinence at the RUH uro-gynaecology clinics. This cohort of patients should have tried conservative treatments for urinary incontinence via the community continence service prior to their appointment. Feedback was received from 51 patients (24 from B&NES, 25 from Wiltshire and 2 with postcodes that could be B&NES or Somerset). In summary, the feedback showed that:

- Two thirds (17/24) of respondents reported that they saw the community continence service soon enough to be able to help them.
- 71% (36) respondents had seen their GP about their continence problem
- 55% (28) of respondents waited for more than 2 years before seeking help for their continence problem. A further 10 respondents waited between 1 and 2 years. Only 12% (6) patients waited less than 6 months.
- All of the youngest respondents (aged 25-34) and all of the oldest respondents (aged 75-84) waited for at least a year before seeking help.
- Ten of the respondents described how urinary incontinence was negatively impacting on their lives.
- Five women indicated they would like to be able to manage their incontinence better if it couldn't be cured.

An online survey was also conducted as it is recognised that continence can be an embarrassing subject with many people not seeking help and managing their incontinence using pad products that can be readily bought from supermarkets and pharmacies. Only 21 responses were received but the results showed that: the majority of respondents (87%) had had a continence problems for longer than one year with 22% respondents having an issue for over 5 years; 24% of respondents

hadn't sought help or advice from any source about their continence problem; and the ability to self-refer to the community continence service was important to most people

ASSESSING PERFORMANCE

- There are a number of national indicators in the CCG outcome indicator set (CCGOIS) that aim to improve the care for people with long term conditions:

Indicator type	Indicator Description	BaNES 2011 / 12	BaNES 2012 / 13	BaNES 2013 / 14	England Average 2014 / 15	To improve	Compared to England average and data trend		Supporting Narrative
National	Health-related quality of life for people with long-term conditions (CCGOIS 2.1)	0.79	0.79	0.77	0.74	⇧	G	⇧	BANES results for 2013/14 in the top 25% of CCGs. Health-related quality of life refers to the extent to which people have problems: walking about, with self-care (e.g. Washing and dressing), usual activities (e.g. work, study). Also if they are in pain or discomfort and feel anxious or depressed.
National	Health-related quality of life for carers, aged 18 and above (CCGOIS 2.15)	0.86	0.84	n/a	0.80	⇧	G	⇔	Please Note: 2013/14 data for BaNES was supressed due to small numbers to responses. Health related quality of life is as in CCGOIS 2.1 above.
National	People feeling supported to manage their condition (CCGOIS 2.2)	70.5	70.3	71.0	65.1	⇧	G	⇧	BANES results for 2013/14 just outside the top 5% of CCGs. These are health conditions, that are expected to last for a significant period of time, and if people feel they have had sufficient support from relevant services and organisations to manage their condition.
National	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (CCGOIS 2.6)	627	672	589	781	⇩	G	⇩	BANES results for 2013/14 in the top 25% of CCGs This measures how many people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. These conditions include, for example, diabetes, epilepsy and high blood pressure.

National	People with diabetes diagnosed less than a year who are referred to structured education (CCGOIS 2.5)	20.3%	26.6%	n/a	18.4%	⇧	G	⇧	BANES results for 2012/13 in the top 25% of CCGs (England results are for 2012/13). These are the latest available results.
National	Emergency admissions for acute conditions that should not usually require hospital admission (CCGOIS 3.1)	854	911	872	1165	⇩	G	⇩	BANES results for 2013/14 in the top 15% of CCGs. These conditions include, for example, ear/nose/throat infections, kidney/urinary tract infections and heart failure.

Sources of Information used in this section include:
Bath and North East Somerset JSNA - **http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics**
Health and Social Care Information Centre – **https://indicators.ic.nhs.uk/webview/** (please note: some of this website is limited to relevant access)

JHWS Priority	**Reduced rates of mental ill health**
Outcome	**Reduced rates of mental ill health**
Officer lead	**Andrea Morland, Senior Commissioning Manager – Mental Health and Substance Misuse**
HWB member lead	**Tracey Cox, BaNES CCG Acting Accountable Officer**

THE BIG PICTURE

- 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.
- Admissions to a mental health bed per 100,000 population is at national average levels.
- 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.

DELIVERING THE PRIORITY

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.
- June 2014 Pupil Parliaments highlighted the need to focus on gender support for females and males, building on equalities work across schools
- A wide 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 including work on the early identification of, and intervention with, children and young people displaying emotional distress. This includes counselling services, peer support and training to support attachment and nurture of the child.

- A new pilot service is starting in November 2014 allowing young people (aged 16-18) to directly access CAMHS practitioners. This may help address “reluctant” young people being referred from other services who subsequently do not engage with treatment and encourage other vulnerable young people to seek help without needing to approach an interim ‘referring’ service.
- The Director of Public Health Awards are given to those schools and colleges that increase the levels of support to targeted vulnerable groups of pupils and which actively promote emotional health and wellbeing in their settings. Settings are encouraged to reflect on local ‘intelligence’ from the School Health Educational Unit surveys and Pupil Parliaments.
- A Wellbeing College has been commissioned as a pilot project by B&NES CCG, Adult Care and Public Health. 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. 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.
- 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).
- Somer Valley FM have been piloting an information campaign to promote the Five Ways to Wellbeing amongst local people demonstrating success in widening the organisation’s seen to be delivering a wellbeing message.

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.

Suicide prevention

- In addition to promoting wellbeing and reducing 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 sudden death of a family member or friend is being explored.
- Targeted specialist support is provided to schools – staff and pupils - who have experienced a suicide of a school member.
- Training sessions on suicide were provided during the Spring of 2014 to around 150 front line staff across B&NES from all sectors.
- 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.

Mental Health services update

Within primary and community mental health services we have seen:

- 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.

Within Specialist Acute Mental Health services we have seen:

- Improvement in the local integration of specialist mental health services into all the pathways of care as described above.
- Improvement in organisations working together to address people's physical and mental health needs such as the mental health liaisons services
- An improvement in a how we support people needing treatment at home or an assessment in a crisis e.g. the Place of Safety assessment suite being used rather than a police cell to assess someone in distress picked up by the police. A new, all age Place of Safety has been opened at Southmead Hospital.
- Work taking place with commissioners to improve the quality of local adult in-patient facilities following serious concerns from staff and CQC about the ward environments.

THE PUBLIC AND PATIENT VOICE

All mental health community service developments are taking place in conjunction with the Mental Health Wellbeing Forum, service users and carers. The mental health commissioning strategy is being rewritten focused around the service users and carer research document "Bridging the Gap".

AWP, Oxford Health and commissioners have already and will continue to 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).

ASSESSING PERFORMANCE

All service will continue to be monitored against the KPIs embedded in their contracts that inform the content of this paper.
In order to monitor ongoing performance against priorities we need to develop metrics for success in relation to:

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

However, work is already taking place with providers of services in relation to Parity of Esteem and the mental health crisis concordat and will inform local measures of success. In addition, the Health and Wellbeing Board have agreed to sing up to the Time to Change campaign in order to support reducing mental health stigma and promoting wellbeing.

We will continue to measure the accommodation and employment status for those with the most serious mental health problems and work with the private and statutory housing and employment sectors to encourage greater understanding and support for adults with mental health problems.

