your care
your way

Making Plans

Consultation document
Phase Two

Let's plan community services together





Bath & North East Somerset Council

NHS
Bath and North East Somerset
Clinical Commissioning Group

Contents

1. Foreword

Recent policy changes and guidance – including the NHS Five Year Forward View, the Better Care Fund and the Care Act 2014 - have given permission to commissioners in both health and social care to explore ways of doing things differently. Both nationally and locally there is renewed interest in finding new ways to genuinely integrate services to deliver better models of care and support in the community.

The ***your care, your way*** review has brought together a wide range of stakeholders from all parts of our health and care system to identify the best way to deliver services that are truly integrated and person-centred. Our services will need to be resilient and adaptable, not only to address the significant challenges we face but to drive lasting and sustainable improvements for our community. Our success will ultimately be measured by the delivery of improved health outcomes and reduced health inequalities that give us confidence that everyone in Bath and North East Somerset has the support they need to live happier and healthier lives.

Your feedback has shown us that individuals, families and communities will benefit if we can reduce the current barriers to efficient service delivery; if services are focused on prevention and tailored to meet individual care and support needs; and if they are commissioned in a way that will stand the test of time. We need continuous transformation in a dynamic and developing environment to ensure that services continue to meet the individual's needs within a time of financial austerity.

The key to any successful transformation of services rests with the strength and maturity of the relationships between us all – between individuals, services, commissioners and providers. The proposals set out in this document will take time to achieve and must be continually nurtured by those commissioning and delivering services and by the people who use them. We want to build, together, a model which will provide trusted, compassionate and responsive services that people recognise as truly personalised in their approach to meeting people's needs.

We urge you to actively participate in this consultation which has the potential to deliver dramatic changes to the way that health and care services are provided in your local area. Please discuss it with your family, friends and colleagues so that as many people as possible have the opportunity to influence the future of their local services.

Dr Ian Orpen, Clinical Chair,
NHS Bath and North East Somerset Clinical Commissioning Group

Cllr Vic Pritchard, Cabinet Member for Wellbeing,
Bath & North East Somerset Council

2. Executive Summary

your care, your way is a bold and ambitious review of community health and care services for children, young people and adults* being carried out jointly by Bath & North East Somerset Council and NHS Bath and North East Somerset Clinical Commissioning Group (BaNES CCG).

Following a seven month period of engagement with a wide range of stakeholders across Bath and North East Somerset, this consultation document sets out our draft proposals for the future of community health and care services from 1 April 2017.

Every aspect of this document has been influenced by the hundreds of conversations that have taken place with our stakeholders since the review was launched at Bath Assembly Rooms on 29 January 2015. In Phase One of the review, we actively sought out the views of patients, service users, carers, clinicians, commissioners and providers and their feedback is summarised in the Phase One Report: 'The Story So Far'.

The publication of this consultation document marks the beginning of Phase Two as we continue to be proactive in reaching out to all our stakeholders to capture their thoughts on the models and ideas we are putting forward.

It is now widely recognised that health and care services both locally and across the country cannot continue to operate in the same way they have done in the past. Our population is ageing, the number of people living with long term conditions is increasing and the demand for health and social care services is growing fast - all at a time of financial austerity.

Our response is to offer you a choice of four potential models for the delivery of community health and care services in the future. Two of the models are not too dissimilar to the current arrangement of services and are based around specific conditions such as diabetes or specific functions like discharge from hospital. The other two models would require a more radical transformation with services either clustered around GP-led Wellbeing Hubs or delivered within local neighbourhoods. Your views may help us to clarify and confirm the model that is right for us or to develop an alternative model that might combine elements from some or all of these in order to achieve the best outcomes for our population.

Whichever direction we take, there are some core values that we believe to be vital to a sustainable future for the local health and care system. We will explore opportunities to develop a single pooled budget across health and social care. We will expect these services to be person-centred and fully integrated with a primary focus on prevention and maximising independence. We will utilise the latest technology to ensure that there is a single care plan for every person that can be easily shared between everyone involved in that person's care. We will invest in new services that support people to navigate through the complex web of services and we will tackle social isolation by building the capacity of our volunteers, community groups and voluntary, community and social enterprise organisations.

To ensure that the ***your care, your way*** review delivers real lasting change for local people we will measure the success of community health and care services using a set of physical and emotional outcomes based around the nine themes identified during Phase One of our review. These outcomes are detailed on page 29

We hope that the ideas put forward in this document will inspire and challenge you to think differently about the way that we provide health and care services in Bath and North East Somerset. The consultation period is open until Friday 30th October and we hope you will encourage as many people as possible to complete the feedback survey.

The results of the consultation and our final business case will be presented to the Council Cabinet and CCG Board for approval in December before we begin the process of identifying which organisation(s) will be awarded the contract to provide the new model of community services you have asked us to deliver.

* The term "people" used throughout this document refers to children, young people and adults

3. Listening to you

Phase One – Engagement

From the very beginning, the ***your care, your way*** review has been about understanding the experiences of our stakeholders and listening to their ideas for improving services and delivering better outcomes for our local population.

Our launch event at Bath Assembly Rooms on 29 January 2015 was attended by over 200 people and we have taken part in events every week since then. Over 1,000 people have been participated in the review so far through meetings, surveys, social media and the ***your care, your way*** website. Highlights of the outreach work so far include the three Area Forum meetings in February, the Youth Parliament in June and the Design Day at Bath Racecourse in May where clinicians, carers, patients and service users sat together to plan how services could look in the future.

We have produced a summary report of every engagement event that we have attended and these can all be viewed at www.yourcareyourway.org. The feedback from all this work is contained in our Phase One report, 'The Story So Far' which is also available to download from the website. This report identified nine key themes that our stakeholders have asked us to address and in Section 8 of this document we set out some specific priorities for how we will tackle all nine of these issues.

Phase Two – Consultation

Having considered all of the ideas and suggestions received so far we have now reached the stage in the review where we would like to present to you our draft proposals for the future of community health and care services in Bath and North East Somerset.

There are three key elements in this document that we would like you to consider carefully, discuss with your family, friends and colleagues and then share your views with us:

- One shared vision for all community health and care services (see p12)
- Four potential models for the organisation of services (see p13)
- 14 priorities in response to the key themes identified in Phase One (see p29-40)

The consultation will run for a period of just over seven weeks from 5pm on Thursday 10 September 2015 to 5pm on Friday 30 October 2015

Your views will be used to help us refine and develop the options we have put forward and will be given careful consideration by the Council and the CCG as we develop our final business case and further develop the models of provision with potential service providers.

How do I take part in the consultation?

In order for us to analyse and understand the level of support for the proposals set out in this document we will be encouraging as many people as possible to complete a short survey to share their views on the shared vision, the four models and the 14 priorities.

The survey can be found online at: **www.yourcareyourway.org** or you can request a hard copy by calling **01225 396512**.

There are also a number of events being held during the consultation period across the Bath and East Somerset area where the proposals will be presented in detail and you will have the opportunity to ask questions to of the project team.

17	**September**	**2pm**	**BaNES CCG AGM**	**Guildhall, Bath**
29	**September**	**7pm**	**Bathavon Area Forum**	**St Gregory's School**
30	**September**	**7pm**	**Keynsham Area Forum**	**Fry's Club, Keynsham**
6	**October**	**7pm**	**Somer Valley Area Forum**	**Beacon Hall, Peasedown St John**
15	**October**	**7pm**	**Chew Valley Area Forum**	**Chew Valley Secondary School**

If you would like to attend any of these events or you would like to invite us to attend a meeting of your local group or organisation then please get in touch using the contact details on the back cover of this document.

Making sure no-one is left behind

We have carried out an Equalities Impact Assessment (EIA) which can be found on the ***your care, your way*** website or can be provided in printed form on request.

The EIA outlines how the Council and the CCG have gathered evidence about groups with protected characteristics and people who may face inequalities. These inequalities could relate to accessing services or health outcomes.

The EIA contains an assessment of the potential positive and negative impacts of the proposals on each of these groups and considers how the proposals for the reconfiguration of services for older people could be amended to improve the experience of people with protected characteristics or those people who may face inequalities.

This assessment will continue to evolve throughout the review and will be informed by feedback from all the groups who may be affected by the proposals. We will be carrying out targeted outreach work throughout the formal consultation period to ensure that the voices of these seldom heard groups are represented clearly and fairly.

4. The case for change

The Council and the CCG work together to plan, pay for and monitor health, care and support services for everyone in Bath and North East Somerset. We are facing a challenging time. Our population is ageing, the number of people living with long term conditions is increasing and the demand for health, care and support services is growing. At the same time, our community expects services to be more personalised and joined-up.

Community health and care services need to adapt and thrive in the face of these significant challenges ahead. The age demographic and associated complexity of need, coupled with increasing quality requirements and financial austerity all signal the need for change. Community services will need to become a driving force for an important shift in emphasis towards prevention and self-care with more care and support delivered in people's homes or their local communities.

We are proud of our reputation for successful partnership working in Bath and North East Somerset. Much has already been achieved in terms of integrating both service delivery and commissioning but we want to be bolder. We need to implement new models that dissolve the boundaries between primary care, community services, hospitals, social care, mental health services and the voluntary, community and social enterprise (VSCE) sector.

