Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Bath and North East Somerset Health & Wellbeing Board

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	Date:	13 January 2015

To: All Members of the Health & Wellbeing Board

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

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

Observers: Councillors John Bull and Vic Pritchard

Other appropriate officers
Press and Public

Dear Member

Health & Wellbeing Board

You are invited to attend a meeting of the Board, to be held on **Wednesday, 21st January, 2015** at **10.00 am** in the **Brunswick Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
Committee Administrator

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

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

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

3. **Recording at Meetings**:-

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

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

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

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

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

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

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

6. **Declarations of Interest**

   At this point in the meeting declarations of interest are received from Members in any of the agenda items under consideration at the meeting.

   (a) The agenda item number in which they have an interest to declare.
   (b) The nature of their interest.
   (c) Whether their interest is a **disclosable pecuniary interest** or an **other interest**, (as defined in Part 2, A and B of the Code of Conduct and Rules for Registration of Interests)

Any Member who needs to clarify any matters relating to the declaration of interests is recommended to seek advice from the Council's Monitoring Officer or a member of his staff before the meeting to expedite dealing with the item during the meeting.

7. **Attendance Register:**
Members should sign the Register which will be circulated at the meeting.

8. **Emergency Evacuation Procedure**

If the continuous alarm sounds, you must evacuate the building by one of the designated exits and proceed to the named assembly point. The designated exits are sign-posted.

Arrangements are in place for the safe evacuation of disabled people.

Health & Wellbeing Board

Wednesday, 21st January, 2015
Brunswick Room - Guildhall, Bath
10.00 am - 12.00 pm

Agenda

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

   At this point in the meeting declarations of interest are received from Members in any of the agenda items under consideration at the meeting.

   (a) The agenda item number in which they have an interest to declare.

   (b) The nature of their interest.

   (c) Whether their interest is a **disclosable pecuniary interest** or an **other interest**, (as defined in Part 2, A and B of the Code of Conduct and Rules for Registration of Interests)

   Any Member who needs to clarify any matters relating to the declaration of interests is recommended to seek advice from the Council's Monitoring Officer or a member of his staff before the meeting to expedite dealing with the item during the meeting.

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

6. PUBLIC QUESTIONS/COMMENTS

7. MINUTES OF PREVIOUS MEETING

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

8. YOUR SAY ADVOCACY NETWORK UPDATE (30 MINUTES)

   B&NES Council have commissioned Your Say Advocacy since 2006 to support and facilitate the 'Networks' for People with Learning Disabilities across the B&NES area.

   Historically this has meant 3 different 'Network' groups meeting in the 3 main geographical areas of B&NES: - Bath, Keynsham and Norton Radstock.

   The Network have worked on local and B&NES wide issues affecting the lives of people with learning disabilities and worked to make change happen to improve people's lives.

   The Board are asked to consider a presentation from Your Say Advocacy

representatives.

9. MAKING IT REAL IN BATH AND NORTH EAST SOMERSET (15 MINUTES)

Bath & North East Somerset Council (B&NES) and BaNES CCG intends to work towards developing, publishing and implementing a 'Making it Real' action plan, with a view to embedding the principles of personalisation, co-production and integration within the decision making processes of adult health and social care commissioning. The embedding of a truly personalised approach is key to the successful implementation of the Care Act.

The Board is asked to endorse:

- The commitment to Making it Real
- The proposal to develop a 'Making it Real' action plan
- The principles of co-production which this will entail
- The draft programme structure and draft action plan as attached at Appendix 5.

The Board is also requested to receive six monthly progress reports.

10. ANNUAL COMMISSIONING INTENTIONS (35 MINUTES)

The Health and Wellbeing Board are to receive a presentation from commissioners across the Council (Adults, Children's and Public Health), the Clinical Commissioning Group and NHS England with an overview of their annual commissioning intentions. This will include consideration of our shared local priorities and our plans for integrated working to deliver on them.

11. HEALTHWATCH B&NES: MAKING EVERY CONTACT COUNTS (10 MINUTES)

This paper will update the Board on what can be learnt from the ideas within the national Making Every Contact Count initiative, as discussed through the Network, and how might we take these ideas forward at a local level.

The Board is asked to:

- Note the outcomes of the meeting
- Consider possible next steps in relation to Making Every Contact Count

12. PUBLIC HEALTH ANNUAL REPORT (5 MINUTES)

It is a statutory responsibility of the DPH (to write) and the Council (to publish) an annual report on the public health. This is to present the latest report to the HWB in its capacity as the body overseeing the population's health and wellbeing.

The Board is asked to note the publication of this report and comment on its contents and format.

13. LOCAL SAFEGUARDING CHILDREN'S BOARD UPDATE (15 MINUTES)

This is a briefing on the work and future scrutiny of the LSCB.

The Board is asked to note this report and make any recommendations for additional scrutiny.

14. TWITTER QUESTIONS (5 MINUTES)

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

Bath and North East Somerset Council | **NHS Bath and North East Somerset**

HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Wednesday, 19th November, 2014, 10.00 am

Councillor Paul Crossley	Bath & North East Somerset Council
Dr. Ian Orpen	Member of the Clinical Commissioning Group
Ashley Ayre	Bath & North East Somerset Council
Councillor Simon Allen	Bath & North East Somerset Council
Bruce Laurence	Bath & North East Somerset Council
Councillor Dine Romero	Bath & North East Somerset Council
Jo Farrar	Bath & North East Somerset Council
Pat Foster	Healthwatch representative
Diana Hall Hall	Healthwatch representative
John Holden	Clinical Commissioning Group lay member
Tracey Cox	Clinical Commissioning Group

Co-opted Non-Voting Member:

Julia Davison	NHS England - Bath, Gloucestershire, Swindon and Wiltshire Area Team

45 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

46 EMERGENCY EVACUATION PROCEDURE

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

47 APOLOGIES FOR ABSENCE

There were none.

48 DECLARATIONS OF INTEREST

Councillor Simon Allen declared an other interest in ‘Time To Change’ agenda item as he has been employed by the Avon and Wiltshire Mental Health Partnership (AWP) NHS Trust.

49 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

The Chairman informed the Board that he agreed to include an update on the RNHRD acquisition by the RUH Bath at this point of the meeting.

The Chairman congratulated the RUH Bath on achieving Foundation Trust status.

The Chairman invited Sarah Truelove (Deputy Chief Executive RUH) to update the Board on the latest developments.

Members of the Board welcomed the news that acquisition of the RNHRD by the RUH might happen as early as February 2015. The Board also welcomed that both hospitals had had clear understanding in their discussions around the acquisition process.

The Board was also assured by hospitals’ representatives, and by the CCG, that public would be informed about acquisition through a number of events over the next couple of months

The Board **RESOLVED** to note an update.

The Chairman informed the Board that ‘Section 256 Agreement’ agenda item would be discussed straight after ‘Minutes of Previous Meeting’ item.

As an item of urgent business agreed by the Chair, John Holden sought a review by the HWB in which papers come to the Board. He contended that it was not always clear what report authors requested from the Board and that this may impact on the Board’s role of providing strategic oversight. John Holden had suggested that papers should be more focused as to purpose and content. Councillor Crossley had commented that the public want to and should see all the detail.
With support from the Chair, it was **AGREED** that a review of our processes be carried out and reported back to the Board.

50 PUBLIC QUESTIONS/COMMENTS

There were none.

51 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting were approved as a correct record and signed by the Chair, subject to the following amendment:

- Page 2, last paragraph, first sentence should read: 'James Scott commented that, given that the RUH has been providing acute services to wider population'.

52 **SECTION 256 AGREEMENT AND FUNDING ALLOCATION 2014/15 (15 MINUTES)**

The Chairman invited Jane Shayler (Deputy Director: Adult Care, Health and Housing Strategy and Commissioning) to introduce the report.

The Board supported the agreed use of Section 256 funding in 2014/15, as presented in the report.

John Holden said that he was pleased with the direction of travel and asked who would be accountable for this money.

Jo Farrar supported the paper and added that it was really important to formalise Section 256 Agreement and Funding Allocations for 2014/15 and beyond.

Councillor Dine Romero asked about the role of the Section 256 money in terms of the early years intervention and preventative work for children and young people, in particular for 'end of life' care and mental health.

Bruce Laurence welcomed the report and noted it had gone through a very complex review process. Bruce Laurence added that there was room for moving some investment into more preventive upstream over time.

Jane Shayler said that oversights of the Better Care Fund spend would be within Joint Commissioning Committee (JCC) remit. The JCC would be providing regular updates on implementation of the BCF to this Board. Chief Executives from the Council and CCG Board have had a clear accountability in respect of some of the expenditure of this money.

Jane Shayler also said that the BCF and Section 256 money would be used for investment into services for adults of working age and older people, which was in the line of guidance for the use of BCF fund.

Jane Shayler responded that challenge with investment into more preventive upstream would be in presenting the evidence that upstream investment would be having a relatively timely effect on immediate and urgent pressures, most which would be statutory responsibilities of the Council and the CCG.

It was **RESOLVED** to support the agreed use of Section 256 funding in 2014/15.

53 **HEALTH AND WELLBEING BOARD TERMS OF REFERENCE (5 MINUTES)**

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

The Board welcomed the Terms of References with the following suggestions to be

included:

John Holden suggested that bullet point 2.1 of the report could be strengthened by adding ‘and audit’ after ‘ongoing oversight’.

Julia Davison suggested that it might be sensible to take into account changes within NHS England and use NHS England instead of Area Teams.

It was **RESOLVED** to agree three amendments to the Health and Wellbeing Board’s terms of reference:

- The Health and Wellbeing Board is co-chaired by the Council’s Cabinet Member for Wellbeing and the Chair of Clinical Commissioning Group.
- That the new statutory responsibility for completing and publishing a Pharmaceutical Needs Assessment is added to the terms of reference.
- That the Health and Wellbeing Board’s new responsibility for the B&NES Better Care Fund, including the ‘sign off’ of the plans, is added to the terms of reference

It was also **RESOLVED** to include suggestions from some Board Members as above.