JHWS Priority	**Enhanced quality of life for people with dementia**
Outcome	**Improving the quality of people's lives**
Officer lead	**Laura Marsh, Commissioning Manager for Long Term Conditions (NHS BaNES CCG)**
Member lead	**Dr Ian Orpen, Health and Wellbeing Board Vice Chair and NHS BaNES CCG Chair**

THE BIG PICTURE

- The percentage of population diagnosed with dementia has increased both locally and nationally, to 0.61 in BaNES and 0.65 in England (September 2014).
- 1,225 people in BaNES are registered as having dementia (September 2014).
- Nationally the Department of Health and Alzheimer's Society have set an estimated prevalence of people with dementia for each CCG area and the expectation is that CCGs will achieve 66% of people with dementia being diagnosed and appearing on GP QOF databases by 2015. The BaNES dementia diagnosis rate was 47.2% in September 2014 and the overall South of England diagnosis rate was 50.9% with no CCG meeting the 66% target.

Health inequality

- People living in rural areas may have difficulty accessing services
- Black, minority and ethnic communities experience lower levels of awareness of long term conditions such as dementia
- 50% of nursing homes residents are estimated to have dementia

DELIVERING THE PRIORITY

Current Service Provision

If a patient is having memory problems and dementia is suspected, patients in BaNES would be referred to the memory clinic which is operated by RICE at the RUH. At the memory clinic, patients are assessed and, if appropriate, diagnosed with dementia. A Dementia Support Worker and Carer's Support Officer are usually present at the clinic in order to provide immediate support to the person diagnosed with dementia and their carer if necessary. There is a history of strong partnership working with the voluntary sector in BaNES and the CCG continues to facilitate the dementia care pathway group in order to bring all partners together on a regular basis.

In order to ensure patients with dementia receive good quality support, the CCG has commissioned:

- A Dementia Support Worker service to support people recently diagnosed or in the process of obtaining a diagnosis of dementia (provided by the Alzheimer's Society)
- Memory Technology to support people with dementia remain as independent as possible (provided by Sirona Care and Health CIC)*
- Integrated hospital and community pathways using dementia co-ordinators and additional mental health liaison nurses in order to ensure patients with dementia are on correct care pathway and to facilitate timely discharge (provided by RUH)*
- A Rural Independent Living Support Service to help people living in rural areas access services (provided by Curo)*
- A Home from Hospital service to support a successful discharge from hospital (provided by The Carers Centre and Age UK BaNES)*
- A Community Hospital and Care Home Support and Assessment service to help community hospitals and care homes better people in their care with dementia (provided by Avon and Wiltshire Mental Health Partnership Trust)*

**These projects were the Dementia Challenge Fund projects that the CCG agreed to fund for 2014-15. Funding for 2015-16 will be decided pending evaluation.*

In addition to the CCG commissioned services, other services include:

- Dementia cafes and singing for the brain is offered in various locations in B&NES with other community developments underway
- Guideposts Trust provides information from dementia diagnosis to end of life care – including a B&NES specific information prescription the website.
- A dementia friendly ward at the RUH (Combe Ward). The garden attached to Combe Ward is currently being completed.
- Home Safety Checks
- Carers Support

Successes with Current Service Provision

- Dorothy House provide dementia training courses for registered practitioners and care homes and are working with AWP's community hospital and care home liaison service to improve end of life care training and support for staff.
- Dementia Friends sessions have been made available for CCG and Council staff and the sessions are now being offered to other organisations including the Sainsbury's store in Odd Down, Bath.

Challenges with Current Service Provision

- There has been difficulty improving the dementia diagnosis rate and BaNES is in the bottom quartile for South of England. The memory assessment pathway for primary care have been reviewed and revised to ensure patients receive a more timely diagnosis but a data quality exercise will now also be conducted to ensure that diagnosed patients have been recorded appropriately. Currently the diagnosis rate is 47.2% against a target of 66%.
- Work regarding the re-provision of assessment beds for service users with dementia is ongoing.

Next Steps for Service Provision

- Continue focus on improving dementia diagnosis rates.
- Continue to support the development of dementia friendly communities.
- Evaluation of the five Dementia Challenge Fund projects.

THE PUBLIC AND PATIENT VOICE

The 'Your Health Your Voice' group (a group of members of the general public who the CCG consult with) were consulted on the provision of mental health inpatient facilities including the assessments beds for service users with dementia in September 2014.

ASSESSING PERFORMANCE

NHS England is committed to pushing up dementia diagnosis rates and has a national target to achieve 66% of people with dementia being diagnosed and appearing on GP QOF databases by 2015. In BaNES we are tracking our progress and working to meet this target.

Indicator type	Indicator Description	BaNES 2012 / 13	BaNES 2013 / 14	BaNES 2014 / 15	South England 2014 / 15	England Average 2014 / 15	To improve	Compared to England average & data trend		Supporting Narrative
Local	Referrals to the RICE memory clinic for assessment / diagnosis	517	641	662	n/a	n/a	⇧	G	⇧	Increased referrals to the RICE Memory Clinic support increased diagnosis. The referrals meet the planned levels in BaNES. (2014/15 is forecast out turn based on data up to August 2014.)
Local	People receiving memory assessments	404	511	550	n/a	n/a	⇧	G	⇧	People referred to the RICE Memory Clinic meet with the service and where appropriate a full assessment is carried out. Around 80% of people referred have an assessment. (2014/15 is forecast out turn based on data up to August 2014.)
National	% of population diagnosed with dementia	0.58%	0.61%	0.61%	0.72%	0.65%	⇧	G	⇧	The % of population diagnosed with dementia is lower than the national average and this is probably due to lifestyle factors (e.g. lower smoking rates, lower obesity rates etc.). The number of diagnoses compared to the GP population (2014/15 results are as at September 2014.)
National	Estimated diagnosis rate for people with dementia.	42.1%	47.3%	47.2%	50.9%	54.1%	⇧	R	⇔	This is the national indicator often quoted in the news. The measure compares an estimated prevalence of dementia within BaNES against the number of people diagnosed with dementia and recorded on GP systems. (2014/15 results are as at September 2014.)

Once people are diagnosed with dementia the aim is to improve the care and experience of these people and their carers. There are a number of services (detailed above) that have been set up and continue to develop to improve care and experience. The five Dementia Challenge Fund projects are currently being evaluated and as the CCG commissioned services develop; performance assessment will be set up and shared.

Sources of Information used in this section include:
Bath and North East Somerset JSNA - **http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics**
Health and Social Care Information Centre – **https://indicators.ic.nhs.uk/webview/** (please note: some of this website is limited to relevant user access)
Primary Care Web Tool – Dementia Prevalence Tool - Authorised access only

JHWS Priority	**Improved services for older people which support and encourage independent living and dying well**
Outcome	**For older people to feel safe and well supported to the end of their life**
Officer lead	**Sarah Shatwell, Senior Commissioning Manager for Non-Acute & Social Care** **Catherine Phillips, Commissioning Manager for Maternity, Urgent Care and Non-Acute Services**
HWB member lead	**Diana Hall Hall, Healthwatch B&NES representative**

THE BIG PICTURE

- The projected population increase in Bath & North East Somerset between now and 2021 is 30% and this is expected to mainly be in older age groups; in particular the 85+ age group is expected to increase by 1.2% in the same time period. The main demand pressure for all forms of health and social care services is arising from the growing elderly population and rising life expectancy.
- The health of people in Bath & North East Somerset is generally better than the England average. Over the last 10 years, mortality rates for all causes have fallen by 32% - reduced from 731 per 100,000 in 1993 to 495 per 100,000 in 2010- a downward trend which is reflected in England and in similar authorities. Life expectancy is rising (currently 80 years for males and 84 years for females in B&NES).
- The four leading causes of mortality in Bath & North East Somerset are conditions of the heart; cancer; conditions of the lungs; and diseases of the bowels, liver, kidney, stomach although levels of all these conditions are lower than all England and South West average rates.