We are committed to making the most of our combined skills, knowledge and experience for the benefit of our population.

Whilst life expectancy in Bath and North East Somerset is higher than regional and national averages, there are significant variations in life expectancy related to socio-economic inequality. In deprived areas, it is more common for people to be living with a number of health conditions and from an earlier age. Evidence suggests that prevention programmes from childhood upwards can prevent disease, improve physical and emotional wellbeing, slow disease progression and reduce demand for specialist services. Therefore, our approach is to ensure that services support prevention as well as help people to self-care, especially in areas of higher deprivation, and enable people to build on their individual and community willingness to connect and to take care of themselves and each other.

Services will need to respond better to people's needs, support healthy lifestyles, enable people to play more active roles in managing their own conditions, restore health and independence when conditions worsen and ensure that people are treated with respect and dignity towards the end of their life.

Providers will need to work more collaboratively with each other; working as equal partners and valuing each other's contribution. This could include forming joint ventures; becoming partners in alliance contracts; delivering care and support within devolved budgets or becoming partners within a formalised model of integrated service delivery. These new approaches will be essential for ensuring that our community health and care services are truly coordinated and person-centred with increasingly complex care needs being met by a range of professionals (and others) in, and near to, people's homes.

5. Where we are now

How are services currently organised?

Community services are those health and care services that are delivered in a person's home or in a nearby local care setting. There are 400 different community health and care services currently operating in Bath and North East Somerset, provided by over 60 different organisations, further details of these can be found in Appendix A.

The table below provides a summary of how these services are currently organised.

Community health and care services

- district nursing
- specialist nursing
- health visitors
- specialist foot care
- speech and language therapy
- occupational therapy
- rehabilitation
- specialist equipment services
- community resource centres
- social work
- respite and supported living care
- learning disabilities support
- end of life care
- community paediatricians

Community mental health services

- dementia services
- early intervention team
- recovery teams
- Talking Therapies Service
- floating support
- child and adolescent mental health services
- Intensive and home treatment teams

Expert outreach services

- specialist care and support
- drug and alcohol support
- substance misuse
- sexual health service
- specialist clinical services for diabetes, stroke, tissue viability etc

Prevention and self-care initiatives

- exercise on referral
- sexual health services
- telehealth support
- health visiting
- school nursing
- social prescribing
- lifestyle education and campaigns
- stop smoking service
- healthy weight support
- food and health service
- Wellbeing College

Support services

- advocacy and information services
- community transport
- village agents

Primary care services

- GP practices
- Dentists
- Pharmacists
- Optometrists

Scope

The services listed below do not fall within the scope of the ***your care, your way*** review. However, it is essential that the commissioning strategies for all these services are closely aligned to the outcomes of this review in order to support the transformational change that is required if we are to continue meeting the care and support needs of local people.

- Primary Care GP Services
- Pharmacists
- Dentists
- Optometrists
- Children's Social Care
- Care Homes
- Secondary Care

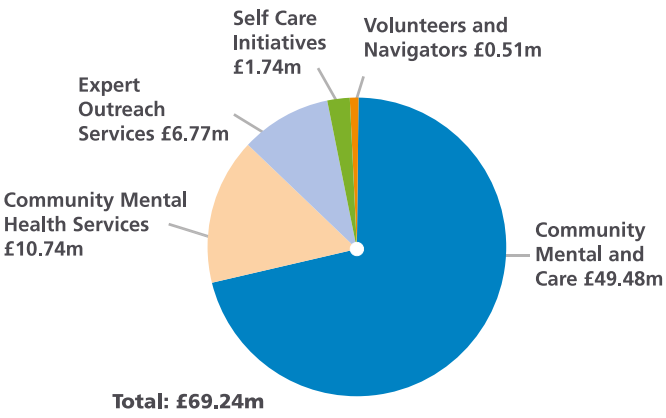
How much do we currently spend on community services?

In line with local strategic intentions and national policy, the CCG and the Council have set out a series of principles that underpin the provision of community services including:

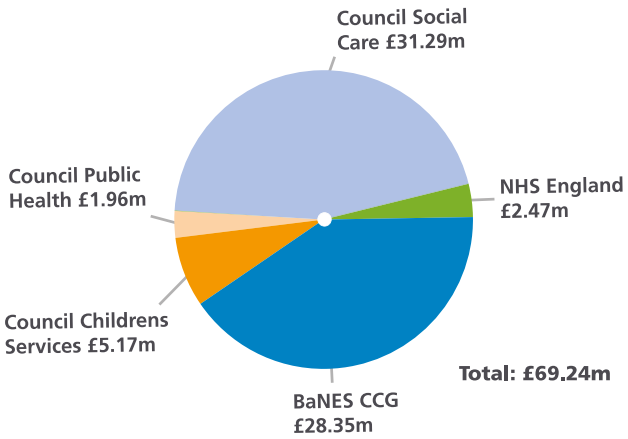
- **Value for money** – all services must be affordable and provide value for money in what will be a challenging economic environment.
- **Resource allocation** – all services must demonstrate that resources are appropriately allocated to address priority areas of need.

During Phase One of the review, our analysis and planning, included establishing, as clearly and in as much detail as possible, patterns and trends in expenditure and activity in respect of all current community services. The following pie charts show that across commissioning organisations we spend £69.24m annually on community services. The charts have shown this spend by care category and by commissioning organisation:

Annual expenditure by care category:

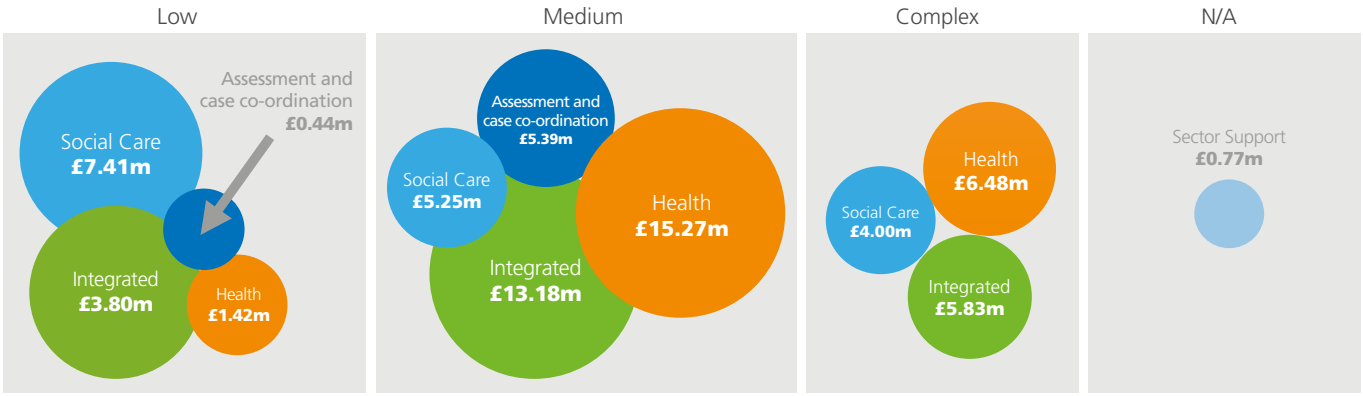


Annual expenditure by organisation:

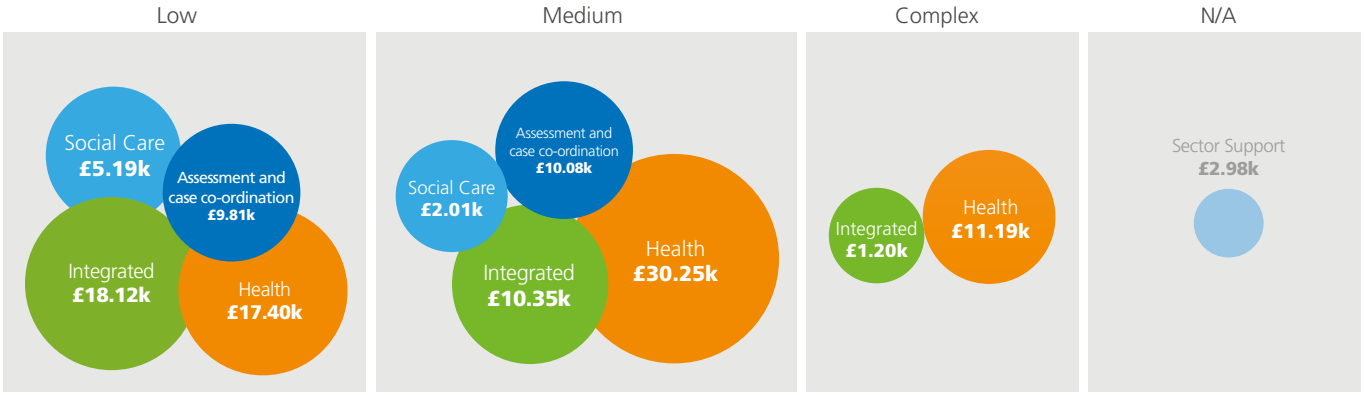


*NHS England figure includes Health Visiting for children aged 0-5, the responsibility for commissioning will transfer to B&NES Council Public Health from Oct 2015.