54 CLINICAL COMMISSIONING GROUP OPERATIONAL RESILIENCE & CAPACITY PLAN FOR 2014/15 (15 MINUTES)

The Chairman invited Dominic Morgan (B&NES CCG) to give a presentation.

Dominic Morgan highlighted the following points in his presentation:

- ORCP – The New National Approach for 2014/15
- The key role of the System Resilience Group (SRG)
- ORCP Planning Requirements and Best Practice
- BaNES ORCP
- ORCP – Key Dates
- BaNES SRG ORCP funding sources, allocations by providers and targeted project areas
- ORCP Reporting Arrangements
- Next Steps

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

The Chairman asked how the quality of patient experience would be measured.

Dominic Morgan replied that the national vision has been that SRGs offer a powerful opportunity to improve care for patients by, for example, fully integrating emergency healthcare development with primary care (where most unscheduled care takes place). In some areas SRGs have already helped to establish more patient-centred care and were encouraging shared learning across health and social care communities by working in partnership.
Successful SRGs should work across boundaries to improve patient experience and clinical outcomes, by establishing partnerships and better working relationships

between all health and social care organisations in a geographical area and health community.

Councillor Romero asked if being classed as ‘Medium – with assurance’ was good rating for Bath and North East Somerset and how many other areas had been classed the same like us.

Dominic Morgan explained that majority of other SRGs had been classed as ‘medium’. Dominic Morgan explained that ‘medium’ SRGs had not been defined as ‘high’ or ‘low’ risk and would be expected to produce plans that contain all actions from the best practice guidance, which would then be assured.

Councillor Romero asked about winter planning considering that last year we had had mild winter, in particular about additional capacity if weather gets worse.

Dominic Morgan explained that winter planning capacity had been based on a five year historical forecast, with continued monitoring of weather.

Pat Foster asked if there were any expectations to involve Patient & Public Forum in the Plan.

Dominic Morgan responded that patient involvement in the Plan would be quite important.

Jo Farrar informed the Board on existence of quite proactive Local Resilience Forum, and suggested that they should be involved in the Plan. Jo Farrar also said that the CCG had received non-recurrent national resilience monies of £1.3m for 2014/15 and asked if there was any contingency plan in case of the cost exceeding that sum.

Dominic Morgan responded that there were on-going discussions regarding the utilisation of £1.3m.

Tracey Cox commented that there was a culture within B&NES and between providers to continuously look into improving their services, as part of best practice. In terms of patient experience – there are a number of routine indicators showing whether the system was succeeding or failing, such as cancellations of operations on the day of procedure, delayed transfers of care and mixed sex accommodation breaches as well as the 4 hour target that were routinely monitored. Tracey Cox concluded by saying that the CCG did not receive confirmation of winter pressure/ resilience funding until well into the financial year or clarity on how much funding was available from the Government which made planning more difficult. Tracey Cox said she would personally lobby to request notification of 2015/16 monies as early as possible or as part of the 2015/16 planning round as this would in turn save a lot of time, money, and discussions with providers and help to plan for future.

The Chairman thanked everyone for their input.

The Chairman concluded this debate by saying that we have demonstrated that our system has a good plan in place and there has been a strong focus on patient safety. The Chairman also asked for Board’s approval to write to NHS England to request earlier notification of additional funding, which would help better planning.

It was **RESOLVED** to note the presentation and to agree with Chairman's comments.

55 ALCOHOL HARM REDUCTION STRATEGY FOR BATH AND NORTH EAST SOMERSET (2014 - 2019) (20 MINUTES)

The Chairman invited Cathy McMahon (Public Health Development and Commissioning Manager) to introduce the report.

The Chairman welcomed the strategy and commented that people should not underestimate impact that the alcohol related harm had had not only on the individual but society as a whole. The total estimated cost in B&NES of the harm arising from alcohol-use disorders was some £45.0 million a year, of which £21.3 million was a result of crime and £5 million healthcare costs.

The Board welcomed the report and supported the refreshed Strategy, especially on increasing the focus and capacity of the treatment system to respond to alcohol clients and proactive management of the night time economy to address crime and anti-social behaviour.

The Board also showed a commitment to lead on prevention and early detection of alcohol misuse amongst the residents, businesses and visitors to Bath and North East Somerset.

John Holden supported officers' recommendation that the Health and Wellbeing Board should endorse the Alcohol Harm Reduction Strategy for Bath and North East Somerset (2014 – 2019) and support its delivery by maintaining its strategic commitment to the reduction of alcohol misuse and encouraging stakeholder engagement to contribute towards delivery of its outcomes. However, John Holden felt that the second recommendation, 'The Health and Wellbeing Board uses its influence as a collective, and as individual organisations and community representatives, to actively engage in the call for evidence based national initiatives to support local delivery such as minimum unit pricing, a reduction in blood alcohol levels for driving, a public health objective in the Licensing Act and restrictions on advertising and sponsorship by the alcohol industry' was not appropriate and for that reason he would not support the second recommendation.

The rest of the Board supported both recommendations as printed.

It was **RESOLVED** that:

1) The Health and Wellbeing Board endorsed the Alcohol Harm Reduction Strategy for Bath and North East Somerset (2014 – 2019) and supported its delivery by maintaining its strategic commitment to the reduction of alcohol misuse and encouraging stakeholder engagement to contribute towards delivery of its outcomes.
2) The Health and Wellbeing Board would use its influence as a collective, and as individual organisations and community representatives, to actively engage in the call for evidence based national initiatives to support local delivery such as minimum unit pricing, a reduction in blood alcohol levels for driving, a public health objective in the Licensing Act and restrictions on advertising and

sponsorship by the alcohol industry.

56 LOCAL SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2013-14 (20 MINUTES)

The Chairman invited Lesley Hutchinson (Assistant Director for Safeguarding and Personalisation) and Robin Cowen (Independent Chair – Local Safeguarding Adult Board) to introduce report.

Members of the Board praised the Annual Report and Business Plan.

The Chairman commented that this year had been a tough year for services, with significant national events, new legislation, with implementation of the recommendations for a serious case review and with ever increasing demand for safeguarding.

Jo Farrar commented that the Local Safeguarding Adults Board had had to balance a degree of sensitivity to the pressures on services and on staff, whilst remaining firmly focused on the quality and effectiveness of safeguarding. Jo Farrar added that she would expect more information on the prevention services and on monitoring results.

John Holden agreed with suggestion from Jo Farrar by suggesting that three page summary could be presented to the Board in June or July 2015.

It was **RESOLVED** to:

1) Note the Annual Report and Business Plan
2) Receive a three page summary on up to date activity of the LSAB, with focus on the prevention services and monitoring results.

57 JOINT HEALTH AND WELLBEING STRATEGY PERFORMANCE REPORT NOVEMBER 2014 (15 MINUTES)

Members of the Board felt that this report should be given more time at the next meeting of the Board (January 2015).

It was **RESOLVED** not to debate the report at this meeting and instead receive the same report at the next meeting of the Board, and allocate more time for discussion.

58 TIME TO CHANGE - TACKLING MENTAL HEALTH STIGMA IN B&NES (5 MINUTES)

The Chairman invited Paul Scott (Public Health Consultant) to introduce this item.

The Chairman thanked Paul Scott for an update and commented that now was the right time to talk on mental health conditions, especially in increasing awareness on men with mental health conditions.

Councillor Romero added that an early years intervention, for children and young people with mental health problems, should not be overlooked.

It was **RESOLVED** to agree that:

- The enclosed plan is implemented in B&NES
- The plan is submitted on behalf of the Board as its pledge to the Time to Change programme
- An update on progress is provided to the board as part of the 6-monthly Health and Wellbeing Strategy delivery report on mental health.

59 **B&NES LOCAL FOOD STRATEGY (15 MINUTES)**

The Chairman invited Jane Wildblood (Corporate Sustainability Manager) and Sophie Kirk (Corporate Sustainability Officer for Food) to give a presentation.

The following points had been highlighted in the presentation (available on the Minute Book in Democratic Services):

- Why we need a strategy
- Vision
- Local Food Strategy delivery themes
- Local food production
- Food provision and access
- Healthy and sustainable food culture
- Where the Strategy will contribute to
- Contribution to specific Health and Wellbeing priorities
- Governance
- Engagement
- Recommendations

Members of the Board welcomed the report and presentation by praising officers who worked on the Strategy.

The Board agreed that the Chairman, Councillor Dine Romero, Ian Orpen and Bruce Laurence would receive, on behalf of the Board, invitation for stakeholder events and engagement sessions as appropriate.

It was **RESOLVED** to:

1) Provide high-level support for the B&NES Local Food Strategy and implementation plan.
2) Nominate to Councillor Simon Allen, Councillor Dine Romero, Ian Orpen and Bruce Laurence to attend stakeholder events and engagement sessions as appropriate.
3) Receive a feedback on the Strategy every 6 months.

60 **TWITTER QUESTIONS (5 MINUTES)**

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

The meeting ended at 12.20 pm

Chair ....

Date Confirmed and Signed ....

Prepared by Democratic Services

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BANES Networks.
Community Interest Company

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B&NES Council have commissioned Your Say Advocacy since 2006 to support and facilitate the 'Networks' for People with Learning Disabilities across the B&NES area.

Historically this has meant 3 different 'Network' groups meeting in the 3 main geographical areas of B&NES:- Bath, Keynsham and Norton Radstock.

The Network have worked on local and B&NES wide issues affecting the lives of people with learning disabilities and worked to make change happen to improve peoples lives.

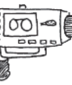
The Networks have worked on projects including :-

Hate Crime
Employment
Education
Transport
Friendships and Relationships
Health and Healthy Lifestyles
Carers and short breaks
Personal Budgets
Changing Places
Housing
Keynsham Regeneration
Challenging Behaviour
Elections

As well as, Special Projects at the request of the Council or CCG

And we have worked with:-
The Police
Council Officers and Councillors
The Healthy Sports and Lifestyles team
GP's and Health professionals
Employers
Faith Groups
Local businesses
Community Groups

We have made 4 information DVD's for people with learning disabilities, on:-



Housing – 'No Place Like Home'
Employment – 'Making it Work'
Annual Health Checks – 'Check it Out'
Fitness and Exercise – 'Working it Out'

The 'Networks' are open to anyone with a learning disability as well as their family members and others who wish to support the Network activities.