Trend in Demand - LTC

Condition	2012	2021	Number Change	Percent Change
Hypertension	42,221	45,270	3,049	7%
Chronic Kidney Disease	13,428	14,823	1,395	10%
Angina	6,406	7,121	715	11%
Diabetes	7,422	8,004	582	8%
Dementia	2,449	2,871	421	17%
Atrial Fibrillation	3,045	3,458	412	14%
Asthma*	13,162	13,513	352	3%
Congestive heart failure	2655	2973	318	12%
COPD	3,656	3,924	268	7%
Stroke	1,057	1,169	112	11%
Rheumatoid arthritis	1,274	1,377	103	8%
Depression*	4,658	4,748	90	2%
Fibromyalgia	4,338	4,394	55	1%
Epilepsy*	1,736	1,787	51	3%
Parkinsons Disease	345	388	43	13%

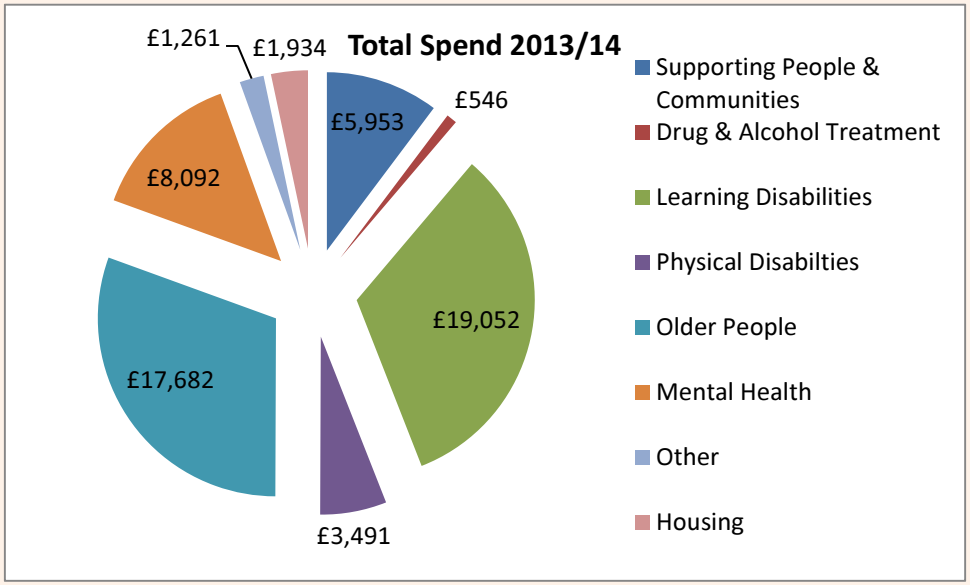
- With these demographic changes comes a corresponding increase in the prevalence of long term conditions such as diabetes, circulatory, respiratory and neurological conditions which means that often people are living longer with increased complexity of health and social care needs. The health of people in Bath & North East Somerset is generally better or in line with the England average, however, as shown in the table below, the prevalence of all conditions is rising, in line with national and regional rates.
- The National Dementia Strategy indicates that there are approximately 700,000 people in the UK with dementia and this number is expected to double within the next 30 years. However, only 45% of people in England receive a formal diagnosis of dementia or have contact with specialist services and without this diagnosis and support, they are unable to make informed plans for their future or access support and treatments that could help.
- The prevalence of reported dementia in Bath & North East Somerset is slightly lower at 0.4% than the national average of 0.5% although we believe there is significant under-reporting; the Clinical Commissioning Group (CCG) is aiming to increase the diagnosis rate. The number of people with dementia is expected to increase by 23% for females and 43% for males between now and 2025 however there are more women than men with this condition both now and predicted for the future. Local surveys tell us that Dementia and Alzheimer's are specific conditions which cause most concern for local people and demand data from partner providers suggests an increasing need for specialist dementia nursing beds.
- Despite relatively low levels of social inequality in Bath & North East Somerset a small number of areas experience significant inequality (Twerton West, Whiteway,

Twerton, Fox Hill North, and Whiteway West. For example the difference in life expectancy is 6.5 years between these areas and the least deprived areas (48 wards are in the least deprived 20%). In the most deprived areas social inequality has a significant relationship with a wide range of health and social care needs and this is reflected in demand for Adult Social Care services.

- There is a 60% higher prevalence of long term conditions and 60% greater severity of conditions for local people living in the most deprived areas of Bath & North East Somerset with a higher prevalence of problematic alcohol use and mental ill health adding further complexity.
- In Twerton West, Twerton and Fox Hill North more than 20% of residents of working age are in receipt of out of work benefits which is significantly greater than the wider Bath & North East Somerset community.
- Recent welfare reform changes suggest that the greatest economic impacts will be experienced by local people living in the most deprived areas with corresponding increase in demand for Council funded support.

DELIVERING THE PRIORITY

The number of people seeking assistance from social services has changed over the past five years. Local analysis of social services contact activity between April 2012 and February 2013 highlighted that more than 4,200 individuals made more than 6,000 separate contacts to request assistance of some kind. In 27% of cases contact resulted in no action being taken by social services as the request related to another Council department or local service provider. These findings prompted the development of a Council wide Information & Advice strategy and also significant review and re-design of the Adult Social Care pathway. Early data from the redesigned pathway shows us that a similar number of contacts are being made with social services however a greater number of people are being diverted into other services such e.g. re-ablement to help them maintain their independence.



In 2013-14 we spent just over £58m on adult social care services in B&NES including residential and nursing home placements, Personal Budgets & Direct Payments and domiciliary care services for all service user groups. More than £17m of the total budget was spent on service for older people.

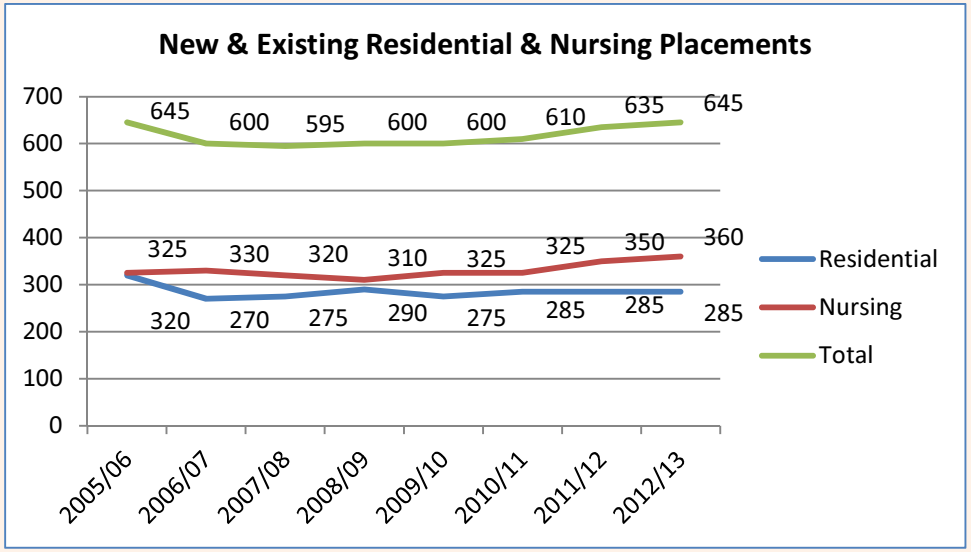
There are currently 57 residential and nursing homes under contract in B&NES, mainly providing placements for older people, but also including a small number for people with learning disabilities and mental health problems. All local providers who meet CQC essential standards and are able to demonstrate compliance with the B&NES services specification for residential and/or nursing care may be issued with an umbrella contract subject to these quality checks.