The following graph shows cost by type of care and level of need:



The following graph shows activity at a referral level across services where data is available:



This information has helped define the current funding envelope for community services and we have further refined and analysed this information in Phase Two. This has been and will continue to be an iterative process throughout Phase Two and Phase Three to reflect feedback from engagement and consultation and start to firm up the commissioning strategy, outcome-based service specifications and develop service models.

How might funding change in the future?

As the review progresses through Phases Two and Three, it is highly likely that both the CCG and Council will face further reductions in funding of public services arising from the Government policy and spending review. This will have to be taken into account as the envelope for funding service provision is finalised. The scale of the challenge will become clearer on the announcement of the Government's four-year plan to reduce public spending by £20bn which will be published on 25 November 2015. Communication on how these funding reductions impact the Council and the CCG will be addressed through our annual financial planning and contracting processes and further inform Phase Two and Three of the review.

Commissioners will work closely with providers to develop service models that reflect this funding envelope and align with the principles that all services must be affordable, provide value for money and demonstrate that resources are appropriately allocated to address priority areas of need.

We expect to see a shift of our resources into community and primary care services for both mental and physical health and care, aligning with our overall intention to provide more people with services in settings closer to home. As a consequence we expect that there will be fewer people treated in hospital settings. We recognise that providers may seek to expand into sectors in which they are not currently operational in response to the opportunities arising from redesigned pathways and investment.

6. Where we could be

Our vision

- Bath and North East Somerset will be a connected area ready to create an extraordinary legacy for future generations - a place with a strong social purpose and a spirit of wellbeing, where everyone is invited to think big.
- We will have health and care services in the community that empower children, young people and adults to live happier and healthier lives.
- Our services will provide timely intervention and support to avoid ill health, prevent social isolation and tackle inequalities. By placing the individual person at the heart of services, they will receive the right support at the right time to meet their needs and conditions.
- Dedicated to supporting greater levels of prevention and to help people self-manage their conditions, community services will ensure that clear routes to good health and wellbeing are available.
- Supporting people to access services when they are needed in as seamless a way as possible, navigators will assist individuals to access pathways of care and support.
- Services will be easy to access and will connect and integrate across acute, primary care, mental health and community service boundaries.

How will we get there?

Having listened to the feedback received in Phase One we have developed four potential models for the organisation of community services in the future. These are:

1. Services based on specific **conditions** e.g. diabetes, dementia, heart failure.
2. Services based on specific **functions** e.g. discharge, prevention, end of life care.
3. Services coordinated by **GP-Led Wellbeing Hubs** configured around clusters of local GP practices.
4. Services coordinated by **community-led Neighbourhood Teams** configured around the existing Area Forum areas.

Each of these four models presents opportunities and challenges for the future arrangement of services and for supporting the vision, the priorities, values and outcomes outlined in this document. The models have been developed in response to what people have told us they want and need from local services. They are not "done deals" and are simply intended to stimulate debate about what might be possible and to explore their relative strengths and weaknesses. The feedback from the formal consultation will then be used to further develop and finalise the models with providers and our community during Phase Three.

Some of the key differences between the four models would be reflected in the way that services are commissioned and delivered. We believe that there are attributes within each model that would improve outcomes for people and enhance opportunities for providers. Whichever direction we take;

- we will expect these services to be person-centred.
- we want fully integrated services with a primary focus on prevention and maximising independence.
- We will ensure that there is a single care plan for every person that can be easily shared between everyone involved in that person's care.
- we will invest in new services that support people to navigate through the complex web of services
- we will tackle social isolation by building the capacity of our volunteers, community groups and voluntary, community and social enterprise organisations.

Some elements of the models are similar to current service provision whilst others would be a bold and ambitious step forward for us all and would require significant change to the way we currently commission and provide services. By the end of the review, it is quite possible that the final model we agree together as a community may combine elements from some or all of these models in order to achieve the best outcomes for our population.

How will we measure success?

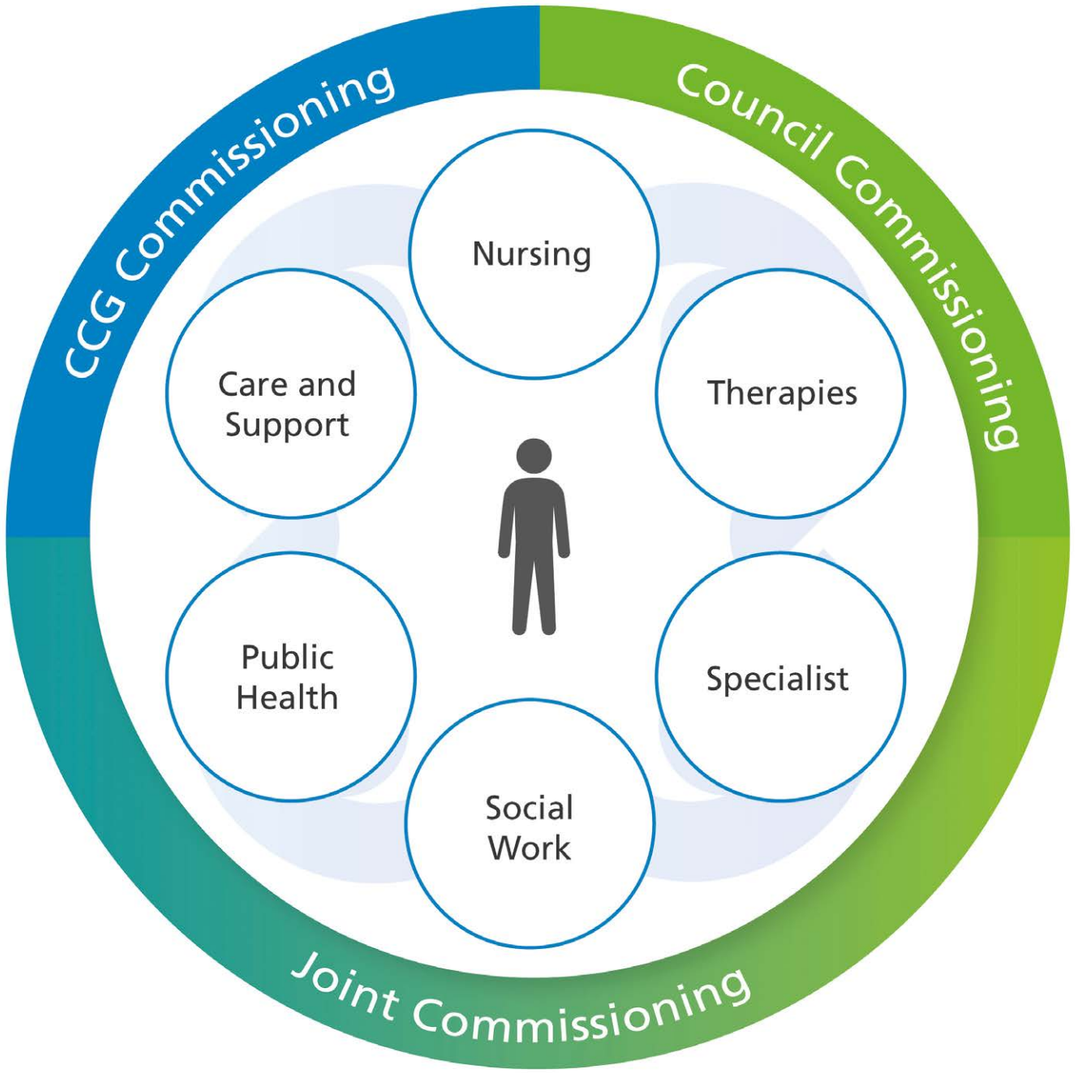
To ensure that the ***your care, your way*** review delivers real lasting change for local people, the Council and the CCG will be measuring the success of community health and care services using a set of physical and emotional outcomes based around the nine themes identified during Phase One of our review.

The most important outcomes are those that are important to everyone who uses community health and care services and their carers. These will be the priorities for us to embed across all health and care systems. Some are built into services already as part of previous and ongoing public engagement but we recognise there is always more that can be done to establish measures that enable us to monitor and evaluate outcomes including the quality, effectiveness and value for money of all services.

All services will contribute to the population outcomes which have been prioritised by the Bath and North East Somerset Health and Wellbeing Board and which are reflected in the Children and Young People's Plan.

To reflect our commitment to delivering personalised services we have mapped the Making It Real Markers for Change against the outcomes of the Health and Wellbeing Board as shown in Appendix C.

Current Model



How are services delivered?

- Community health and care services are delivered against a wide range of service specifications mostly based on activity levels with some services commissioned against outcomes.
- Most services have a model pathway and a set of indicators for measuring the outcomes for individuals and the performance of the provider(s) against that particular condition and the agreed pathway.

Who is in charge?

- Local operational leadership sits with the management team of each provider which is responsible for co-ordinating input and activity to deliver the contract for that particular service whilst ensuring appropriate governance, quality assurance and engagement with patients or service users.
- Currently, individual commissioning staff work with providers to manage performance and assure quality service provision. A number of commissioners work for both the Council and the CCG in a joint commissioning role. The Council and CCG have a Joint Commissioning Committee of services commissioned under a Joint Working Framework.