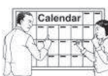
Different people have different reasons for being part of the Networks – for some people it is a real chance to have a voice and make change happen and for others it has offered a more social opportunity.

These difference have meant that people have wanted different things from the Network and so in 2012 the Networks began to really change and we formed a 'Project Group' of members who wanted to be more active in the running of the Network and in making real change happen in B&NES.

In 2012 the Project Group formed their own Community Interest Company called BANES Networks CIC and the Project group members all became co-directors of this new company along with Kirstie and Jude from Your Say.

BANES Networks CIC is really proud of what it has achieved in quite a short period of time and we would like to share this with you today.

The CIC members are all working hard to learn how to run a Community Interest Company – this means we have to learn about money and accounts and understand more about budgets and working as a team.



Eventually we hope that we will be able to be commissioned directly by the Council to give people with learning disabilities their voice in B&NES, rather than working through Your Say – but we still have some time to go before we are ready for this.

Just some of our work......we want to share with you just a few of the things we are most proud of:-

One Stop Shop – for many years the Keynsham Network was really involved in the regeneration of Keynsham , including being one of the partners consulted on the designs for the new development in Temple Street , including the Once Stop Shop and Council Offices. The Network asked that the development include a fully accessible Changing Place Toilet and we were really pleased when this was agreed and included in the design.

We have carried on being involved in the new development and last year we were invited to become Partners in the Once Stop Shop.

This was really exciting and created a real work opportunity for us, offering advice, support and help to other people with learning disabilities using the One Stop Shop in Keynsham.

It has taken a bit of juggling of the Your Say budgets but we have found a way to make sure that once a week for ½ a day, a Your Say Advocate and a CIC member are available at the One Stop Shop.

It is still early days and we are going to move our time slot from the morning to the afternoon to make ourselves more available to people who may be busy in the mornings – but we really think that this is a really positive step and shows what people with learning disabilities can offer.

Quality Checking – in 2012 part of the new contact with Your Say was to develop a Quality Checking service – where people with learning disabilities use their own experiences, skills and knowledge to monitor and review the services delivered to their peers.

We call this being an 'Expert by Experience'.

Over the last 2 years we have completed 10 Quality Checks of residential and supported living services for people with learning disabilities across B&NES.

The Quality Checking team are all employees of Your Say Advocacy and the role of Quality Checking is one we take very seriously. There are 5 members of the Quality Checking Team.

We have seen some really good services as well as some services that have made us worry – and we share what we have found out with the Council and the service themselves which some suggestions about things they could do differently or better.

Bath Bistro – this is an Employment project we set up to help us to build skills as well as earn a little money.

Our Bistro runs on the 2nd Wednesday of every month and provided a 3 course meal – with 3 choices for each course – prepared by ourselves and then served by us to paying customers.

The Bistro gives 12 people each month the chance to experience real skills building in a catering kitchen and in a restaurant setting.

We usually have about 40 customers and in January 2014 we made an arrangement that each month we would also feed the guests of Julian House.

One of the great things about Bistro is that anyone can come along and so we have lots of customers who have learning disabilities, who might find other restaurants quite difficult to visit, as well as lots of people without disabilities who keep coming back because they enjoy the food.

We are really proud of Bistro – we have to work really hard but it is worth it. 2 of us have chosen to go on and do Catering Course at College and one person has left as they are now in full time employment.

In 2014 we worked with B&NES Council to secure 2 Allotment plots and we have a small group who work weekly at the Allotment – where we plan to grow as much fruit and vegetables as possible for the Bistro and other food projects.

Training – as 'Experts by Experience' we also use our skills and knowledge to help others to think about the experiences and realities of having a learning disability.

The CIC offers a number of free training opportunities each year to service providers, service users, community groups and others on a range of different subjects, which include:-

Understanding the History of Learning Disabilities
Challenging Behaviour and what this means
Safeguarding - from our perspective
Hate Crime awareness and reporting
Mental Capacity Act
Equality

In 2014 we also did a lot of work with Freeways to help train staff and service users on how to make their user representation better and give people with learning disability a bigger voice in the organisation.

Partnership Conversation – one of our challenges from 2012, when Your Say's contract was renewed, was to try to re-start the Partnership Board in B&NES.

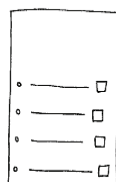
Our old Partnership Board had stopped for lots of different reasons, but mainly because it was hard to work out what its job was and who was needed to make change happen.

We spent a long time trying to think of new ways to make a Partnership Board work and in 2013 we had the idea of having a 'Partnership Conversation'.

The idea was that if we could get a group of people together to talk about and have a 'conversation' about a subject that was really important to people with learning disabilities then we might be able to make change happen.

We spent quite a long time thinking about who we needed to invite to become our Partners in these Conversations – and in July 2014 we had our first 'Partnership Conversation'.

Partnership Conversation – we invited the following partners to join us:-



Mike MacCallam
Cllr Simon Allen
Sergeant Geoff Cannon – Avon and Somerset Police
Luke Joy Smith – Dimensions
Bev Craney – Swallow
Debbie Patten – Sirona
Lydia Clark – Carers Centre
Dr Ian Orpen – CCG
Dave Twine – Manvers Street Baptist Church
Chris East – Employment Services
Natalie Candy – Active Sport and Lifestyles Team

Not everyone has made it to a Conversation yet and we are still talking about and thinking about the membership as we know that without Partners then there will be no Conversation or actions.

We have now held 3 'Partnership Conversations' and we have so far explored the issues of 'Keeping Safe at home and out and about' as well as supporting people with learning disabilities to have 'Healthier Lifestyles'

We have a whole list of other issues we want to explore and we want to use the 'Partnership Conversation' as a way to feed into the Health and Wellbeing Board – the Council and CCG.

Our other Conversation topics include:-

- How people with learning disabilities get their support and how much choice they have in this
- Having the lives we want – not those others choose for us
- Decision making and what happens when no one listens to our voice
- Work – access to real work opportunities and how we can influence this
- Protecting out rights
- Money – especially Personal Budgets and how in control we really are of our own budgets.

How can 'Health and Wellbeing Board' help us....

We would like the Health and Wellbeing Board to recognise that the BANES Networks CIC and the Network members are an essential link to finding out what is really important in the lives of people with learning disabilities.

With a data base of over 500 people with learning disabilities as well as regular meetings and opportunities we can help you to find out about what works and what needs to change to improve the lives of, and quality of services to, people with learning disabilities across B&NES.

We hope the 'Partnership Conversation' is one way we can share information directly with the Health and Wellbeing Board – but we would also like to invite you to work with us by using us as a group that you can consult with and ask questions about learning disability issues.

Any Questions?

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

healthwatch Bath and North East Somerset

MEETING	B&NES HEALTH AND WELLBEING BOARD
DATE	21/01/2015
TYPE	An open public item

Report summary table	
Report title	'Making it Real' in Bath and North East Somerset
Report author	Wendy Sharman (01225 477922)
List of attachments	The following are included and referenced as follows in this report: 1. Equalities impact assessment 2. Risk register 3. Making it Real Markers for Change 4. Steps you need to take to declare a commitment to Making it Real 5. Draft programme structure and draft action plan 6. Integrated personal commissioning programme documents
Background papers	As attached
Summary	Bath & North East Somerset Council (B&NES) and BaNES CCG intends to work towards developing, publishing and implementing a 'Making it Real' action plan, with a view to embedding the principles of personalisation, co-production and integration within the decision making processes of adult health and social care commissioning. The embedding of a truly personalised approach is key to the successful implementation of the Care Act.
Recommendations	The Board is asked to endorse: • The commitment to Making it Real • The proposal to develop a 'Making it Real' action plan • The principles of co-production which this will entail • The draft programme structure and draft action plan as attached at Appendix 5 The Board is also requested to receive six monthly progress reports.
Rationale for recommendations	Norman Lamb MP, Care and Support Minister wrote to all local authorities in 2014 to encourage them to sign up to Making it Real, stating councils and other organisations "have used Making it Real to build strong momentum for personalisation locally, and I want this to be a universal experience." The Care Act centralises person centred care and support planning, but also gives local authorities broad responsibilities around supporting wellbeing and preventing, reducing and delaying needs within our population. B&NES aims to work

	collaboratively with our communities in order to deliver the Care Act, and adopting the principles of co-production outlined in Making it Real will support this. The recommendations in this report fully support the cross cutting commitment to public, patient and provider engagement within the Joint Health and Wellbeing Strategy, more specifically the following outcomes: **Theme 1 - Helping people to stay healthy**, specifically: • Improved support for families with complex needs • Create healthy and sustainable places **Theme 2 - Improving the quality of people's lives**, specifically: • Improved support for people with long term health conditions • Enhanced quality of life for people with dementia • Improved services for older people which support and encourage independent living and dying well **Theme 3 – Creating fairer life chances**, specifically: • Improve skills, education and employment • Increase the resilience of people and communities including action on loneliness In addition, a key objective of NHS England (outlined in the Government's Mandate to the NHS) is for the NHS to become dramatically better at involving people; empowering them to manage and make decisions about their own care and treatment. This includes through the provision of personal health budgets which became mandatory in April 2014 for those who are entitled to Continuing Health Care (CHC) funding so that they can have a greater say in how their health and social care needs can be met. These recommendations also fully support the strategic vision of Bath and North East Somerset as being "internationally renowned as a beautifully inventive and entrepreneurial 21st century place with a strong social purpose and a spirit of wellbeing, where everyone is invited to think big – a 'connected' area ready to create an extraordinary legacy for future generations."
Resource implications	The Transformation and Strategic Planning Manager will take the lead in developing and supporting the MIR Implementation Group and action plan and subsequent co-production policy statement(s). Funding will be required to deliver the action plan and it is intended to use the Transformation budget.
Statutory considerations and basis for proposal	An equalities impact assessment has been carried out in relation to this proposal (see Appendix 1). This report follows the recommendation by Norman Lamb MP to develop a Making it Real action plan and endorse the principles behind Making it Real. The principles of Making it Real also support the implementation and principles of the Care Act.
Consultation	The proposal to develop a Making it Real action plan has been discussed with Bath and North East Somerset CCG, Sirona Care

	& Health and The Care Forum. It should be noted that the purpose of Making it Real is to ensure that reports such as this are co-produced with service users and carers as well as ‘professional’ partners. A key part of the proposed Making it Real action plan will be to ensure this occurs in the future.
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance. The risk register is at Appendix 2.