Once a contract is established Sirona are responsible for making placements in care homes as part of their delegated social work function. We estimate that around 55% of all care home beds are occupied by people who fund their own care which means that Sirona commission 45% on behalf of the Council.

The self-funder market in B&NES is strong and the Council must work closely with providers to ensure that we can secure the number of placements we require to meet statutory demand. We are aware that the balance of income between self-funding clients and those placed by the local authority is a key factor in making provider finances stack up.

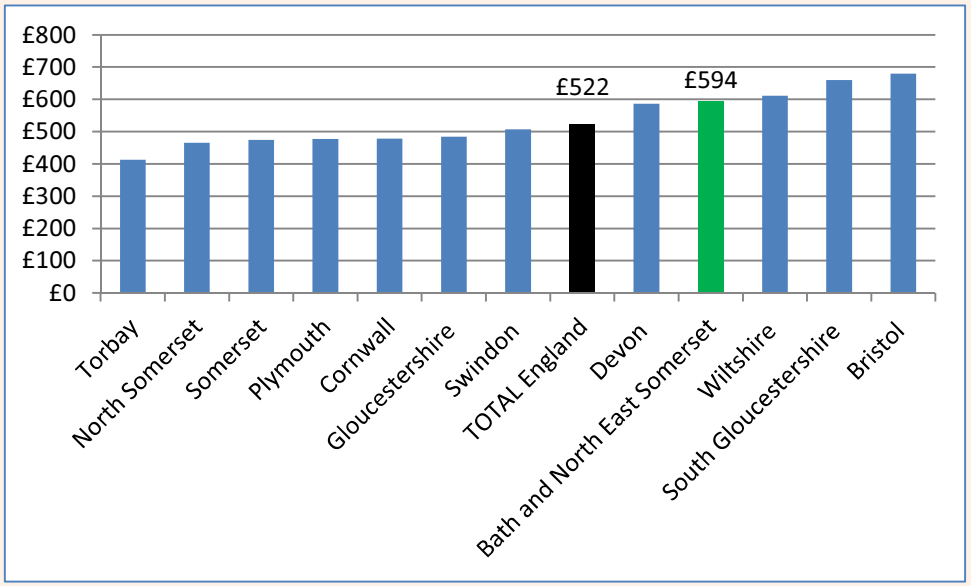
There are four large providers in B&NES (including Sirona) who supply 51% of all placements commissioned by the local authority with the remainder being supplied by the other 53 providers. Price is the greatest limiting factor in relation to the largest providers with smaller operators being able to offer more competitive rates locally, likely to be a reflection of the types of business models smaller providers operate e.g. not for profit, sole traders, family concerns.

B&NES benchmarks high in terms of residential and nursing home placements when compared to other local authorities, the chart below show the number of *new and existing* placements that were made in each calendar year by B&NES over the last eight years. Although the overall number of placements has not changed significantly, there has been a marked shift from residential to nursing placements with a substantial proportion of the latter being dementia nursing placements.



Snapshot analysis of care home residents in B&NES shows that 26% are male and 74% female with average ages of 81 and 86 years respectively, which compares with average life expectancies across the whole of B&NES 80 and 84 years respectively. This suggests that the quality of care home provision in the area contributes to a rise in life expectancies and/or that we are effectively targeting the most needy, and this in turn has an impact on the duration of placements as illustrated by the table below.

A significant proportion of individuals placed by B&NES (31%) maintain their placements for two years or more which contributes to a cumulative effect, when considered alongside new placements, of increasing demand pressure. However, the average length of stay for B&NES care home residents (Council placements) is an estimated 621 days which compares to 801 days found by a large scale investigation commissioned by BUPA[1]. This may reflect the fact that local authority placements tend to be made at later life stages when compared to self-funders who tend to enter the care market earlier, although the local data does support the view that the rate of placements in B&NES is higher in part due to shorter length of stay and a higher 'turnover' rate.



The average weekly cost of supporting people in residential or nursing care in B&NES is approximately £594 compared to the all England average of £522.

At the time of writing there were four domiciliary care 'strategic partners' under

[1] Length of stay in care homes (Julien Forder and Jose-Luis Fernandez, January 2011)

contract in B&NES and four spot providers, plus a small number of 'one off agreements'. The contract with strategic partners is a framework agreement under which providers are paid in advance for the projected number of hours they will deliver, then this amount is adjusted to reconcile with the actual hours delivered. Between October 2013 and December 2013 the total hours delivered by all contracted providers ranged between 4672 and 5040 which is within projected demand limits.

The strategic partners are commissioned to accept the majority of all referrals for domiciliary care made by Sirona part of the statutory social care assessment and care management process. As at 31st December 2013 just over 81% of all commissioned domiciliary care was being delivered by the strategic partners with the remaining 19% being delivered by either contracted spot providers (16%) or under 'one off agreements' (3%).

The table below shows the number of domiciliary care hours commissioned in B&NES at equivalent points during 2012-13 and 2013-14. The fall in hours during the first two quarters of 2013 relates to the exit of one contracted domiciliary care provider from the market and the corresponding transfer of service users to other support services.

The transfer process highlighted the fact that a significant proportion of service users who had been receiving a traditional care service no longer required it, and could be appropriately transferred to alternative forms of support such as the local independent living service or pilot 'enabling service'. These findings provided further support for the re-modelling of our adult social care pathway to focus greater attention on short term, rehabilitative interventions, and also indicate the need for providers to enhance their levels of specialism to support more complex packages of care in order to avoid residential admissions.