How are services funded?

- The Council and the CCG have pooled budgets for areas such as learning disabilities, Better Care Fund, and mental health but the majority of the money is held within separate NHS and Local Authority accounts.

Condition or needs-based model

How would services be delivered?

- Service specifications are based on provider activity in relation to specific conditions or needs e.g. diabetes, dementia, substance misuse, long term conditions, physiotherapy and heart failure.
- Each service has a model pathway and a set of indicators for measuring the outcomes for individuals and the performance of the provider(s) against that particular condition and the agreed pathway.

Who would be in charge?

- Services focussed on each condition or need would be coordinated by a Management Executive Board or Group made up of relevant providers which would be responsible for coordinating provider input and activity to deliver the outcomes for specific conditions or needs whilst ensuring appropriate governance, quality assurance and engagement with patients or service users.
- Each provider is represented by a senior manager on a Strategic Executive Group responsible for overseeing the delivery of services and accountable to the commissioner.

How would services be funded?

- A single budget is managed by the commissioner who contracts with providers independently of each other.
- Alternatively, a budget for each of the conditions or needs is devolved to an alliance or federation of providers working together that are contracted to deliver the specification for that particular condition or need.

What would the user experience be?

- I have a care and support plan that is designed to meet my particular condition or need.
- My care and support is co-ordinated by a named individual with expertise in my particular condition or need.
- I receive support from specialists with expertise and knowledge of my condition, who may work for the same, or different providers.
- If I have multiple needs I may be in touch with a range of staff who will each focus on providing care and support for a particular need/condition.
- If I develop additional needs I will be supported to develop an additional care and support plan for that particular condition/need.

Function-based model

How would services be delivered?

- Services commissioned to deliver each of the nine functions of community health and care services.
- Each function would a set of indicators for measuring the outcomes for individuals and the performance of providers against each of the functions.

Who would be in charge?

- Services focussed on each function would be coordinated by a Management Executive made up of relevant providers which would be responsible for coordinating input and activity to deliver the outcomes for their specific function whilst ensuring appropriate governance, quality assurance and engagement with patients or service users.
- Each provider would be represented by a senior manager on a Strategic Executive Group responsible for overseeing the delivery of services and accountable to the commissioner.

How would services be funded?

- A single budget would be managed by the commissioner who contracts with providers independently of each other.
- Alternatively, a budget for each function would be devolved to an alliance or federation of providers working together that are contracted to deliver the specification for that particular function.

What would the user experience be?

- I have a care and support plan that is designed to deliver services related to my need at a particular time.
- My care and support is coordinated by a named individual with expertise to deliver services according to the particular function of community services.
- As my needs change over time I will receive my care and support from different staff and/or providers according to the services I require.
- If I require support in more than one area at any given time I may be in touch with a range of staff who will each focus on providing care and support related to a particular function of community services.
- If I have a range of specific conditions my care and support will be coordinated to be delivered in line with my care and support needs at that particular time, and may be provided by a number of staff.

GP-led Wellbeing Hubs

How would services be delivered?

- Services would be coordinated by a GP-led Wellbeing Hub, configured around groups of GP practices serving a population of 30,000 to 50,000 people, and focused on delivering health and care outcomes.
- The Wellbeing Hub co-ordinates the services delivered by providers from different sectors e.g. social care, secondary care and voluntary, community and social enterprise (VCSE) organisations.
- Each Wellbeing Hub would be supported by the commissioner to undertake community mapping to identify the health and care needs of the local population and harness the strengths of the community to identify the most effective local response.
- The overarching service specification for the Wellbeing Hub would be set by the commissioner with separate service specifications agreed by the Wellbeing Hub for contracting with providers according to local need.

Who would be in charge?

- Each Wellbeing Hub would be managed by a Wellbeing Executive Group led by GPs which would be responsible for monitoring outcomes for the local population and for co-ordinating input and activity to deliver the contract for the Wellbeing Hub whilst ensuring appropriate governance, quality assurance and engagement with patients or service users.
- Each Wellbeing Executive would bring together senior representation from providers, primary care, secondary care, public services, voluntary community and social enterprise organisations and the local community (supported by subject matter experts) with the authority to commit spending on services tailored to their local community.
- A Strategic Executive Group would be responsible for high-level system leadership of the Wellbeing Hubs, ensuring effective coordination and collaboration between the hubs and promoting the sharing of best practice.

How would services be funded?

- A devolved commissioning budget to each Wellbeing Executive to commission health and care services on behalf of its population – accountable to the Commissioner.

What would the user experience be?

- I have a care and support plan that is designed to meet all of my needs in one overarching plan.
- My care and support is coordinated by a named individual working within my local Wellbeing Hub, who can bring together the specialist staff required to meet my needs.
- I am supported to access services in my local community delivered by local multi-disciplinary teams.
- If I have multiple needs then services to meet these can be delivered alongside each other within one plan, with people working as a team around me, coordinated by the Wellbeing Hub.
- The local multi-disciplinary team can respond flexibly to meet my care and support needs as and when they change using the local resources of community health and care services.

Community-led Neighbourhood Teams

How would services be delivered?

- Services would be coordinated by community-led Neighbourhood Teams configured around the existing Area Forum areas.
- Community health and care services would be delivered within a wider range of public services commissioned by the Neighbourhood Team and delivered in local communities.
- Each Neighbourhood Team would be supported by the commissioner to undertake community mapping to identify the needs of the local population and harness the strengths of the community to identify the most effective local response.
- The overarching service specification for the Neighbourhood Team would be set by the commissioner with separate service specifications agreed by the Neighborhood Team for contracting with providers according to local need.

Who would be in charge?

- Each Neighbourhood Team would be led by a Neighbourhood Executive including leadership from local health and social care services. The Neighbourhood Executive would be responsible for monitoring outcomes for the local population and for co-ordinating input and activity to deliver the contract for their area whilst ensuring appropriate governance, quality assurance and engagement with its community.
- Neighbourhood Executives would bring together senior representation from providers, primary care, secondary care, public services, voluntary community and social enterprise organisations and the local community (supported by subject matter experts) with the authority to commit spending on services tailored to their local community.
- A Strategic Executive Group would be responsible for high-level system leadership of the Neighbourhood Teams, ensuring effective coordination and collaboration between the teams and promoting the sharing of best practice.

How would services be funded?

- A devolved commissioning budget to each Neighbourhood Executive to commission health and care services within the wider commissioning of services on behalf of its population – accountable to the commissioner.

What would the user experience be?

- I have a care and support plan that is designed to meet all of my needs in one overarching plan.
- My care and support is coordinated by a named individual working within my local Neighbourhood Team, who can bring together the specialist staff required to meet my needs and has access to local community resources.
- Clinicians work within the Wellbeing Hubs work within the Neighbourhood Team to harness the strengths of the local community to help meet my needs.
- If I have multiple needs then services to meet these can be delivered alongside each other within one plan, with people working as a team around me. The Neighbourhood Team will support me to access a wider range of local, community based services and facilities.
- The Neighbourhood Team is able to help me find local solutions to meet my needs and to help self manage within my own community.

The following table summarises what the different models would be like for individuals.

Condition Specific	Function-led	GP-led Wellbeing Hub	Neighbourhood Team
I have a care and support plan that is designed to meet my particular condition or need.	I have a care and support plan that is designed to deliver services related to my need at a particular time.	I have a care and support plan that is designed to meet all of my needs in one overarching plan.	I have a care and support plan that is designed to meet all of my needs in one overarching plan.
My care and support is co-ordinated by a named individual with expertise in my particular condition or need.	My care and support is co-ordinated by a named individual with expertise to deliver services according to the particular function of community services.	My care and support is co-ordinated by a named individual working within my local Wellbeing Hub, who can bring together the specialist staff required to meet my needs.	My care and support is co-ordinated by a named individual working within my local Neighbourhood Team, who can bring together the specialist staff required to meet my needs and has access to local community resources.
I receive support from specialists with expertise and knowledge of my condition, who may work for the same, or different providers.	As my needs change over time I will receive my care and support from different staff and/ or providers according to the services I require.	I am supported to access services in my local community and delivered by local multi-disciplinary teams.	The Neighbourhood Team can harness the strengths of the local community to help meet my needs.
If I have multiple needs I may be in touch with a range of staff who will each focus on providing care and support for a particular need/ condition.	If I require support in more than one area at any given time I may be in touch with a range of staff who will each focus on providing care and support related to a particular function of community services.	If I have multiple needs then services to meet these can be delivered alongside each other within one plan, with people working as a team around me, co-ordinated by the Wellbeing Hub.	If I have multiple needs then services to meet these can be delivered alongside each other within one plan, with people working as a team around me. The Neighbourhood Team will support me to access a wider range of local, community based services and facilities.
If I develop additional needs I will be supported to develop an additional care and support plan for that particular condition/ need.	If I have a range of specific conditions my care and support will be co-ordinated to be delivered in line with my care and support needs at that particular time, and may be provided by a number of staff.	The local multi-disciplinary team can respond flexibly to meet my care and support needs as and when they change using the local resources of community health and care services.	The Neighbourhood Teams are able to help me find local solution to meet my needs, and to help me self manage within my community.