THE REPORT

1 AN OVERVIEW OF PERSONALISATION

1.1 The 2006 White paper ‘Our Health Our Care Our Say’ set the direction for more personalised services, delivered in community settings, enabling greater choice and control for people who need support so that they can live full and meaningful lives

1.2 It also advocated for people who use services to have a greater voice in how services are developed, designed, delivered and evaluated.

1.3 Personalised services are those that are delivered in consultation with the person receiving them. Personalised services are ‘done with’ rather than ‘done to’ a person.

1.4 ‘Putting People First’ (2007) was the sector’s response to ‘Our Health Our Care Our Say’. It is a protocol setting out the shared vision for an adult social care system that was personalised and values led.

1.5 An example of an individual benefiting from a personalised approach is below (example taken from Community Care):

(1) Josephine had to cut short her career as a graphic designer due to the severity of rheumatoid arthritis. Her application for an individual budget gave her £324 per week of care. This is partly spent on massage, acupuncture and pedicures which help relieve some of the symptoms of the condition. Of most significance though is the employment of three personal assistants 30 hours a week to provide care and take her out on shopping trips. Finding PAs that could drive was hugely important giving Josephine regular contact with the outside world, whereas previously she’d been unable to get out much.

1.6 A key objective of NHS England (outlined in the Government's Mandate to the NHS) is for the NHS to become dramatically better at involving people; empowering them to manage and make decisions about their own care and treatment. This includes through the provision of personal health budgets which became mandatory in April 2014 for those who are entitled to Continuing Health Care (CHC) funding so that they can have a greater say in how their health and social care needs can be met.

1.7 A personal health budget is an amount of money to support a person’s identified health and wellbeing needs, planned and agreed between the person and their local NHS team.

1.8 Further references can be found at the following sources:

(1) The National Health Service (Direct payments) Regulations 2013
(2) National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised) DoH.

2 MAKING IT REAL – AN INTRODUCTION

2.1 Think Local Act Personal (TLAP) is the sector wide commitment to transform adult social care through personalisation and community-based support. It committed

over 30 national organisations to work together and to develop, as one of the key priorities, a set of markers.

2.2 These markers are being used to support all those working towards personalisation. The markers will help organisations check their progress and decide what they need to do to keep moving forward to deliver real change and positive outcomes with people.

2.3 The result is Making it Real, a framework developed by the whole Partnership, but led by members of the National Co-production Advisory Group, which is made up of people who use services and carers.

2.4 Making it Real is built around "I" statements. These express what people want to see and experience; and what they would expect to find if personalisation is really working well.

2.5 The "I" statements are set of "progress markers" - written by real people and families - that can help an organisation to check how they are going towards transforming adult social care.

2.6 The aim of Making it Real is for people to have more choice and control so they can live full and independent lives.

2.7 The "I" statements are at Appendix 3 – the Making it Real markers for change.

2.8 The CCG has also completed the NHS England markers of progress for CCGs introduced in 2014. This is a self-assessment tool that enables CCGs to understand local progress and plan their next steps. The CCG can access a local report comparing its progress with the national picture. BaNES CCG was not part of the early pilot site for PHBs but has made good progress against the markers in 2014.

3 EXPECTATIONS OF ORGANISATIONS THAT ENDORSE 'MAKING IT REAL'

3.1 Organisations that wish to endorse the principles of Making it Real begin the process by registering on the website www.thinklocalactpersonal.org.uk/Browse/mir/.

3.2 There are a series of steps that an organisation then follows to demonstrate their commitment to the Making it Real process and outcomes. These steps are outlined in Appendix 4 and include developing an action plan and identifying the top three priorities for change in the following 12 months.

3.3 Once registered, organisations then require Board level endorsement to continue the steps to Making it Real.

3.4 The purpose of this paper is to obtain that endorsement.

3.5 Each stage of Making it Real, including action plans and priorities, is made publicly available through the Think Local Act Personal website above.

4 AT WHAT STAGE IS BATH & NORTH EAST SOMERSET COUNCIL?

4.1 Bath & North East Somerset Council (B&NES) has made a commitment to Making it Real and has taken the first step by registering this commitment on the Making it Real website.

4.2 B&NES was an early adopter of personalisation and integration and is in a strong position to deliver against the Making it Real markers. However, there are identified areas that need improvement, including service user and carer involvement and co-production.

4.3 It is recommended therefore that the initial Making it Real action plan is written to prioritise further development in those areas.

4.4 A series of events are planned to support and promote the Making it Real agenda and approach. The first of these will be on 20th January, when a session will be held to introduce commissioners across the council and CCG to the principles of co-production, with examples of how this has worked within Children's Services. This will be followed by representation to the Health and Wellbeing Board on the 21st January to seek endorsement for our approach.

4.5 An event for providers has been organised to discuss the principles of Making it Real and to encourage them to develop action plans of their own to further this agenda. We are also planning further events to look specifically at implementing co-production during monitoring and evaluation.

4.6 A series of 'breakfast' type sessions are planned for the senior leadership teams of the council and CCG around co-production. These will introduce the concept and principles of co-production and review case studies of best practice. An on-going communications exercise is also planned to ensure members of staff within the Council and CCG that are unable to attend any of the sessions are up to date and aware of developments.

4.7 A draft programme structure is at Appendix 5 outlining the recommended approach to Making it Real in Bath and North East Somerset.

5 WHAT ARE THE LINKS WITH OTHER AREAS?

5.1 The implementation of the Care Act (2014)

(1) The Care Act (2014) is the single biggest change to care and support legislation in a generation. The Act consolidates 60 years of previous legislation, and also introduces new rights and obligations for people with care and support needs and local authorities respectively.

(2) The embedding of a truly personalised approach is key to the successful implementation of the Act and the Care Act Implementation Board is working to ensure the cultural change is in place to enable practitioners to have different conversations with people about their care and support. The aspirations of Making it Real are fully compatible with the aspirations of the Care Act and this proposal seeks to both avoid duplication and create continuity in delivering both agendas.

(3) The Care Act Implementation Board is currently responsible for the delivery of the outputs and outcomes of the Care Act for Bath and North East Somerset.

(4) It is proposed that during the development stage of the Making it Real Implementation Group, it sits alongside the Care Act Implementation Board, and that Care Act work streams include representation from the developing Making it Real Implementation Group (MIR Implementation Group).

(5) Once the Making it Real Implementation Group and its membership are established, it may be in a position to succeed the Care Act Implementation Board, as the main vehicle to direct and effect change within Adult Social Care. This will need further discussion and agreement in the future.

5.2 Integrated Personal Commissioning (IPC)

(1) In July 2014, NHS England set out plans for a new Integrated Personal Commissioning (IPC) programme. This will for the first time blend comprehensive health and social care funding for individuals, and allow them to direct how it is used.

(2) In October 2014, Tracey Cox- BaNES CCG Chief Officer endorsed the application submitted by the South West Strategic Clinical Network on behalf of organisations across the South West to become an early adopter of the IPC:

a) "On behalf of BaNES CCG and my Local Authority Colleagues, Ashley Ayre, Strategic Director People & Communities, and Councillor Simon Allen, Chair of the Health and Wellbeing Board, we are happy in principle to support this application."

(3) Appendix 6 contains the supporting papers for the IPC programme in the SW.

6 WHAT ARE THE RESOURCE IMPLICATIONS AND RECOMMENDATIONS?

6.1 This work will be managed and co-ordinated by the Transformation and Strategic Planning Manager with the initial support of the current multi-agency Personalisation Implementation Group. This Group will form the pre-MIR Implementation Group and will be responsible for the actions outlined in the draft action plan in Appendix 5.

6.2 Funding will be required to deliver the action plan and it is intended to use the existing Transformation budget.

7 WHAT IS REQUESTED OF THE HEALTH AND WELLBEING BOARD?

7.1 The Health and Wellbeing Board is requested to endorse:
(1) The commitment to Making it Real
(2) The proposal to develop a 'Making it Real' action plan
(3) The principles of co-production which this will entail
(4) The draft programme structure as at Appendix 5

7.2 It is also requested that the Health and Wellbeing Board receive six monthly reports detailing progress towards the Making it Real markers of change.

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

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Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Equality Impact Assessment / Equality Analysis

Title of service or policy	‘Making it Real’ in Bath and North East Somerset
Name of directorate and service	People and Communities, Adult Social Care Commissioning
Name and role of officers completing the EIA	Wendy Sharman, Transformation and Strategic Planning Manager
Date of assessment	January 2015

Equality Impact Assessment (or 'Equality Analysis') is a process of systematically analysing a new or existing policy or service to identify what impact or likely impact it will have on different groups within the community. The primary concern is to identify any discriminatory or negative consequences for a particular group or sector of the community. Equality impact Assessments (EIAs) can be carried out in relation to service delivery as well as employment policies and strategies.

This toolkit has been developed to use as a framework when carrying out an Equality Impact Assessment (EIA) or Equality Analysis on a policy, service or function. It is intended that this is used as a working document throughout the process, with a final version including the action plan section being published on the Council's and NHS Bath and North East Somerset's websites.