	April	June	August	October	December
2012	5016	4922	5006	4627	4796
2013	4489	4451	4661	4658	4874
Net change	-527	-471	-345	+31	+78

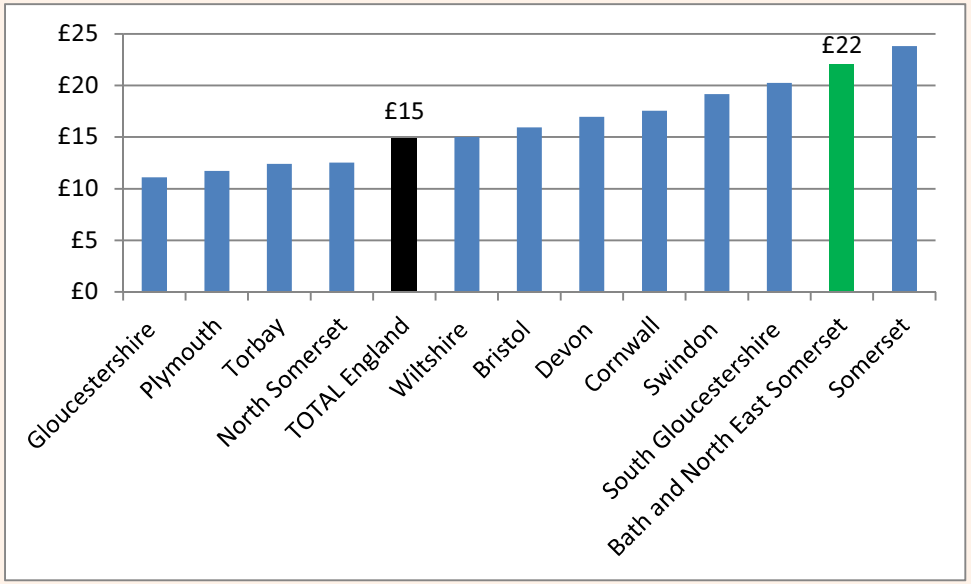
The average gross hourly cost of home care in B&NES is around £22 compared to the all England average of around £15.

The fall in domiciliary care commissioning is however of some concern when seen in the context of national trends which show a 3% increase in expenditure on domiciliary care services and day services in recent years. Based on the comparator rates above, the relative cost of supporting someone to live at home could be considered to be more expensive than placing them in residential care, especially if their care needs are high, which may to some extent explain the bias towards residential provision in the area.

Another factor influencing the range and type of care packages that are supported in the community, with domiciliary care being the main element, is the availability, specialty and quality of current provision, particularly in supporting service users at the end of their life, as well as the availability of related end of life care support for community care packages.

The National Audit of Intermediate Care captures key data about our integrated health & social care re-ablement service. The service, delivered by Sirona received 3115 referrals in 2011-12, rising to 3462 in 2013-13. The acute hospital was the main source of referrals to the service followed by GPs then other community sources. Of all referrals received in 2011-12 95% were accepted and this rose to 96% in 2012-13. The number of individual contacts with service users also rose during this period from 24,198 to 29,31l although the average duration of the service fell by one day from 38 to 37 suggesting a higher intensity service is now being delivered i.e. more contacts over fewer days.

The number of whole time equivalent staff engaged in delivering the service has been boosted from 48.65 in 2011-12 to 55.51 in 2012-13 with further investment in 2013-14 to facilitate seven day working. Performance data for the service shows that on average 85% of service users are able to continue to live independently after receiving re-ablement.



A range of other re-ablement services have been trialled during 2012-14 with the aim of supporting an increasingly diverse range of service users in less traditional ways, for example through the delivery of home safety checks prior to hospital discharge, extended practical support in the home post discharge and bespoke step down units in community settings (refurbished and adapted social housing stock). Re-ablement support has been delivered to younger people, people with problematic drug/alcohol use and non-weight bearing service users via these innovative pilots.

The Care Act which received Royal Assent on 14th May 2014 places evermore attention on providing help for people who fund their own care. We are aware that, as a Council, we will need to review our activities in the near future to ensure that people who self-fund make the right choices at the right time to make best use of their resources. Our early analysis shows that due to proposed changes to financial eligibility thresholds for care and a more generous care cost cap, more people are likely to fall into eligibility for social care. This, alongside a broader offer to carers will impact both on the volume of assessments the Council will need to offer and the share of market provision we will need to secure.

The Association of Directors of Adult Social Services (ADASS) has developed a financial model to assess the likely impact of the Act on local authority finances. The model uses current demand information to project the potential financial picture at the point at which the full impact is felt, thought to be 2019.

Overall estimates have been made to inform the strategic planning process however, such early estimates should be treated with caution as they are constrained by a number of factors:

- Availability and accuracy of information, particularly in relation to people who currently fund their own care
- Lack of final guidance from central Government, due in November 2014
- Unknown market response to Care Act as it comes into force
- The potential behaviour of service users and carers
- Flaws in modelling tools

The model is premised on two elements:
The care cap - the amount an individual will have to pay towards their own care before social services has a duty to fund them
Threshold changes - the income and capital an individual may keep, below which amount social services must pay for their care

In B&NES it is estimated that these key changes will have limited impact on services for older adults until 2019. However, it is estimated that the council will see a potential loss of income in relation to younger disabled adults i.e. the financial changes will mean that social services becomes responsible for funding the care needs

of younger disabled adults to a greater extent than is currently the case and as a result income from charging for services is likely to be forfeited.

A third significant element of the Act will be the **Deferred Payment Scheme** under which recipients of social services will be able to set the value of any property they own against the cost of their care. The immediate cost of care will be met by the local authority, potentially resulting in financial flow issues as well as changes in the administrative arrangements to manage the scheme.

It also recognised that the volume of requests for both service user and carer assessments will increase significantly and that the provision of social care services to carers is also likely to increase given the broader definition of eligible carers signalled by the Act. Carers assessments could potentially increase by as many as 2998 based on current rates with the provision of services increasing by as many as 330 additional care packages or direct payments.

Providers should anticipate a potential increase in demand for services such as replacement care however it is challenging at this stage to estimate the likely scale of this. Contractual arrangements with carers' services and with a range of other providers will be reviewed as required as the new legislation is enacted.

In summary, it is anticipated that the changes brought about by the Care Act are likely to result in additional cost pressures on the Council in the region of £2.4m, some but not all of which will be met by new burdens funding from central Government.

We have identified the need to develop the market in a number of service areas, building on existing good practice and mainstreaming models of care & support that we have already tested. The redesign of our adult social care pathway means we will be placing much greater emphasis on short term services which promote people's recovery and less emphasis on longer term packages of care which may create dependency.

A large proportion of community health and social care services in B&NES, including professional services such as community nursing, re-ablement and social work are delivered under contract by Sirona. A major priority for commissioners at the time of writing is to clarify more accurate timescales for the re-procurement process and to establish which service elements within the current contract will be re-let. The outcome of early discussions will have significant bearing on commissioning intentions for the wider care market in B&NES across all areas including residential, domiciliary, community and voluntary sector provision.

In the meantime, our current commissioning priorities are outlined below:

Complex Nursing & Dementia Care Beds

Whilst demand for standard residential beds is declining, we are experiencing increasing difficulty in securing a sufficient volume of complex nursing and dementia nursing beds within our care home sector in B&NES. If we continue to see demand pressure at the same rate as presently, accounting for demographic growth and duration of placements, we estimate that we will require between 75 to 120 additional placements over the next five years.

Providers will need to consider the physical suitability of care home premises as well as any registration and staffing requirements to be in a position to respond to market demands. Models of provision will need to be flexible enough to support service users with the following conditions and presentations:

- Progressive and degenerative conditions such as Motor Neurone Disease, Parkinson's Disease, stroke, heart conditions and dementias
- Complex and/or challenging behaviour associated with a range of dementias or acquired brain injury
- Intensive nursing needs to maintain skin and tissue viability
- Bariatric care

Domiciliary Care Services
As the care and support needs of people supported to remain in the community become more complex, the domiciliary care market will need to respond accordingly. As well as a shift in culture and practice towards the delivery of active re-ablement support, providers will need to further develop and increase their specialisms in the following areas:

- Dementia care
- End of life care
- Support with complex health packages e.g. managing long tern neurological conditions

Providers are also likely to need to adapt to different ways of delivering their services for example offering localised, patch based interventions in specific geographical areas (rural support model), offering low level enabling services (independent living model) and managing Personal Budgets on behalf of service users (Individual Service Fund model).