Model Summary

The key attributes of each model described above are summarised as follows:

Model	Current model	Condition or needs-based model	Function-based model	GP-led Wellbeing Hubs	Community-led Neighbourhood Teams
Service Delivery	Mostly based on activity levels with some services commissioned against outcomes.	Services based on specific conditions e.g. diabetes, dementia, heart failure.	Services based on specific functions e.g. discharge, prevention, end of life care.	Services coordinated by Wellbeing Hubs configured around groups of local GP practices.	Services coordinated by Neighbourhood Teams configured around the existing Area Forum areas.
Leadership	Commissioners performance manage and quality assure provision under the oversight of a Joint Commissioning Committee.	Condition or needs-based Management Executives overseen by multi-disciplinary Strategic Executive Group.	Function-based Management Executives overseen by multi-disciplinary Strategic Executive Group.	GP-led Wellbeing Executives overseen by multi-disciplinary Strategic Executive Group.	Community-led Neighbourhood Executives overseen by multi-disciplinary Strategic Executive Group.
Funding	Some pooling of budgets across health and social care.	Integrated budgets across health and social care.	Integrated budgets across health and social care.	Devolved commissioning budget to each Wellbeing Executive.	Devolved commissioning budget to each Neighborhood Team.

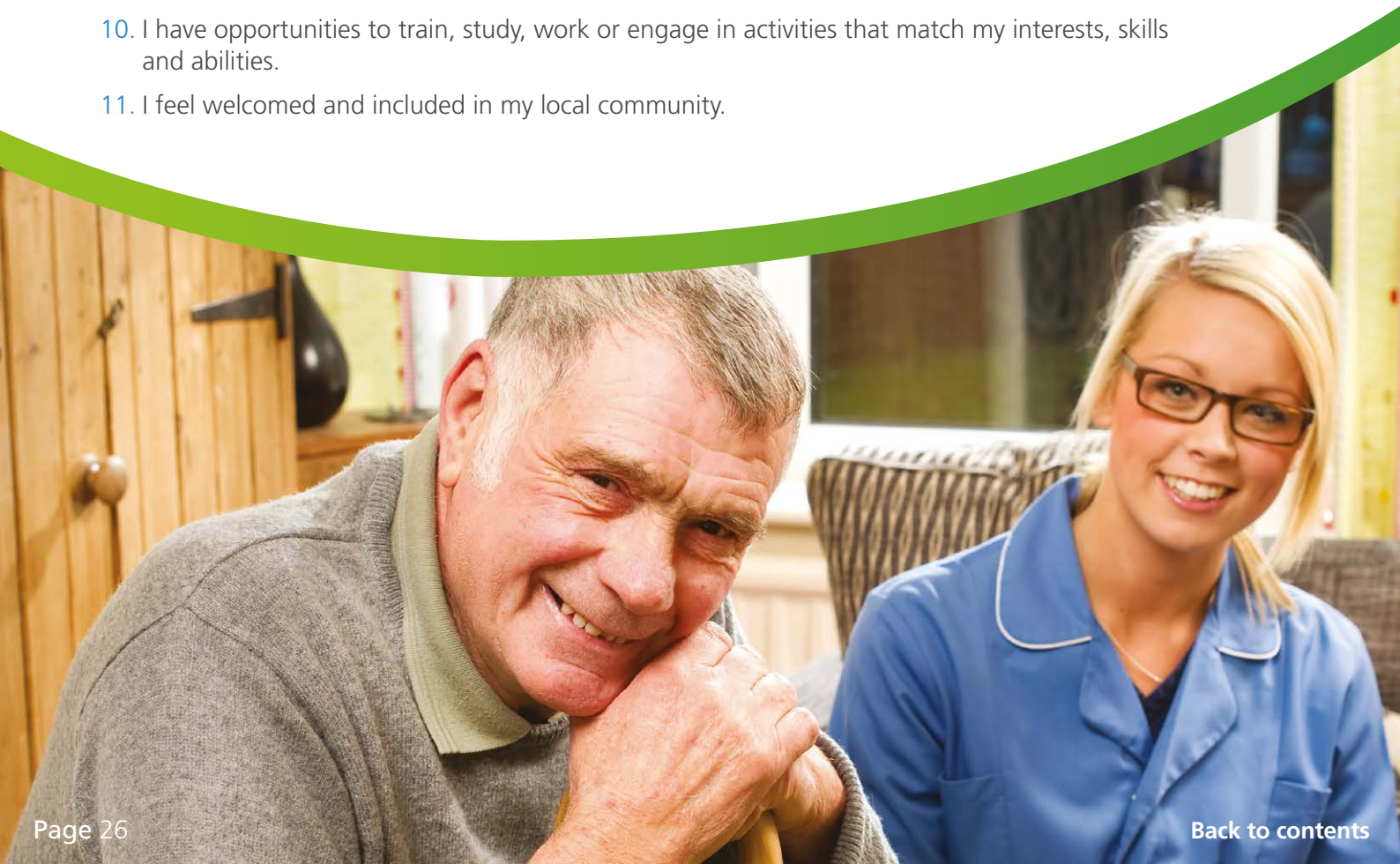
7. Our shared values

The feedback we have heard so far in this process has highlighted the need for all of us to play our part in ensuring that our communities are happy and healthy places to live. The Council, the CCG and the organisations we commission to provide health and care services in the community have a vital role in this but we also need individuals and their communities to take responsibility for looking after themselves and their family, friends and neighbours too.

The values listed below set out what every person should expect from community health and care services in the future, how the Council and the CCG will make this happen and our expectations of the organisations that will provide those services.

Individuals

1. I have access to a range of support that helps me to live the life I want and remain a contributing member of my community.
2. I am in control of planning my own care and can decide when, where and how to receive the support I need.
3. I know the amount of money available to me for care and support needs and I can determine how this is used (whether it's my own money, a direct payment or a managed personal budget).
4. I have a network of considerate and competent people who support me including carers, family, friends, neighbours, volunteers and paid support staff if required.
5. My support is fully coordinated so I only have to tell my story once and I know who to contact to get things changed.
6. I feel safe and supported to manage any potential risks to my wellbeing.
7. I have systems in place to access support at an early stage to avoid a crisis.
8. I can easily access reliable and consistent information about community health and care services which is easy to understand.
9. I have information and advice on the range of options for choosing my support staff.
10. I have opportunities to train, study, work or engage in activities that match my interests, skills and abilities.
11. I feel welcomed and included in my local community.



Commissioners (the Council and the CCG)

1. We will ensure that the voices of people who use community health and care services are represented at all stages of this process.
2. We will ensure all statutory and constitutional duties are met and that for those statutory adult social care responsibilities undertaken through delegation to a specified provider or providers, commissioners retain a direct relationship with the provider(s) for the purposes of oversight and assurance.
3. We will commission services to improve the physical and emotional wellbeing of the population using a framework of positive outcomes as a monitoring tool.
4. We will commission services that will deliver evidence-based and evidence-informed outcomes that are focussed on the needs of the individual.
5. We will encourage a culture change across our local health and care system by ensuring the workforce has the right mix of skills and support to deliver person-centred services in a fully integrated and seamless way.
6. We will develop a common skills framework for everyone working in community health and care services and will create a shared budget for training.
7. We will explore opportunities to develop a single pooled budget (or similar mechanism) for community health and care services to include spending on adult social care, community health, public health, primary care, community mental health services and some acute hospital services (which will be determined on a service-by-service basis).
8. We will continue to integrate commissioning across the boundaries of health, social care and public health, between children's and adults' services and consider opportunities to extend this to other Council-funded services.
9. We will take an asset-based approach to commissioning - mobilising and building on community strengths as set out in Appendix B.
10. We will ensure the commissioning of health and care services is aligned with the strategic priorities of the CCG and Council.

Providers

1. You will deliver services in people's homes or in nearby local settings that enable them to remain independent as possible, for as long as possible.
2. You will take a person-centred approach that looks at all aspects of a person's health and wellbeing and you will agree with them what support they require.
3. You will provide services that are good value for money with as much resource as possible dedicated to front line services and, also, maximise opportunities for the sharing of back office functions to minimise overheads.
4. You will make it easy for people and those supporting them to navigate through the health and care system including access to 'care navigators' when required.
5. You will work with each other to shared objectives and responsibility to ensure the integrated and seamless provision of services.
6. You will work in partnership with local communities to deliver services through a range of resources whilst maximising the potential of voluntary, community and social enterprise partners through an asset-based approach (see Appendix B).
7. You will prevent avoidable admissions to hospital and support appropriate and sustainable discharge whilst empowering people to be active participants in the organisation of their care.
8. You will provide alternative options to GP appointments that enable people to receive an appropriate, timely and trusted response to their needs.
9. You will harness the potential of new technology to lead innovation in service delivery and the sharing of information between providers.
10. You will ensure all your staff receive the appropriate level of training in line with the common skills framework for community health and care services.
11. You will encourage your staff to be more focussed on prevention, early intervention and empowering individuals to be more independent and connected with their communities.
12. You will share good practice and collaborate on new approaches aimed at enhancing service delivery and promoting positive outcomes for people.