1.	**Identify the aims of the policy or service and how it is implemented.**	
	Key questions	**Answers / Notes**
1.1	Briefly describe purpose of the service/policy including • How the service/policy is delivered and by whom • If responsibility for its implementation is shared with other departments or organisations • Intended outcomes	This Equality Impact Assessment (EIA) has been written to support the paper being presented to the Health and Wellbeing Board entitled 'Making it Real in Bath and North East Somerset' (MIR). The MIR paper proposes that B&NES develop a Making it Real Implementation Group and action plan. This action plan will set out how the council will work towards the goals of 'Making it Real', the Think Local Act Personal progress markers towards the transformation of social care. The Making it Real action plan will be delivered by B&NES in partnership with the people who use our services and their carers, Bath & North East Somerset Clinical Commissioning Group (CCG), Sirona Care and Health, the voluntary and community sector (VCS) and other providers. The implementation will be overseen by the Making it Real Implementation Group. The intended outcome of Making it Real is for the services that are commissioned by B&NES and the CCG to be delivered in a truly personalised way. The aim of Making it Real is for people to have more choice and control so they can live full and independent lives.
1.2	Provide brief details of the scope of the policy or service being reviewed, for example: • Is it a new service/policy or review of an	The proposal to develop a Making it Real action plan is a new proposal that builds on existing policy guidance. The directive to sign up to Making it Real and the associated action planning came from Norman Lamb MP, Care and Support Minister in 2014 to encourage participation in the process by Local Authorities and partner organisations. This request has been repeated from central government several times. The Making it Real approach is also best practice, is the national direction of travel, it is consistent

	existing one? • Is it a national requirement?). • How much room for review is there?	with and supportive of requirements under the Care Act 2014 and is intended to greatly benefit our communities, with associated financial benefits for the authority. The proposal is to develop a Making it Real action plan and Implementation Group which would guide the implementation of Making it Real within Bath and North East Somerset.
1.3	Do the aims of this policy link to or conflict with any other policies of the Council?	This proposal is consistent with current council policies, including the Joint Health and Wellbeing Strategy, the procurement strategy 'Think Local' and the Public Services Board vision for Bath and North East Somerset. The proposal is also consistent with the NHS England objective for the NHS to become better at involving people, empowering them to manage and make decisions about their own care and treatment.

2. Consideration of available data, research and information

Monitoring data and other information should be used to help you analyse whether you are delivering a fair and equal service. Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data** (including ethnicity, gender, disability, religion/belief, sexual orientation and age)
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
- Recommendations of **external inspections** or audit reports

	Key questions	**Data, research and information that you can refer to**
2.1	What is the equalities profile of the team delivering the	The team that will deliver this programme is as yet not formed. The proposal is to develop a Making it Real Implementation Group that would have representation from both 'professionals' and people

	service/policy?	who use services. The Implementation Group will need to take into account its equalities profile and ensure that its work streams reflect the equalities profile of the area.
2.2	What equalities training have staff received?	All employees of Bath & North East Somerset Council are required to undertake Equalities training as part of their induction and mandatory training. Equalities training must be updated every 3 years. Equalities training requirements are a core part of our contracting and procurement processes, with all providers asked to confirm their compliance with the Equality Act (2010). Equalities training will form part of the support provided to the service user and carer representatives on the Implementation Group.
2.3	What is the equalities profile of service users?	According to the current Joint Health and Wellbeing Strategy: • People aged 75 years and over made up approximately 57% of the adult social care clients in Bath and North East Somerset in 2012-13 • People with physical disabilities made up approximately 58% of the adult social care clients in B&NES in 2012-13 The gender profile from our service user and carer data is: • Carers 1st Apr to 30th Sep: Female 294 (69%), Male 132 (31%), Total 426. • Service users as on 30th Sep: Female 1442 (61%), Male 932 (39%), Total 2374. Compare this to the general population statistics from the 2011 census which shows that 51.1% (89,944) of the population of B&NES are female and 48.9% (86,072) are male. Other data relating to our service user profile is as follows:

RAP TABLE P4 - 18 to 64 - BNES & AWP - Ethnicity & Services for the period, 1st April 2014 to 31st March 2015, to 30th Sep 2014

		Total Number Clients	1. Community	2. Residential	3. Nursing
01. White	01. White British	882	746	122	19
	02. White Irish	1	1		
	05. White - Other	14	13	1	
02. Mixed	06. Mixed White and Black Caribbean	5	4	2	
	07. Mixed White and Black African	2	1	1	
	08. Mixed White and Asian	4	3	1	

	09. Mixed - Other	2	1	1	
03. Asian or Asian British	12. Asian Bangladeshi	1	1		
	13. Asian Other	1	1		
04. Black or Black British	14. Black Caribbean	13	11	2	
	15. Black African	3	2	1	
	16. Black - Other	6	5	1	
05. Chinese or other ethnic group	17. Chinese	4	2	2	
	18. Other ethnic group	5	4	1	
06. Not stated	19. Refused	2	2		
	20. Not yet obtained	60	55	6	1

RAP TABLE P4 - 65 and over - BNES & AWP - Ethnicity & Services for the period 1st April 2014 to 31st March 2015, to 30th Sep 2014

		Total Number Clients	**1. Community**	**2. Residential**	**3. Nursing**
01. White	01. White British	1660	1001	299	442
	02. White Irish	12	7	3	3
	05. White - Other	22	12	4	7
02. Mixed	06. Mixed White and Black Caribbean	1	1		
	09. Mixed - Other	5	4	1	
03. Asian or Asian British	10. Asian Indian	8	7	1	
	13. Asian Other	3	2		1
04. Black or Black British	14. Black Caribbean	10	5	2	3
	16. Black - Other	1			1
05. Chinese or other ethnic	17. Chinese	2	2		

group					
	18. Other ethnic group	2	1	1	
06. Not stated	19. Refused	5	2	2	1
	20. Not yet obtained	84	45	23	19

The ethnicity breakdown of all personal budget holders is as follows:

Rap Ethnicity Subgroup	Not Using SDS Process	SDS Process	Total
01. White British	2	1205	1207
02. White Irish	0	6	6
03. Traveller of Irish Heritage	0	0	0
04. Gypsy/Roma	0	0	0
05. White - Other	0	21	21
06. Mixed White and Black Caribbean	0	4	4
07. Mixed White and Black African	0	1	1
08. Mixed White and Asian	0	3	3
09. Mixed - Other	0	2	2
10. Asian Indian	0	7	7
11. Asian Pakistani	0	0	0
12. Asian Bangladeshi	0	1	1
13. Asian Other	0	3	3
14. Black Caribbean	0	14	14
15. Black African	0	1	1
16. Black - Other	0	5	5
17. Chinese	0	2	2
18. Other ethnic group	1	4	5
19. Refused	0	0	0
20. Not yet obtained	0	51	51
00. Total	3	1330	1333

An analysis of the comparison between the above statistics and those of the general population is shown below:

Ethnicity subgroup	65+	18-64	PB Holders	Census population stats

01. White British	91.5%	87.8%	90.5%	90.1%
02. White Irish	0.7%	0.1%	0.5%	0.7%
03. Traveller of Irish Heritage			0.0%	0.0%
04. Gypsy/Roma			0.0%	0.0%
05. White - Other	1.2%	1.4%	1.6%	3.8%
06. Mixed White and Black Caribbean	0.1%	0.5%	0.3%	0.5%
07. Mixed White and Black African		0.2%	0.1%	0.2%
08. Mixed White and Asian		0.4%	0.2%	0.5%
09. Mixed - Other	0.3%	0.2%	0.2%	0.4%
10. Asian Indian	0.4%		0.5%	0.6%
11. Asian Pakistani			0.0%	0.1%
12. Asian Bangladeshi		0.1%	0.1%	0.1%
13. Asian Other	0.2%	0.1%	0.2%	0.7%
14. Black Caribbean	0.6%	1.3%	1.1%	0.4%
15. Black African		0.3%	0.1%	0.3%
16. Black - Other	0.1%	0.6%	0.4%	0.1%
17. Chinese	0.1%	0.4%	0.2%	1.1%
Other ethnic group: Arab				0.2%
18. Other ethnic group	0.1%	0.5%	0.4%	0.2%
19. Refused	0.3%	0.2%	0.0%	0.0%
20. Not yet obtained	4.6%	6.0%	3.8%	0.0%

This final table shows interesting differences between the general population (last column) and our service user populations. For example, the second largest population group after White British is White-Other, reflecting recent populations from Eastern Europe. However, this increase is not reflected proportionally in our service user statistics (i.e. the general population is 3.8% but this group makes up only 1.6% of personal budget holders). Also, people identifying as Black Caribbean make up 0.4% of the general population, however 1.3% of service users aged 18-64 and 1.1% of personal budget holders identify as this ethnic group.