Despite the recent downward trend, with a focus on increased specialism of provision we anticipate that demand for domiciliary care services will rise steadily over the next five years. This will be partly in response to changing models of service delivery which aim to avoid the need for traditional residential care and support people to live as independently as possible with interventions from re-ablement services wherever possible. Based on these trends we estimate that we will require additional hours of domiciliary care over the next five years and we would also like to see the market for Personal Assistants grow in order to offer greater flexibility and more personalised services to service users and carers

Re-ablement & Rehabilitation
Our existing integrated re-ablement model is set to expand with additional investment from the Better Care Fund in 2015/16, with investment in 2014/15 by the Council to enable early implementation. Our intention is to provide a short term, intensive period of re-ablement to anyone who has clearly defined rehabilitation potential or appears to be in need of social care services. The model of service delivery we are building on comprises three main components:

- Integrated health & social care assessment leading to an integrated re-ablement plan, contributing to onward assessment (where appropriate) for longer term care
- Partnership with domiciliary care strategic partners
- A range of settings for re-ablement including bespoke step down units, non-weight bearing beds in care homes and ‘at home’ as well as in-reach re-ablement into care homes and extra care schemes

In order to deliver our expanded vision for integrated health & social care re-ablement we will rely strongly on our domiciliary care strategic partners to work collaboratively with Sirona to provide a seamless service to users. We anticipate that the service will receive in the region of 6000 referrals per year and will require domiciliary care capacity up to the equivalent of 48 full time re-ablement workers.

Domiciliary care staff will be required to work in a different way to deliver re-ablement care and support plans and this is likely to have an impact on the volume of longer term packages of care that we commission. Staff will need to be trained and supervised to shift their thinking and practice from ‘caring for’ towards re-abling.

THE PUBLIC AND PATIENT VOICE

Service users have indicated, particularly in relation to end of life support, that we could improve how things work in the following ways:

- Make it easier for people to access a hospital bed at home to help with the delivery of end of life care
- Make it easier to access night care at home for people who are near the end of their life
- Improve the clinical skills and investment in training and support for care staff

- Make it easier to access continence pads
- Make it easier for families and carers to have a say about their loved ones' end of life
- Build the confidence of care staff so unnecessary admissions to hospital can be avoided towards the end of a person's life

ASSESSING PERFORMANCE

The Adult Social Care Survey and Carers survey provides feedback on both service performance and service user satisfaction on a range of social re related issues.

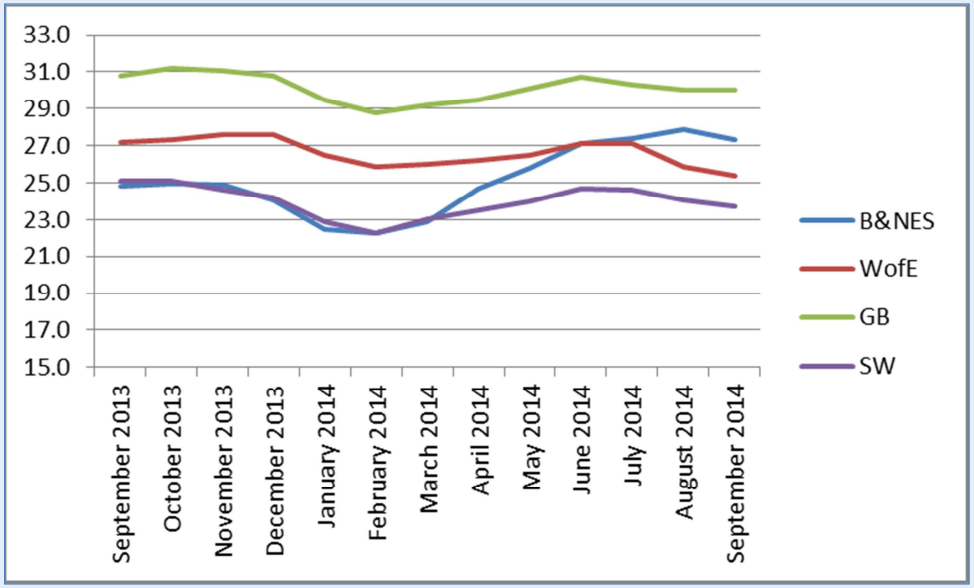
	2011/12	2012/13	2013/14	Trend / RAG rating	Notes
1A - Social care-related quality of life	18.7	18.8	19.3		Not a percentage, maximum score 24
1B - Proportion of people who use services who have control over their daily life	76	78.2	80		
1C(1) - Proportion of people using social care who receive self-directed support	47.4	51.3	56.3		
1C(2) - Proportion of people using social care who receive direct payments	12.6	14.9	17.4		
1D - Carer-reported quality of life		8.5			From carer survey 2012/13, no surveys in 11/12 or 13/14
1I - Proportion of people who use services and their carers, who reported that they had as much social contact as they would like	49.3	45.7	46		
2A(2) - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	973.2	970.8	896.4		Figures for 2013/14 provisional as using projected population estimates for mid-2013
2B(1) - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service)	93.9	86.2	86.3		

2B(2) - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (offered the service)	2.1	3.2	3.8		Indicator for 2013/14 provisional as it has been calculated using available HES data 2012/13
2C(1) - Delayed transfers of care from hospital per 100,000 population	12.7	12.3	10.8		Indicator for 2013/14 provisional, calculated by NP from data available on NHS website
2C(2) - Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	4.7	6.8	5.8		Indicator for 2013/14 provisional, calculated by NP from data available on NHS website
3A - Overall satisfaction of people who use services with their care and support	63.1	63.2	66		
3B - Overall satisfaction of carers with social services		47.6			From carer survey 2012/13, no surveys in 11/12 or 13/14
3C - Proportion of carers who report that they have been included or consulted in discussion about the person they care for		70.4			From carer survey 2012/13, no surveys in 11/12 or 13/14
3D - Proportion of people who use services and carers who find it easy to find information about services	73	74.8	78		This is the social care client component only for 2011/12 & 2013/14. Only 2012/13 value has the combined client and carer survey values
4A - Proportion of people who use services who feel safe	68.3	65.1	70		
4B - Proportion of people who use services who say that those services have made them feel safe and secure	75.2	78.5	82		

JHWS Priority	Improve skills, education and employment
Outcome	Improve skills, education and employment
Officer lead	Benjamin Woods, Group Manager - Economy & Culture, Skills & Regeneration
HWB member lead	Bruce Laurence, Director of Public Health, B&NES Council

THE BIG PICTURE

Bath and North East Somerset has managed to weather the storm of the economic crisis of 2008 and the following recession. Unemployment is now below 1%, which is its lowest point since May 2008. This is encouraging but there are still levels of long term benefit claimants that represent a resident group experiencing ongoing barriers to entering the labour market. There are issues with lower levels of growth compared to the rest of the region and resident wages remain below national comparators (2% lower). This is especially concerning when compared to average house prices being over 40% higher than the national average.