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8. Responding to your feedback

Phase One provided us with an enormous amount of feedback about the way community services are performing now and ideas for delivering improvements in the future. We organised this feedback into nine themes that needed to be addressed and this section sets out some specific priorities for how we will tackle all nine of these issues.

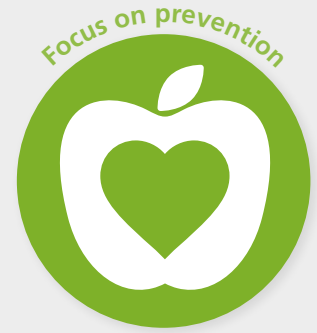
Our approach in addressing each of these will acknowledge that there are overlaps between areas, for example the links between reducing social isolation, building community capacity, whole system navigation and the role of social prescribing.

There are 14 priorities in total summarised as follows:

Priority 1:
A single assessment and support plan

Priority 2:
Integrated personal budgets

Priority 3:
Delivering cultural change



Priority 4:
Acting earlier to sustain health and wellbeing

Priority 5:
Supporting people to self care

Priority 6:
Seeking proposals to reduce social isolation

Priority 7:
Expanding the social prescribing service

Priority 8:
Building community capacity

Priority 9:
Care navigators to support those with the most complex needs

Priority 10:
Developing the capability and capacity of the workforce

Priority 11:
Volunteer recruitment

Priority 12:
Joining up a person's health and care records

Priority 13:
Sharing information about services

Priority 14:
Explore the potential of new technology

Provide more joined up care and support

You told us that the separation between different services can make it hard for you to find your way around the system.

You said we need to join up the money, join up the information and join up the people so that everyone involved in your care knows your story and works better together.

Priority 1: A single assessment and support plan

In future, people will have a single assessment and support plan that is coordinated and based around their individual needs, wishes and preferences. The planning and delivery of services will bring together everyone involved in supporting an individual to manage their care. Providers will deliver services through multi-disciplinary teams coordinated at a local level that put people at the centre of their support and treatment plans.

Services will be designed to prevent (a person's) needs escalating. People accessing services will benefit from a single support plan that is appropriate to their level of need. support plan that is individually designed and will flex around the needs of the individual rather than the person having to 'fit in' with service requirements. There will be greater thought given to the social, psychological and economic impacts of managing complex needs both for the person and their family.

We will use available and emerging technology to ensure that people have a single record that is transferrable and offer real-time access to staff so that a person does not have to keep repeating their story to different professionals (see p39 for more details).

Having a single plan will enable a whole system approach to providing person-centred care and support. We will expect providers to work in partnership alongside people and their communities to ensure integrated and seamless provision of services.

Priority 2: Integrated personal budgets

We will continue to promote and develop new ways of paying for services at individual and organisational levels. This will include the offer of integrated personal budgets that enable an individual to purchase support that meets both their health and social care needs. 'Local Payment' models are also emerging to support health and care economies make the shift to payment approaches that will underpin new models of integrated care and support.

Consider the whole person

You told us that we need to treat you as a person rather than focussing on your illness or health condition.

You said we need to understand your physical, mental and social needs so that you feel supported to improve your overall wellbeing.

Priority 3: Delivering cultural change

When we talk about personalisation, we are talking about a fundamental shift in the way we view, and work with, people who need care and support. It means seeing the whole person, focusing on their strengths, interests, abilities and networks, not just their diagnoses, illnesses and deficits. It means taking into account a person's physical, mental, emotional and spiritual needs. It means taking time to listen to an individual's own voice, particularly those whose views are not easily heard. It means working with the person in the context of their lives, building support around their preferences and choices and helping them to help themselves.

It also means actively engaging local communities and partners, including people who use services and their carers, in the design, development, commissioning, delivery and review of local support and ensuring that leaders at every level of every organisation work towards a genuine shift in attitudes and culture.

We want community health and care services to empower people to live their lives, rather than just doing things for them. We are committing to work this way because it's what we believe in, and what our community has told us they want. During Phase One, people clearly told us they wanted support to consider the whole person, provide more joined-up care, reduce social isolation and build community capacity. Working in a personalised way fully supports this.

One way we have demonstrated our commitment to personalisation is by signing up to Making it Real and we encourage everyone who provides community health and care services to do the same. Making it Real is a series of 'I' statements (known as Markers for Change) which were co-produced by people who use community health and care services. They describe what support should feel like if it is truly personalised.

At the start of the ***your care, your way*** review, we identified some key outcomes that we wanted community health and care services to deliver. We have now mapped these outcomes against the Markers for Change to make sure the focus remains on personalised support (see Appendix C – Outcomes).

Focus on prevention and self care

Waiting for something to go wrong before you get the right support doesn't make sense.

You told us that community services need to work with you to stop you from getting ill, or to prevent a health condition getting worse.

You recognise that you share responsibility in this but that you may need some help or encouragement from us.

Priority 4: Acting earlier to sustain health and wellbeing

Many people have told us that when they are ill or have a crisis then the service response is good. However, when they recover from a period of physical or mental ill health and begin to regain their independence then support can tail off, meaning that people are at risk of becoming ill again or even reaching crisis point before they get the services and support they need.

We will ensure that people's needs are proactively planned for to sustain health and independence, and appropriately responded to at all times, and not just when people are most unwell or in need. This includes: providing access to housing employment; healthy environments and communities; preventing exposure to harmful hazards; providing access to preventative services such as immunisations as well as providing access to good quality education and information about healthy lifestyles and signposting to local opportunities which people need to stay mentally and physically well.

It also includes activities aimed at detecting and treating people with disease or injury as soon as possible to ensure they are able to stop their condition getting worse or to prevent illness or injury reoccurring. It involves identifying people who are most likely to become ill due to lifestyle choices such as smoking, being overweight, drinking too much, being socially isolated and being inactive etc. and then intervening early to reduce the risks of them becoming ill by encouraging and supporting healthy behaviours.

Prevention also includes activities for people with an ongoing chronic illness, disability or injury in order to improve their ability to function, their quality of life and life expectancy. This can include therapy, rehabilitation techniques or support groups.

Priority 5: Supporting people to self-care

Self-care is all about individuals taking greater responsibility for their own health and wellbeing. It starts with people making daily choices about lifestyle, such as brushing teeth, eating healthily or choosing to do exercise in order to stay fit and maintain good physical and mental health. People can also take care of themselves when they have common symptoms such as sore throats, coughs and minor ailments for example by using over-the-counter medicines. The same is true for long term conditions where people often self-manage without intervention from a health professional.

People can also return to self-care during a period of recovery following major trauma when responsibility for care is entirely in the hands of the healthcare professionals.

Empowering people with the confidence and information to look after themselves when they can, and visit a GP or specialist only when they need to, can reduce the number of consultations and enable clinicians to focus on caring for higher risk patients.

Reduce social isolation

You told us that social isolation and transport are big issues, and not just in rural areas.

You said that we need to work more closely with local communities and the voluntary sector so that no one feels on their own or without the care and companionship they need.

Priority 6: Seeking proposals to reduce social isolation

Social isolation is an increasing problem in our society. It's not just a matter of feeling lonely, social isolation affects people's health. It increases the risk of depression, disability, cognitive decline, dementia and death. Older people who are socially isolated are more likely to need professionally provided care and support and more likely to need residential care. Reducing social isolation means increasing the interactions people have with others. Face-to-face interaction is important, allowing physical contact, but embracing new technology to make the best use of social media and the internet also provides a wealth of opportunities.

We will encourage key partners and particularly providers from the voluntary, community and social enterprise sector, who frequently offer support to people at the most vulnerable points in their lives, to collaborate and work alongside people to mobilise community, family and local care and support networks and resources to tackle social isolation at individual and neighbourhood levels.

We will be seeking proposals to reduce social isolation in the following ways:

- Take an early intervention and preventative approach, particularly for older people and vulnerable or disadvantaged groups.
- Build on community strengths and the resources of local people to help each other e.g. volunteering, befriending schemes and the Village Agents.
- Encourage increased face-to-face contact for people.
- Support digital inclusion by helping individuals or specific groups to be connected, keeping people 'in touch' with each other and their communities.

We recognise that work on social isolation and loneliness needs to be part of wider local commissioner efforts to build social resilience within local communities. In particular, poor transport can be an important factor in restricting access to further education, training and employment and can also restrict access to health facilities as well as shops and amenities. Community transport provides a vital lifeline for those most vulnerable to isolation and loneliness, such as the elderly and the disabled and should be recognised for the vital contribution it makes for improving the quality of life for some of our most vulnerable citizens.

Tackling local transport barriers can help alleviate social isolation for a range of people across the life course and will be a key priority for us to address with commissioners and providers of those services.

Priority 7: Expanding the social prescribing service

Social prescribing links people with non-medical activities and sources of support in the community that might benefit their wellbeing. There is increasing evidence to support the use of social interventions for people experiencing a range of common mental and physical health problems. Social prescribing has been shown to be particularly applicable for vulnerable and at risk groups; people with mild to moderate depression and anxiety; and people who are frequent attendees in primary care.

The social prescribing service in Bath and North East Somerset aims to improve the health and wellbeing of people who are frequent attendees at GP practices. The service encourages social interaction, prescribed activities such as weight loss and exercise programmes and access to both mainstream services and community resources to improve their quality of life.