2.4	What other data do you have in terms of service users or staff? (e.g. results of customer satisfaction surveys,	From the Personal Social Services Adult Social Care Survey, England - 2013-14, in general, residents of Bath & North East Somerset report greater levels of satisfaction with their care and support when compared to the England average. However in response to a question asking about quality of life, respondents in B&NES gave more negative responses, particularly from people with

	consultation findings). Are there any gaps?	a learning disability (2.7% of people with a learning disability answered that 'my life is really terrible' compared to the England average of 0.6% for this group). When asked to think about how safe they felt, 2.3% of respondents answered that they 'don't feel safe at all' compared to the England average of 1.8%. Questions relating to the care and support needs of individuals indicated that respondents in B&NES have a higher need for support with finances and paperwork than the England average and have a higher reported incidence of moderate anxiety or depression. Perhaps most worryingly, 27.3% of respondents indicated that they never leave their home, compared to the England average of 23.7%. More respondents indicated that they receive support from someone living in another household, but a higher than average number of respondents indicated that they did not buy additional or top up care (70.2% B&NES compared to 64.5% England average). From the same survey, nationally people who identify as Buddhist, Muslim, Jewish or Sikh are more likely to report they are dissatisfied with the care and support they receive (however the numbers of individuals identifying as Buddhist is very low and may not be statistically significant). Similarly, Buddhist, Muslim and Jewish individuals report that their quality of life is bad, very bad or so bad it could not be worse. People identifying as Hindu and Muslim report having little or no control over their daily lives, with the Buddhist group reporting the greatest control. In general Muslim, Hindu and Buddhist groups report the lowest scores in this survey, however, when considering whether care and support services help in feeling safe, these groups report feeling safer than others. The Personal Social Services Survey of Adult Carers in England - 2012-13 gave some interesting data as generally carers in B&NES report significantly lower usage of support services (either for themselves or the people they support) than the England average (36.5% of respondents indicated that they had not received any support in the last 12 months compared to the England average of 15.5%). Carers in B&NES reported caring for more 35-44 year olds and 75-84 year olds than the England

		average, with more carers indicating they cared for people with a mental health problem and alcohol or drug dependency than the England average. Carers also report lower usage of services such as short breaks, respite and personal assistants than the England average. Respondents did use information and advice services more than the reported usage in England as a whole, and also received support from carers groups or someone to talk to in confidence more than the England average. Carers reported they were able to spend their time doing the things they value or enjoy more than the England average (25.2% in B&NES compared to 21.8% England average) but nearly 60% of respondents said they had some control over their daily lives but not enough. Finally, a high proportion of carers indicated that there had been no discussions that they had been aware of in the last 12 months about the support or services delivered to the person they care for, 31.6% compared to 24.1% England average. Additionally, 5.6% of carers indicated they never felt involved or consulted, compared to the England average of 5.0%.
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	No engagement has been undertaken as part of the development of this EIA. This is because the purpose of this programme and the EIA accompanying it is to seek endorsement for developing a Making it Real Implementation Group which will in turn develop a Making it Real action plan. The Implementation Group and plan should embed the personalisation and co-production approach across adult social care and health. Co-production moves away from individual engagement and involvement events, towards an on-going productive conversation with people who use services, their carers and professionals. Equalities issues should be addressed as part of this on-going conversation.
2.6	If you are planning to undertake any consultation in the future regarding this service or policy, how will you include equalities considerations within this?	As mentioned above, equalities considerations will be central to the Making it Real Implementation Group and subsequent development of the action plan. We will actively seek to ensure that all equalities groups are supported to be involved in the development, delivery and evaluation of the Making it Real action plan. Co-production and seeking views from across the spectrum of service user and carer experience and backgrounds is central to Making it Real. The pre-Implementation Group will develop as part of its initial actions an EIA to ensure equalities needs are taken into consideration.

	3. Assessment of impact: 'Equality analysis'		
	Based upon any data you have considered, or the results of consultation or research, use the spaces below to demonstrate you have analysed how the service or policy: • Meets any particular needs of equalities groups or helps promote equality in some way. • Could have a negative or adverse impact for any of the equalities groups		
		Examples of what the service has done to promote equality	**Examples of actual or potential negative or adverse impact and what steps have been or could be taken to address this**
3.1	**Gender –** identify the impact/potential impact of the policy on women and men.	Making it Real is an approach which puts the service user at the centre of the support they receive. The purpose of this is to enable all service users to direct their own support, tailored to their needs.	In general, men tend to be under-represented in our service user and carer statistics (and our staff groups) compared to the general population (see above), a fact which may mean that the needs and experiences of this group may get overlooked. Support for male service users and carers will be considered within the EIA produced and updated by the Implementation Group.
3.2	**Pregnancy and maternity**	One of the Markers for Change in Making it Real states that 'I have help to make informed choices if I need and want it'. This could easily apply to individuals with care and support needs who are pregnant or considering starting a family. The Making it Real approach ensures that individuals are enabled to direct their own support and understand their options in all aspects of their lives.	Support to enable positive discussions with people who have a disability or illness who may be pregnant, considering a family, or in need of advice, may not always take place. Making it Real should enable those conversations to happen in a supportive and constructive way.
3.3	**Transgender – –** identify the impact/potential impact of the policy on transgender people	One of the Markers for Change states 'I have considerate support delivered by competent people'. This particular Marker ensures that	Transgender people report a variety of impacts on their ability to enjoy a full life, including assumptions made about support workers and

		the individual is in control of the people who are supporting and advising them, and that they are in control of the support they receive, a particularly sensitive issue for this community.	accommodation. By adopting a 'Making it Real' approach, each individual will be able to develop support that is tailored to their needs and wishes with staff who have received appropriate training and support themselves.
3.4	**Disability** - identify the impact/potential impact of the policy on disabled people (ensure consideration both physical and mental impairments)	Adopting a Making it Real approach should have a highly positive impact for people with disability, whether physical or mental.	A potential impact of a Making it Real approach which will need to be closely monitored may be an increased exposure to risk, such as risk of financial abuse. However, this can be managed and monitored carefully and positive risk taking explained, encouraged and supported.
3.5	**Age** – identify the impact/potential impact of the policy on different age groups	Making it Real encourages an individual's needs and wishes to be taken into account when planning for their support. This will be regardless of an individual's age and will support the outcomes that matter to that individual.	The Making it Real action plan and Implementation Group will be concerned with adults only, but links will be made with children and young people's services to ensure continuity for those children and young people transitioning to adult services.
3.6	**Race** – identify the impact/potential impact on different black and minority ethnic groups	There are significant differences in the experiences of different ethnic groups within Bath and North East Somerset, as can be seen from the tables above. Adopting a Making it Real approach should enable individuals and communities to take more control over their health and wellbeing, and tailor the support they need.	The ethnic population of Bath and North East Somerset is changing as can be seen in the tables above. It will be important that these changes are reflected in the services that commissioned and that the EIA the Implementation Group develops and maintains takes this into account.
3.6	**Sexual orientation -** identify the impact/potential impact of the policy on lesbians, gay, bisexual & heterosexual people	A person's sexual orientation should not affect the care and support they receive. By adopting a Making it Real approach, service users and carers can take control of the workforce that supports them, and properly train and manage them. This should ensure the support they receive both meets their needs but is also delivered in a non-judgemental way.	Issues around sexual orientation and identity will be picked up in the EIA the Implementation Group develops and maintains.

3.7	**Marriage and civil partnership** – does the policy/strategy treat married and civil partnered people equally?	The approach of Making it Real should not discriminate between people who are married or in a civil partnership.	No potential unintended consequences identified at this stage, however this will be kept under review during the development of the Implementation Group EIA.
3.8	**Religion/belief** – identify the impact/potential impact of the policy on people of different religious/faith groups and also upon those with no religion.	The Making it Real approach should have a positive effect on people of religious / faith groups and also those of no faith. This is because support and services are developed with the individual at the centre and in control. This should ensure that a person is supported to continue to participate in activities of faith that are important to them. Supporting statements from the Making it Real Markers for Change are: • 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. • I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities. • I feel valued for the contribution that I can make to my community.	Data from the Personal Social Services Adult Social Care Survey have been detailed in 2.4 above in relation to religion and belief. While these responses are national and may not reflect the picture in Bath and North East Somerset, there is potential for the Making it Real approach to improve some of these outcomes. This will be kept under review during the development of the Implementation Group EIA.
3.9	**Socio-economically disadvantaged** – identify the impact on people who are disadvantaged due to factors like family background, educational attainment, neighbourhood and employment status.	Making it Real should have a positive impact on individuals who are disadvantaged due to the factors listed here. This is because the premise of Making it Real is to look beyond simply care and support and to consider the needs and aspirations of the person within their community and family life. By focussing on the person as a whole, the impact of some socio-economic factors, while not being wholly mitigated, may be lessened.	Information regarding the needs and issues faced by people who are identified as being disadvantaged by the factors listed here should be considered as part of the main EIA developed and maintained by the Implementation Group.
3.10	**Rural communities** – identify the impact / potential impact on	Making it Real has a strong focus on the individual feeling a positive part of their	Making it Real will encourage individuals to consider their wider support networks and

	people living in rural communities	community. This will be of particular importance to people with care and support needs who live in rural areas, as generally there are fewer 'traditional' services in these areas.	communities when thinking about their needs. This may lead to non-traditional methods of support being identified, for example from community members or groups, which are not specifically commissioned for social care purposes.

4. Bath and North East Somerset Council & NHS B&NES
Equality Impact Assessment Improvement Plan

Please list actions that you plan to take as a result of this assessment. These actions should be based upon the analysis of data and engagement, any gaps in the data you have identified, and any steps you will be taking to address any negative impacts or remove barriers. The actions need to be built into your service planning framework. Actions/targets should be measurable, achievable, realistic and time framed.

Issues identified	Actions required	Progress milestones	Officer responsible	By when
Need for further development of this EIA by pre-Implementation Group. To be reviewed regularly to ensure equalities issues are considered throughout the development of the Making it Real action plan and associated policy statements.	Pre-Implementation Group to develop a draft EIA.	Development of draft EIA	Transformation and Strategic Planning Manager, and pre-Implementation Group	End Feb 2015
Implementation Group EIA needs to be reviewed prior to formal constitution of the Implementation Group.	Draft EIA to be reviewed and finalised before Implementation Group constituted.	Final EIA published.	Transformation and Strategic Planning Manager, and pre-Implementation Group	End May 2015

5. Sign off and publishing

Once you have completed this form, it needs to be 'approved' by your Divisional Director or their nominated officer. Following this sign off, send a copy to the Equalities Team (equality@bathnes.gov.uk), who will publish it on the Council's and/or NHS B&NES' website. Keep a copy for your own records.