Health inequality
The graph shows those claiming JSA over 12 months as a % of all claimants in B&NES. Over the last 12 months the proportion of those claiming over 12 months has fluctuated but has remained on a steady increase to a level above the West of England and the South West. **(NOMIS Claimant count age and duration Oct 2014.)**

DELIVERING THE PRIORITY

The B&NES Economic Strategy was approved by Cabinet in September 2014, this is split into three themes; Place, Business & People. The People theme concentrates on the provision of employment and training for local residents and has a sector focus on the Core sectors of Health Care, Hospitality, Retail & Tourism. There is also a focus on improving the provision of Targeted, Recruitment & Training through the planning and procurement process.

THE PATIENT AND PUBLIC VOICE

There is ongoing feedback from employers that young people are not equipped with the right vocational skills in the work place to meet their business needs. Increasingly qualifications are becoming viewed as secondary to the ability to operate competently in the work place. This is also reinforced by the reported lack of available labour force in construction and production engineering/ manufacturing.

This is also further supported by a recent Business West Business Survey suggested that 66% of employers found difficulties recruiting suitably skilled staff and a low percentage believe that school leavers (7%), college leavers (17%) and the long term unemployed (6%) are well prepared for work. The survey also found that this

difficulty in recruiting was one of the top three barriers to growth.

The local care sector has also reported through a work force development event in July that there are increasing issues in both recruiting and retaining staff with the necessary personal skills to deliver a quality care provision.

ASSESSING PERFORMANCE

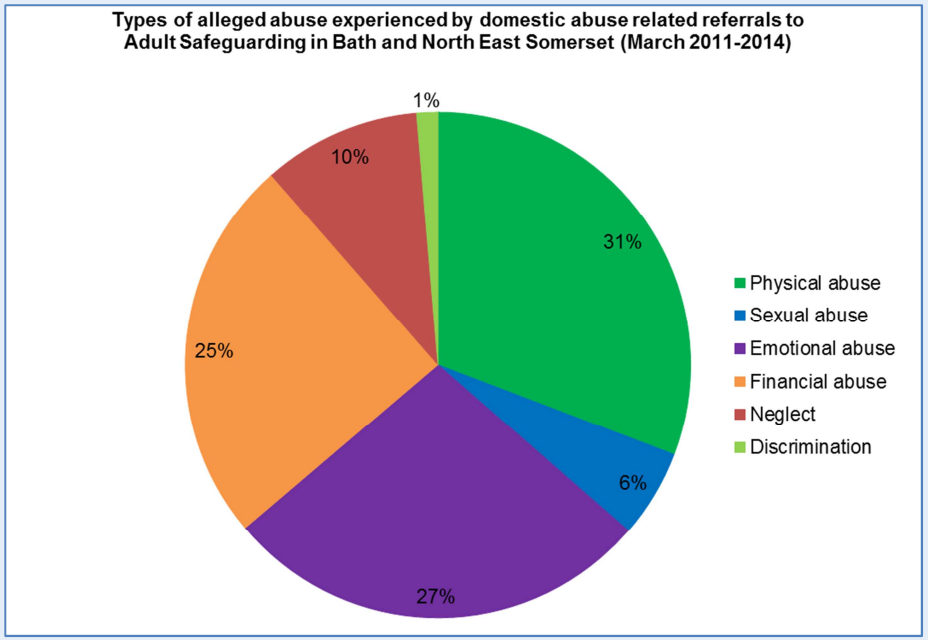
- Economy and Culture quarterly performance report Total Number of Apprenticeship Starts in the Council and through planning and procurement. 2014 – 2015 target 20 – Q1&Q2 on target with 7 starts.
- S106: Purnell residential development – 12 x work experience placements (with CSCS card provision) and 1 x Apprenticeship start. BWR 3 year training and employment programme complete with 10 x apprenticeships engaged
- Procurement: Keynsham Town Hall development – 2 x apprenticeship starts and 1 x placement for child leaving care. Undercrofts – 10 x work experience placements included in developer agreements
- Core Sectors: Care workforce development event July 2014 attended by over 30 local care providers, has led to the development of a Care Sector Based Work Academy

JHWS Priority	**Reduce the health and wellbeing consequences of domestic abuse**
Outcome	**Reduce the health and wellbeing consequences of domestic abuse**
Officer lead	**Andy Thomas, Group Partnership Manager - Strategy and Performance (B&NES Council)**
HWB member lead	**Cllr Paul Crossley, Leader of B&NES Council**

THE BIG PICTURE

- **£17m** – the estimated cost of domestic and sexual abuse to public services in B&NES
- An estimated 5,936 women aged 16-59 in B&NES will have been a victim of domestic abuse in the past year

Health inequality
There is a "rich picture" of information about this issue locally available in the **Domestic Abuse** section of the JSNA. Estimates suggest women who suffer from ill-health and disability in Bath and North East Somerset are almost twice as likely to experience domestic abuse as those who do not. The main health and vulnerability issues affecting the referrals to Adult Safeguarding linked with domestic abuse in Bath and North East Somerset between March 2011 and March 2014 is set out in the diagram.



THE PATIENT AND PUBLIC VOICE

We involved SEEDS, our domestic abuse survivors' group in recent workshops to co-design new services. From listening to survivors, we have learnt that:

- It is hard to take the first step and tell someone about what they are going through
- Victims would most prefer to receive support from Doctors amongst any professional but nationally only 15% of victims have any reference on an NHS care record
- IDVAs are highly valued in creating a "seamless journey"
- Victims value a range of different ways of reporting domestic abuse

The Health and Wellbeing network also held a workshop on this issue in January 2014 and the meeting notes can be found **here**.