The social prescribing service has recently been expanded and we anticipate that we will further develop and expand the social prescribing model to embed it as a foundation of community health and social care provision, increasing interactions for individuals, keeping people in touch, and maximising the strengths of local communities and its members.

Extended across Bath and North East Somerset, the service will continue to make good and appropriate use of volunteers, particularly people who have themselves been recipients of the social prescribing service, using their shared knowledge and experience to deliver peer support. Roles for volunteers could include those of navigator, facilitator, befriender, or of carrying out practical tasks such as transportation. The training and support of volunteers will reflect the fact that volunteers' own mental and physical health may vary, or that they become overwhelmed by other's problems. It will encourage and support them to remain in the service over a long period, gaining skills and experience, and bringing continuity to the role for the benefit of all parties.

Build community capacity

You want community health and care services to make the most of existing community centres and facilities.

You also want us to work more closely with local groups and volunteers in your community so they can play their part in keeping you healthy and happy at home.

Priority 8: Building community capacity

Community capacity is the term used to describe how well a community is equipped to respond to the needs of its members, for example how well a community responds to issues of social isolation or identified transport needs.

Building community capacity is a vital component of the way we will commission future service models of care. Current evidence suggests that participation in community networks brings with it significant benefits for wellbeing. Developing the capacity and skills of the members of a community places the focus both on individuals as well as collective groups in such a way that they are better able to identify and help meet their needs and to participate more fully in society.

Economic and social factors are also key contributors to people's care and support needs and are unequally distributed across society. Disadvantage is associated with feelings of isolation, low self-esteem, low perceived power and loss of meaning and purpose. These factors damage physical and mental health both directly and indirectly via behaviours such as drug and alcohol abuse and smoking.

Building community capacity means motivating individuals and communities to identify what services they need in their area and to work together to utilise existing strengths and skills to help the community meet their needs. It promotes empowerment, validation, engagement, ownership, participation, teamwork, respect, being listened to and much more.

We will expect providers to work alongside individuals and communities to support them to achieve the best possible outcomes for their health and wellbeing. Providers and commissioners are in a perfect positon to empower the community to develop their existing skills and knowledge and make a unique difference to their own community through delivery of a number of priorities:

- Establishing and developing a building community capacity approach, with training, peer support and workshops.
- Identifying and equipping champions for building community capacity with the expert skills and knowledge to provide a source of ongoing support, advice and expertise.
- Sharing and celebrating examples of good practice and excellence in building community capacity throughout stakeholders and the communities.
- Equipping people with full information and a pathway to support future building community capacity activities.

Guide people through the system

You told us we don't do enough to tell you about all the services that are available to support you.

You said that we should invest in 'navigators' who can help you find out about the groups and services in your local area.

Priority 9: Care navigators to support those with the most complex needs

We are proposing a new approach for Bath and North East Somerset that will create a system of care navigation which will act as a bridge between individuals with care and support needs and providers who have the skills and resources to meet those needs.

Care navigation will not replace a clinical role or act as a gatekeeper to services. It could be jointly delivered through a range of providers coming together to maximise particular areas of expertise, knowledge and resource to ensure the best outcomes for individual people using services. There is also an opportunity to harness and strengthen the role of volunteers in assisting people to access the support they need under the umbrella of navigation.

Some people have told us that the need for a navigation system is diminished if we can ensure that services are easily understood and accessible to all and that people are receiving good person-centred care and support. However, we think that any local system will need to include a trained 'care navigator' for people with the most entrenched multiple and complex needs. We also think this may be the case for people who don't engage in services, revolve in and out of services or are excluded from services.

The care navigator will be the 'go-to' person for people needing additional support to understand and work their way through what can be a very complex system. The care navigator may also be a helpful point of contact for professionals seeking to ensure that their services are effective and don't exclude 'seldom heard' groups.

The care navigators will be co-located both within services and in the community and will develop a deep understanding of both. Co-location alongside professionals, as well as within community settings, would make it easier to link in with other relevant services such as housing, leisure and employment support too.

Care navigators do not need to be the expert but they would know who the expert on any given topic is and would be able to effectively link people and experts together whilst developing trust and good communication. Most importantly, care navigators will ensure that a person is supported to be in control of their care and support and can access services and support that help them to live the life they want and remain an active, contributing member of their community.

Value the workforce and volunteers

You told us that we need to invest in our workforce and provide more opportunities for training and career progression.

You said this would give staff the time, skills and motivation to provide better quality care.

Priority 10: Developing the capability and capacity of the workforce

One of the key factors in ensuring the successful delivery of integrated community services will be the workforce on whom we depend to deliver care and services. Commissioners and providers will need to take the necessary action to ensure that their workforce is sufficient and skilled, well-led and supported to deliver high quality services. We will work with stakeholders to develop education strategies, training and employment of staff to deliver the flexible, multi-skilled workforce that services of the future will need. Staff retention will be improved through this and the development of career structures that offer opportunities for diversification and advancement.

Priority 11: Volunteer recruitment

Bath and North East Somerset has a strong voluntary, community and social enterprise sector that often relies on the use of volunteers to be able to deliver local services. In recent years there has also been a growing use of volunteers across the public and independent sectors.

There are a large number of benefits from volunteering to the volunteers themselves. It is an excellent way in which to increase self-confidence and skills which in turn increase employability. Volunteering can also improve people's health and wellbeing.

We will assist organisations with their recruitment, retention and up-skilling of volunteers, ensuring that support is given to local voluntary, community and social enterprise organisations that are taking on services and assets so that they are in the best possible position to efficiently run them.

We will also support co-ordination and promotion of volunteering opportunities through a central point such as the Bath and North East Somerset Volunteer Centre which will be the 'go-to' place for all information on volunteering in Bath and North East Somerset, making it easier for residents to find out about opportunities.

Share information more effectively

You told us that there needs to be better communication between the different teams providing your care and support

You said that everyone involved in your care, including you, should be able to access a single care and support plan so that you don't have to repeat your story over and over.

Priority 12: Joining up the person's health and care records

The delivery of care and support that is integrated around the individual requires a corresponding integration of Information Management Technology (IMT) Systems. The future model will be one that is supported by an IMT strategy that recognises the need for relevant information to be available to all relevant professionals to support care as well as to relevant people in receipt of care or those involved in their care. Clinical and administrative systems need to facilitate the sharing of appropriate data, not inhibit it and make best use of modern technologies to provide an efficient and effective experience.

Health and social care records will be kept digitally with the NHS number as the unique identifier and have the ability to communicate automatically with other parts of the health and social care system across organisational boundaries, while respecting individual consent and the need to safeguard against harm to the individual.

The care and support record will be maintained on the Council's new electronic system eg record system, provided by Liquid Logic. The health record will be maintained on the provider electronic patient record. The use of interoperable systems and full provider engagement with the Bath and North East Somerset community wide interoperability and information sharing agenda will ensure that relevant information is available to support care and support to an individual.

Priority 13: Sharing information about services

We will support a single source of information about local services allowing faster access and sharing of up to date information above what is available in the community. Having a centralised information service will enable providers to spend less money on marketing their services and spend more of their budgets on front line care and support. We welcome innovative proposals for how this service could operate which could include:

- An easy-to-use website for people to search for local services.
- A call centre offering information about services over the phone.
- Information and advice provided by email and social media channels.
- Outreach workers that visit vulnerable and seldom heard people in their own homes and communities to tell them about the different services available to them.

Embrace new technology

The world of technology is moving quickly, and you think we could use it more effectively. Many of you like the idea of using apps and other technology to manage your own health and care but it needs to be simple and easy to use.

You also recognise that we need reliable connectivity to make this happen, especially in the rural areas.

Priority 14: Explore the potential of new technology

We continue to see enormous developments in the range of technologies and digital tools and approaches available to people within our community and to organisations. Smart phones and tablet computers are now everywhere; town centres and public buildings routinely offer wireless access; data and systems are increasingly stored in the 'cloud'. These advances have enabled people, businesses and public bodies to change the ways in which they interact, gain access to information and services, and organise their work. However, we also acknowledge that some of our communities, particularly in rural areas, have told us that there are significant issues with broadband and access to the internet. The Council's digital strategy recognises this and sets out how access will be improved.

Commissioners recognise the opportunities offered by technology and digital tools and approaches to target and deliver services better and save money. Many local providers have already explored different methods of improving access to services including tele-care and apps to inform or alert service users. At the same time, they have made their workforce more productive by introducing mobile technologies, route planning tools and video-conferencing.

Technology and digital tools and approaches are central to achieving integrated and seamless community services. This includes both the application of new technologies and the development of skills by both commissioners and providers. For commissioners and their providers, we expect these tools to enable:

- Greater accessibility of data and more sophisticated means by which to form a deeper understanding of local patterns of need and interaction across services, allowing resources to be better managed, planned and directed to where they will have the greatest impact.
- More effective management of demand – for example, enabling user self-service and supporting peer-to-peer advice-giving and assistance via social media.
- More reliable, speedy, and precise handling of routine, repetitive tasks – allowing costly and scarce professional expertise to be targeted at cases which need judgement or at new and unexpected situations.
- Faster access to, and sharing of, data between key stakeholders, avoiding the need to collect the same information many times over and saving time on research and information collation.
- New ways of working that potentially reconcile the goals of providing a better quality of experience of the person accessing services.