Signed off by: (Divisional Director or nominated senior officer)

Date:

Risk Register Name	Making it Real action plan development		
Risk Register Owner	Wendy Sharman	Date updated:	09-Jan-15

Nr	Description	Date Entered on Register	Risk or Opportunity?	Risk/Opportunity Owner	Category	Corporate Or Service Action Plan	Details of Links to Corporate or Service Action Plan	Current Risk Score: Likelihood 1 (L)	Likelihood 2 (L)	Likelihood 3 (M)	Likelihood 4 (H)	Likelihood 5 (H)	Impact 1 (L)	Impact 2 (L)	Impact 3 (M)	Impact 4 (H)	Impact 5 (H)	This Period	Trend: Periods Ago 1	Periods Ago 2	Periods Ago 3	Strategy to Manage Risk	Current Status of Actions RAG	Commentary on Current Status of Action Plans	Final Implementation Date	Financial Impact	Scale of Financial Impact
R01	The Health and Wellbeing Board may not endorse the approach. This would result in the need to reconsider our approach to personalisation and co-production.		Risk	Transformation and Strategic Planning Manager	Stakeholder			1									5	5				Treat	On Target	A comprehensive report and draft action plan have been compiled for the Health and Wellbeing Board to seek their support for the Making it Real agenda. Support has been obtained in advance from Council and CCG Directors for the recommended approach.			
R02	There is a risk that partner organisations will not endorse the approach, this will mean that the MIR action plan is not co-produced with partner organisations, alongside service users and carers.		Opportunity	Transformation and Strategic Planning Manager	Stakeholder			1								4		4				Treat	On Target	A session for providers is planned for January to discuss the MIR approach and co-production. Discussions have already taken place with voluntary sector partners around this.			
R03	There is a risk that service users and carers will find it difficult to participate in the development of the action plan. This will mean we are not able to fulfill the purpose of Making it Real which is to co-produce our action plan.		Opportunity	Transformation and Strategic Planning Manager	Stakeholder					3							5	15				Treat	On Target	As part of the action plan to develop the pre-Board and Board, communications to service users and carers will be clear in the support that will be available to them in order to enable them to participate in the work of the Board. Funding to enable their support will be set aside.			
R04	There is a risk that service users and carers will present their own experiences and issues and not feel able to speak on behalf of a community of service users.		Opportunity	Transformation and Strategic Planning Manager	Stakeholder						4					4		16				Treat	On Target	Community leadership training program has been sourced from Islington Council. This has been delivered, revised and evaluated and has been made available to B&NES to purchase. It has been extremely successful in its implementation in Islington.			
R05	There is a risk that the funding available will not be adequate to support the implementation of Making it Real. This will mean participation and co-production will be harder to effectively deliver.		Risk	Transformation and Strategic Planning Manager	Resources					3					3			9				Treat	On Target	Funding currently available. Transformation and Strategic Planning Manager to monitor the financial position and report regularly to Director and Board.			
R06	There is a risk that we will not be able to co-produce our action plan with service users and carers who are representative of the breadth of people who come into contact with our services.		Opportunity	Transformation and Strategic Planning Manager	Stakeholder						4				3			12				Treat	On Target	An equalities impact assessment will need to be carried out during the development of the MIR action plan to ensure all equalities groups are proportionately represented and considered. Equalities information from the JSNA will guide this part of the Board's work.			
R07	There is a risk that the Making it Real action plan will have a disproportionate emphasis on adult social care and will not include a strong focus on health services.		Opportunity	Transformation and Strategic Planning Manager	Stakeholder				2							4		8				Treat	On Target	Endorsement has been obtained from the CCG for the Making it Real approach. The Transformation and Strategic Planning Manager will maintain close communication with CCG Directors to ensure this risk remains on target.			
R08																											
R09																											
R10																											
R11																											
R12																											
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								Current Risk Score											Trend								
Nr	Description	Date Entered on Register	Risk or Opportunity?	Risk/Opportunity Owner	Category	Corporate Or Service Action Plan	Details of Links to Corporate or Service Action Plan	Likelihood 1	2	3	4	5	Impact 1	2	3	4	5	This Period	Periods Ago 1	2	3	Strategy to Manage Risk	Current Status of Actions RAG	Commentary on Current Status of Action Plans	Final Implementation Date	Financial Impact	Scale of Financial Impact
								L		M		H	L		M		H										
R23																											
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R67																											
R68																											
R69																											
R70																											
TOTAL																		69									
	7																										

	This Period	Periods Ago 1	2	3
Average	9.9			
Maximum	16			
Minimum				

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Making it Real
Markers for change

Information and Advice. Having the information I need, when I need it.

- I have the information and support I need in order to remain as independent as possible.
- 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.
- I have help to make informed choices if I need and want it.
- I know where to get information about what is going on in my community.

Active and supportive communities. Keeping friends, family and place

- 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.
- I have a network of people who support me - carers, family, friends, community and if needed paid support staff.
- I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities.
- I feel welcomed and included in my local community.
- I feel valued for the contribution that I can make to my community.

Flexible integrated care and support. My support my own way

- I am in control of planning my care and support.
- 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.

Workforce. My support staff

- I have good information and advice on the range of options for choosing my support staff.
- I have considerate support delivered by competent people.
- I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers.
- I am supported by people who help me to make links in my local community.

Risk enablement. Feeling in control and safe

- I can plan ahead and keep control in a crisis.
- I feel safe, I can live the life I want and I am supported to manage any risks.
- I feel that my community is a safe place to live and local people look out for me and each other.
- I have systems in place so that I can get help at an early stage to avoid a crisis.

Personal budgets and self-funding. My money

- I can decide the kind of support I need and when, where and how to receive it.
- 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, direct payment, or a council managed personal budget).
- I can get access to the money quickly without having to go through over-complicated procedures
- I am able to get skilled advice to plan my care and support, and also be given help to understand costs and make best use of the money involved where I want and need this.

Steps you need to take to declare a commitment to Making it Real

1. **Register your organisation**

"We are getting ready to Make a Declaration". Register your organisation and the name of your Making it Real lead.

2. **Make a board level declaration**

Make a board level declaration confirming that your organisation supports the move towards Making it Real. Ensure that the declaration is co-produced with people who use services and carers.

3. **Making it Real 'I' statements**

Internally identify, through discussions with people who use services, carers and citizens* and your local workforce, where your organisation is in relation to the Making it Real 'I' statements (opens new window).

4. **Develop a Making it Real action plan**
   - Identify the gaps and challenges your organisation will need to address, to support the outcomes identified in Making it Real.
   - Develop a Making it Real action plan confirming what actions your organisation has agreed to take.

5. **Share your action plan**

Share your action plan publicly through your local websites and communication networks or on this website

6. **Identify 3 priority areas**

On the basis of your Making it Real action plan, identify 3 priority areas you will share via the TLAP website.

7. **Add the 3 Making it Real priority areas**

Add the 3 Making it Real priority areas to the TLAP website.

8. **Download the TLAP Making it Real kitemark**

Download the TLAP Making it Real kitemark.

9. **Display the TLAP Making it Real kitemark**

Display the TLAP Making it Real kitemark on your local websites to confirm you are part of Making it Real

10. **Put a report on your local website**

After 6 months, **put a report on your local website** to confirm how much progress you have made against your Making it Real action plan. Identify what still needs to be done and how this will be achieved.

11. **Upload an update**

Upload an update on how much progress you have made against your top 3 priorities.

12. **Upload a short summary of a successful initiative**

Upload a short summary of a successful initiative which others can learn from

13. **Repeat these steps every 6 months**

*It is important that people who use services, carers and citizens co-produce each stage of Making it Real action plans and that co-production is visibly demonstrated in reports provided.

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Draft programme structure and action plan for Making it Real

Aim
To design a programme structure and action plan to effectively support the delivery of the outputs and outcomes of Making it Real for Bath & North East Somerset Council.

Proposed programme structure
The proposed structure builds on examples of best practice developed by Islington Council, and the paper 'Co-production in social care: What it is and how to do it' produced by the Social Care Institute for Excellence (SCIE). The SCIE report recommends approaches to co-production, and includes case studies. The recommendations from the report (see **Appendix A**) are based on a framework for change management centred on four key areas:

1. Culture
2. Structure
3. Practice
4. Review

The proposed structure for B&NES will result in fully embedding co-production and the principles of Making it Real throughout the decision making processes of Bath & North East Somerset Council Adult Social Services. It will do this by eventually establishing a 'Making it Real Implementation Group' supported by working groups (see fig. 1 below). The Implementation Group will sit alongside the Care Act Implementation Board and will share a number of work streams with that Board (thus reducing duplication of effort).

This Implementation Group will be co-chaired by a service user or carer and the Director, Adult Care and Health Commissioning.

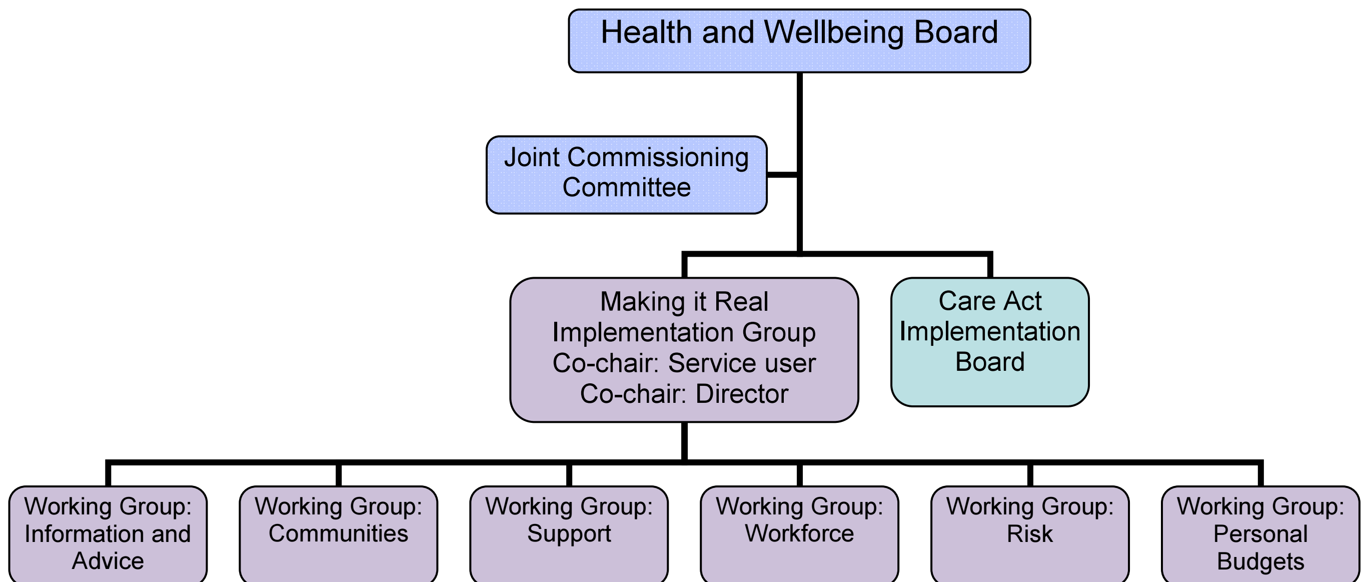

Fig 1. Proposed Implementation Group structure for Making it Real. Note that the proposed working groups above reflect the high level outcomes identified as the Making it Real Markers for Change. It is unlikely all these groups will be running at the same time, as the Implementation Group will be agreeing an action plan based on its top three priorities.