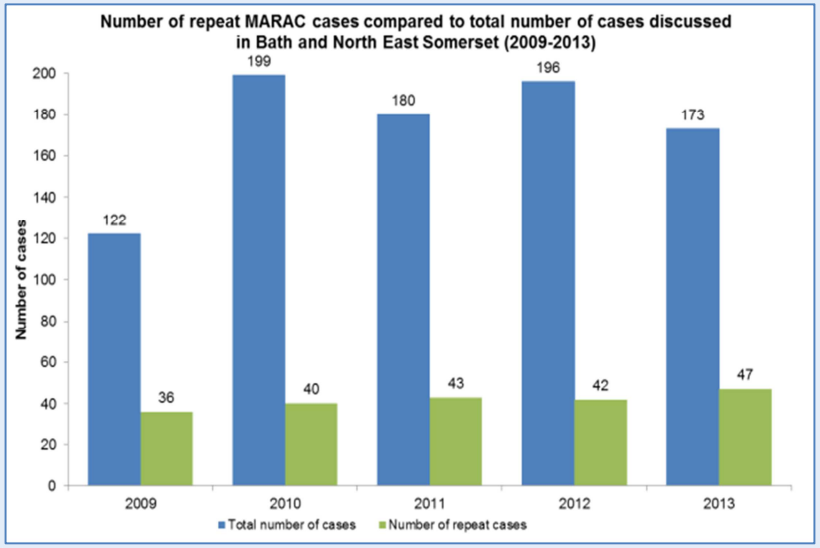
DELIVERING THE PRIORITY

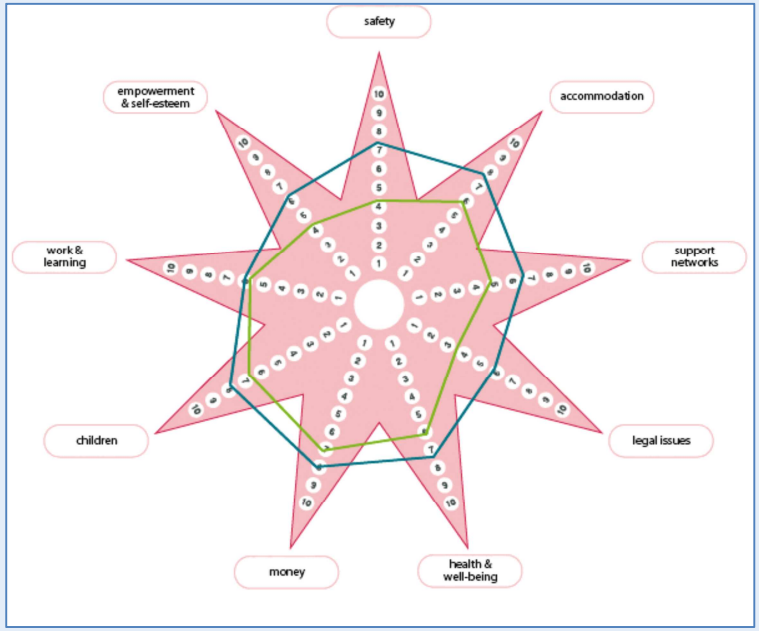
- A summary of existing provision can be found in the **report** on this issue to the January 2014 Board. Our work through the Public Service Transformation Network has highlighted that there are effective services for "high-risk" victims through the MARAC and IDVA services.

- A key challenge however is helping “low to medium” risk victims as well as those who are likely to underreport. Victims of domestic abuse would prefer to be able to disclose to their GP and want them to have the confidence to offer support to those patients who they believe are or have suffered domestic abuse. Conversely GPs and other health professionals report their lack of experience and skills in identifying and responding to domestic abuse.
- The IRIS (Identification and Referral to Improve Safety) project addresses this through a clear pathway from GPs to domestic abuse services. CCG and PCC funding has been brought together to commission IRIS. IRIS will begin operating in November 2014. In addition:
- The new Avon and Somerset-wide “Lighthouse” project aims to improve services for victims of crime, and includes all victims of domestic abuse in its “enhanced” service. Bath & North East Somerset has taken the lead on a cross-Avon and Somerset bid to central government for more early intervention services for victims of domestic abuse, linked to the Lighthouse.
- Bath-based **Voices UK** has been founded by women who have experienced Domestic Abuse. It provides peer support and recovery programmes for women who are experiencing or have experienced Domestic Abuse and is a platform for enabling voices of victims and survivors to inform and improve service provision in response to their needs. The MATES project is designed and led by women survivors of Domestic Abuse to give other women with similar experiences the chance to meet & support each other
- Work is taking place to align commissioning for domestic abuse related services across the Council
- It has been agreed that the Bath & North East Somerset MASH will include domestic abuse

ASSESSING PERFORMANCE

- The key national indicator has historically been MARAC (multi agency risk assessment conference) repeats. We also monitor the number of domestic violence incidents and work with the Police to identify trends. Reporting across Avon and Somerset area has increased and there is some evidence that this is linked to efforts being made to address under-reporting.
- We are increasingly also able to measure the outcomes for people we help using the “outcomes star”.





JHWS Priority	**Increase the resilience of people and communities including action on loneliness**
Outcome	**To be agreed jointly with Public Services Board "everyone has a good network" theme**
Officer lead	**Andy Thomas, Manager Partnership Delivery- Strategy and Performance (B&NES Council)**
HWB member lead	**Pat Foster, Healthwatch B&NES representative**

THE BIG PICTURE

- **3,000** estimated additional residents aged over 75 in our area by 2021
- **38%** projected increase in over 95s over the same period
- **37%** percentage defining themselves as "single"- higher than regionally and nationally

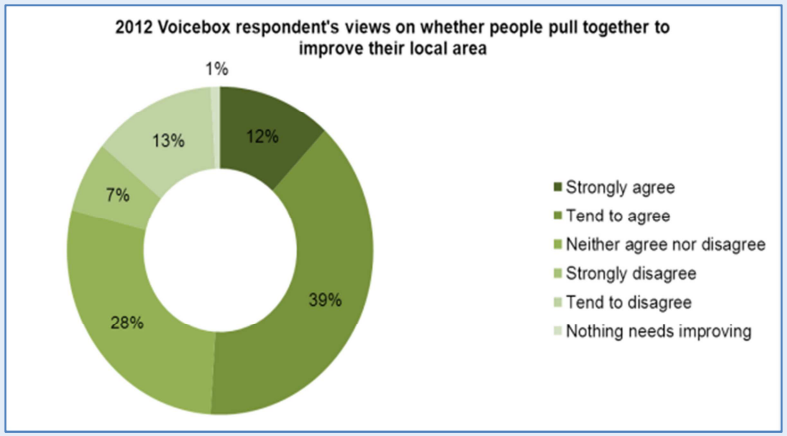
Health inequality

The Health and Wellbeing Board at a recent meeting noted a number of risk factors identified with loneliness, including age and living in rural communities. A recent study by the International Longevity Centre (ILC-UK) and the charity Independent Age noted that there was a particular risk for older men who - the research suggests - are often reluctant to take part in activities designed for older people.

THE PUBLIC AND PATIENT VOICE

"Now I've been to the Village Agents Roadshow and seen the support on offer, it's given me confidence about staying put"

- It is important to distinguish between isolation and perceptions of loneliness and involvement in social networks. We have therefore commissioned research in Bath & North East Somerset (using the international "Duke Scale") so that we can better identify the issues across our area.
- The Health and wellbeing Network at a session in July highlighted a number of key issues including the need to focus on the "quality" of face-to-face relationships between public services and isolated individuals. The notes of the meeting can be found **here.**
- We are also starting to measure the resilience of our communities e.g. our Voicebox highlights that that information about local services was the main mechanism that respondents stated might help them improve things in their local area (35%)



DELIVERING THE PRIORITY

- A summary of existing provision – ranging from befriending schemes to the "Hub in the Pub"- is set out in the **report** to the Board in July. This priority also draws on a range of projects and workstreams which have focused on building stronger communities. In

particular, the Connecting Communities programme aims to build resilience in localities and help communities to help themselves by using all of the capacity available in local communities. The Supporting People and Communities team have identified 81 contracts that help deliver this outcome

- The key challenge in delivering this priority is identifying gaps in provision and bringing together a disparate range of services. In addition, funding for key schemes such as Village Agents is not secure (funding for the Village Agents scheme ends in April 2015)
- A working group is being established to link together a variety of commissioning frameworks. However, "on the ground" projects that deliver what people want are essential. For example, on 1st October Age UK B&NES's Men's Event marked Older People's Day. Hosted at the Bath Cricket Club, the day featured a speech from former England and Bath rugby player Nigel Redman. The event was organised to give Age UK B&NES the opportunity to hear first-hand from men in our area about what sorts of events they would want to be involved with. The results of this are set out below:

ASSESSING PERFORMANCE

The Campaign to End Loneliness has awarded a "Gold" standard for our Joint Health and Wellbeing Strategy - one of only 11 to be awarded it.

150 - number of local volunteers for Age UK B&NES

20 Parishes with Village Agents