9. What happens next?

The consultation will run for a period of just over seven weeks from 5am on Thursday 10 September 2015 to 5pm on Friday 30 October 2015.

Please provide your feedback by completing the online survey at **www.yourcareyourway.org** or request a hard copy by calling **01225 396512.**

There are a number of events being held during the consultation period across the Bath and North East Somerset area as detailed below. If you would like to attend any of these events then please let us know by contacting **yourcare@bathnes.gov.uk** or by calling **01225 396512**.

Phase Two

10	September		Consultation Period Begins	
17	September	2pm	BaNES CCG AGM	Guildhall, Bath
29	September	7pm	Bathavon Area Forum	St Gregory's School
30	September	7pm	Keynsham Area Forum	Fry's Club, Keynsham
6	October	7pm	Somer Valley Area Forum	Beacon Hall, Peasedown St John
15	October	7pm	Chew Valley Area Forum	Chew Valley Secondary School
30	October		Consultation Period Ends	

Once the consultation period is closed the results will be analysed and a final report will be submitted to the Council's Cabinet and the CCG Board for final approval in December. We will then begin detailed discussions with providers to develop the final model for community health and care services and we will consult the community on this during summer 2016.

Once the consultation has been completed we will award contracts to the chosen provider(s) and carry out the necessary preparations to begin operating the new model from 1 April 2017.

Phase Three

Wednesday 2 December	Council Cabinet to approve outline business case
Thursday 3 December	CCG Board to approve outline business case
Winter/Spring 2016	Develop models with providers
Summer 2016	Formal consultation on final proposals

Phase Four

Autumn 2016	Contracts awarded to chosen provider(s)
1 April 2017	New arrangements come into place

Appendix A: Community Service Providers

Age UK – Bath & North East Somerset	Learning and Living
Alzheimer's Society	Leonard Cheshire Disability
Action on Hearing Loss	Mencap
Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)	Next Link Domestic Abuse Services
Bath & North East Somerset Council	Options
Bath Area Play Project	Off The Record - Bath & North East Somerset
Bath Community Transport	Oxford Health NHS Foundation Trust
Bath Mind	Prospects
Bath Opportunity Pre-School	Pulse Community Healthcare
BEMS+	Quarriers
Brandon Trust	Rethink Mental Illness
Candlelight	Royal United Hospitals Bath NHS Foundation Trust
Care South	Safe & Sound Homecare Services
Carewatch	Second Step Housing Association
Children's Centres	Sirona Care & Health CIC
Children's Hospice South West	Solon South West Housing Association
Community Pharmacies	Somerset Care
Creativity Works	Soundwell Music Therapy Trust
Curo	Southside
deafPLUS	SPA (Peggy Dodd) Bath
Developing Health and Independence	Specialist Drug and Alcohol Service (AWP)
Dimensions	St Mungo's Broadway
Dorothy House	St Peter's Hospice
First Steps (Bath)	Stonham (a division of Home Group Ltd)
Freeways	Stroke Association
Primary Care (GP's)	SWALLOW
Guinness Housing Association	Swan Advocacy
Great Western Hospitals NHS Foundation Trust	The Carers' Centre
Jessie May Trust	The Home Farm Trust
Julian House	The National Autistic Society
KeyRing - Living Support Networks	Time2Share
Kick Start Enterprise	United Response
KIDS	Wansdyke Play Association
Knightstone Housing Association	Way Ahead
Kumari Homecare	West of England Centre for Inclusive Living
Lifeways Community Care	Your Say Advocacy Service

Appendix B: Asset Based Approach

Desirable	Typical
Start with strengths and potential – the assets of individuals and communities	Start with strengths and potential – the assets of individuals and communities
Promote wellbeing and positive health Treat the whole person	Promote wellbeing and positive health Treat the whole person
Foster strengths and assets to prevent problems	React to problems
Work with	Do to
People are co-producers of health outcomes	People are consumers of health services
Emphasise the role and knowledge of communities, networks and neighbourhood organisations Citizens act as peers and agents in their own health and work alongside professionals	Emphasise the role and knowledge of professionals and agencies
Empower people to take control of their lives and health Act as brokers, facilitators, catalysts, collaborators	Fix broken people
Work with local people to support their ideas, potential and priorities	Deliver intervention programmes
Work with citizens to tackle the social, economic and environmental determinants of health and challenge health inequalities	View the social causes of ill health and inequality as outside the remit of health and care services
Focus on what a community has and could have Collaborate and work alongside people to mobilise community, family and local care and support networks and resources Self-organisation and community organisation Support peer groups, social prescribing and local networks	Focus on what a community does not have
Work alongside citizens to improve health and care outcomes	Consult residents about health services

Appendix C: Outcomes

Health and Wellbeing Board Outcomes	Making It Real Markers for Change
All people in Bath and North East Somerset are healthy	I have access to a range of support that helps me to live the life I want and remain a contributing member of my community
All people have the opportunity to have the best health and wellbeing throughout life	
All people are a healthy weight	
All families with complex needs receive appropriate support	I have a network of people who support me - carers, family, friends, community and if needed paid support staff My support is coordinated, co-operative and works well together and I know who to contact to get things changed
All people are free from the misuse of substances	I have access to a range of support that helps me to live the life I want and remain a contributing member of my community
All people adopt healthy behaviours to stay healthy	
All people live in healthy and sustainable places	I feel welcomed and included in my local community I feel that my community is a safe place to live and local people look out for me and each other
All people are protected from infectious diseases	
People who lack capacity receive appropriate support to enable them to maintain their health	I have considerate support delivered by competent people
All people are supported to recover from periods of ill health or injury	I have care and support that is directed by me and responsive to my needs My support is coordinated, co-operative and works well together and I know who to contact to get things changed
More people have better mental health	
More people with mental health problems will have better physical health	
All people in Bath and North East Somerset have a good quality of life	I have access to a range of support that helps me to live the life I want and remain a contributing member of my community
All people with long term conditions are supported to stay well	
All people have good mental wellbeing and all children and young people have good emotional wellbeing and resilience	
All disabled people are living lives free from discrimination	I feel welcomed and included in my local community I feel that my community is a safe place to live and local people look out for me and each other
All people with dementia and their families and carers are supported to maintain the best quality of life	My support is coordinated, co-operative and works well together and I know who to contact to get things changed
All older people are supported to live independently and are able to die well	I am in control of planning my care and support
All adults with learning disabilities are supported to live independently and are able to die well	
People have a positive experience of care and support	I am in control of planning my care and support
More people with mental health problems will recover	I have care and support that is directed by me and responsive to my needs
All people in Bath and North East Somerset have equal life chances All people have access to good quality education and employment opportunities. Young people aged 16-19 are in education, training and employment including young people with Education Health and Care Plans.	I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities

Appendix C: Outcomes

Health and Wellbeing Board Outcomes	Making It Real Markers for Change
All people are able to live free from domestic abuse.	I feel safe, I can live the life I want and I am supported to manage any risks
Vulnerable adults, children and young people's life chances are not adversely affected as a result of domestic abuse	I have systems in place so that I can get help at an early stage to avoid a crisis
All people are able to live free from social isolation and loneliness	I have access to a range of support that helps me to live the life I want and remain a contributing member of my community
All children and young people up to 25 with Special Education Needs and disabled young people enjoy good health and lead fulfilling lives	I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities
All children are identified and supported through seamless transition stages, from early years to adolescence and early adulthood	My support is coordinated, co-operative and works well together and I know who to contact to get things changed
All children and young people are active citizens who feel they have a voice and influence.	I feel valued for the contribution that I can make to my community
All vulnerable children and young people and their families receive timely and effective early intervention	My support is coordinated, co-operative and works well together and I know who to contact to get things changed
All disabled people are supported to receive services in an equitable manner	I have care and support that is directed by me and responsive to my needs
All vulnerable people are safe and secure	I feel safe, I can live the life I want and I am supported to manage any risks
All children and young people in Bath and North East Somerset are safe	
All children and young people in care make the same or better progress in educational attainment as their peers	I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities
All children and young people on free school meals make the same or better progress in educational attainment as their peers	
All children and young people on Child Protection Plans make the same or better progress in educational attainment as their peers	
All children and young identified as having challenging behaviour make the same or better progress in educational attainment as their peers	
Children are identified and supported through seamless transition stages, from early years to adolescence and early adulthood	I am in control of planning my care and support My support is coordinated, co-operative and works well together and I know who to contact to get things changed
Parents are confident and able to support and meet the needs of their children	I have access to easy to understand information about care and support which is consistent, accurate, accessible and up to date I can speak to people who know something about care and support and can make things happen

Get involved!

Come to an event:
Come to a ***your care, your way*** event or invite us to your local community group

Write to us:
your care, your way,
BaNES CCG, St.Martin's Hospital, Clara Cross Lane, Bath, BA2 5RP

Find us on Facebook:
facebook.com/yourcareyourway

Discuss on Twitter:
#ycywbanes

Send us an email:
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Let's plan community services together

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