The Making it Real Implementation Group
In order to be successful and fully achieve the vision of Making it Real, the Implementation Group will need to influence culture and practice throughout adult social care and the CCG. It

can only do this by being co-chaired, and by one of the co-chairs to be a key influencer and decision maker within the organisations.
To this end, as stated above, the Implementation Group will be co-chaired by a service user representative and the Director, Adult Care and Health Commissioning. This is an important and vital aspect of the Implementation Group, and one which visibly demonstrates our commitment to listen to our communities and service users and co-produce solutions to the issues arising within Bath and North East Somerset. Service users and carers, along with providers and voluntary and community sector representatives will also attend the Implementation Group.

Having broad representation at a high level will be important to ensure that the principles of co-production are embedded throughout the organisation, supporting the culture change identified by SCIE as being necessary to fully embrace co-production.

The Implementation Group in its development stage will sit alongside the Care Act Implementation Board as shown in fig. 1 above, and representatives of the Implementation Group will attend the Care Act work streams. Once the Implementation Group and its membership are established, it may be in a position to succeed the Care Act Implementation Board, as the main vehicle to direct and effect change within Adult Social Care.

The initial Implementation Group membership will include senior commissioners from the Council and CCG, alongside provider organisations from both the voluntary and private sectors. These members will work to deliver the action plan mentioned below. As the Implementation Group membership grows and develops, it may be necessary to establish a small Executive to set agendas for the Implementation Group meetings. Membership of this Executive will be balanced between experts by experience and professionals.

The proposed work streams
The work streams identified in Fig. 1 correspond to the Making it Real 'Markers for Change' (see ATT2). The work streams are compatible with the work of the Care Act Implementation Board, and a representation of the cross-over of these pieces of work is shown in **Appendix B** below.

It is unlikely that all six work streams will be running at the same time. The Implementation Group will need to agree its top three priorities to work on, develop and action plan to meet these and work streams will be aligned to those.

Suggested initial action plan
There are several initial actions that will need to be undertaken before the Implementation Group can become fully operational and constituted. These actions will be defined by setting an early action plan, drafted at **Appendix C** below. This action plan will lead to the development of the first Making it Real action plan, which should be co-produced.

Budgetary requirements
The effective delivery of the initial work plan below will require financial support to enable service users and carers to fully participate in the Implementation Group. It is reasonable to assume that there will be financial implications of producing and delivering the Making it Real action plan, which will include training and support for service users and carers to actively participate in the process, training for staff within B&NES and the CCG, support from members of the National Co-production Advisory Group (NCAG), and support to evaluate the impact / effectiveness of Making it Real and the co-production approach.

It is intended to use the Transformation budget for this work.

Programme Initiation
A series of events are planned to support and promote the Making it Real agenda and approach. The first of these will be on 20th January, when a session will be held to introduce commissioners across the council and CCG to the principles of co-production, with examples of how this has worked within Children's Services. This will be followed by representation to the Health and Wellbeing Board on the 21st January to seek endorsement for our approach.

An event for providers has been organised to discuss the principles of Making it Real and to encourage them to develop action plans of their own to further this agenda. We are also planning further events to look specifically at implementing co-production during monitoring and evaluation.

A series of 'breakfast' type sessions are planned for the senior leadership teams of the council and CCG around co-production. These will introduce the concept and principles of co-production and review case studies of best practice. An on-going communications exercise is also planned to ensure members of staff within the Council and CCG that are unable to attend any of the sessions are up to date and aware of developments.

Making it Real is a transformational way of considering how we support and recognise people with care and support needs. It offers us an opportunity to fully engage the people we support, to encourage them to become active citizens, to understand their strengths and the abilities they have and how they can add value to their communities.

Appendix A
Co-production in social care: What it is and how to do it
Recommendations

How to do co-production – gives recommendations on how to develop co-productive approaches in organisations and projects. The section and its recommendations are based on a framework for change management structured around a four piece jigsaw covering culture, structure, practice and review. The recommendations are:

Culture

- Ensure that co-production runs through the culture of an organisation.
- Ensure that this culture is built on a shared understanding of what coproduction is, a set of principles for putting the approach into action and the benefits and outcomes that will be achieved with the approach.
- Ensure that organisations develop a culture of being risk aware rather than risk averse.

Structure

- Involve everyone who will be taking part in the co-production from the start.
- Value and reward people who take part in the co-production process.
- Ensure that there are resources to cover the cost of co-production activities.
- Ensure that co-production is supported by a strategy that describes how things are going to be communicated.
- Build on existing structures and resources.

Practice

- Ensure that everything in the co-production process is accessible to everyone taking part and nobody is excluded.
- Ensure that everyone involved has enough information to take part in coproduction and decision making.
- Ensure that everyone involved is trained in the principles and philosophy of coproduction and any skills they will need for the work they do.
- Think about whether an independent facilitator would be useful to support the process of co-production.
- Ensure that frontline staff are given the opportunity to work using co-production approaches, with time, resources and flexibility.
- Provide any support that is necessary to make sure that the community involved has the capacity to be part of the co-production process.
- Ensure that policies and procedures promote the commissioning of services that use co-production approaches.
- Ensure that there are policies for co-production in the actual process of commissioning.

Review

- Carry out regular reviews to ensure that co-production is making a real difference and that the process is following the agreed principles.
- Co-produce reviews and evaluations.
- Use the review findings to improve ways of applying the principles of coproduction, so that continuous learning is taking place.
- During reviews and evaluations, work with people who use services and carers, to think about ways of showing the impact that co-production has, as well as the processes that are involved

Appendix B

Tables demonstrating the interrelated themes of the implementation of the Care Act 2014 and the proposed work streams based on the markers for change from Making it Real

Relevant Care Act 2014 Sections grouped into general themes (numbers relate to the sections in the Act)		
General	**Assessment**	**Support**
1. Wellbeing	6. Co-operation	25. Care and support plans
2. Prevention	9. Assessments	26. Personal budgets
3. Integration	10. Carers assessments	27. Reviews
4. Information and advice	24. Steps to take following an assessment	31. Direct payments
5. Diversity and quality in the market		
67. Advocacy		

Making it Real proposed work streams (based on the Markers for Change)	Relevant Care Act Sections/Themes		
	General	Assessment	Support
Information and Advice. Having the information I need, when I need it	4. 67.		
Active and supportive communities. Keeping friends, family and place	2.	10.	25.
Flexible integrated care and support. My support my own way	1. 3.	9. 24.	25. 27.
Workforce. My support staff	4. 5.		
Risk enablement. Feeling in control and safe	1.	9.	25. 27.
Personal budgets and self-funding. My money	4.	9. 24.	25. 26. 31.

Appendix C – Suggested initial action plan

Action	Owner	Done by	Outcome
Initiation stage			
1. Identify members to join pre-Implementation Group	Transformation and Strategic Planning Mgr	Jan 2015	Potential Implementation Group members are identified. To include providers, CCG and local authority.*
2. Develop draft Terms of Reference for the (pre) Implementation Group	Transformation and Strategic Planning Mgr	Jan 2015	Potential Implementation Group members are aware of the purpose of the Implementation Group and its aims.
3. Invite pre-Implementation Group members to first meeting	Transformation and Strategic Planning Mgr	Feb 2015	Pre-Implementation Group meets and agrees Terms of Reference, initial work plan and priorities.
Pre-Implementation Group stage			
1. Review structures already in place for service user and carer involvement	• Pre-Implementation Group • Transformation and Strategic Planning Mgr	Feb 2015	• Pre-Implementation Group has an understanding of how service users and carers are currently able to influence service delivery and development. • Potential service user Group members are identified.
2. Develop EIA and review engagement methods with providers, including the VCS	• Pre-Implementation Group • Transformation and Strategic Planning Mgr	Feb 2015	EIA developed to consider needs and access for all equalities groups. Pre-Implementation Group has an awareness of how providers are currently able to influence service delivery and development.
3. Contact service users and carers to invite them to learn more about the Implementation Group and our plans	• Pre-Implementation Group • Transformation and Strategic Planning Mgr	Feb 2015	• Service users and carers are aware of and understand our plans • Service users and carers have an opportunity to engage with the development of the Implementation Group
4. Review training and support needs for service users and professionals to attend and contribute to full Implementation Group meetings	• Pre-Implementation Group • Transformation and Strategic Planning Mgr	Mar 2015	• Requirements for service users and carers to be able to participate in Implementation Group meetings and represent views which are broader than their own etc. are understood. • 'Professionals' attending Implementation Group meetings understand the abilities and needs of other Implementation Group members.

* Ideally the pre-Implementation Group would include service users and carers, however, it is likely that service users and carers will require training and other support in order to attend. The pre-Implementation Group will become the full Implementation Group once it is co-chaired by a service user / carer.

Action	Owner	Done by	Outcome
5. Community leadership training or similar is delivered	• Pre-Implementation Group • Transformation & Strategic Planning Mgr	May 2015	To develop the skills of service users and carers to enable them to participate in the Implementation Group
6. Review EIA	• Pre-Implementation Group	May 2015	EIA is reviewed to ensure equalities issues are understood and addressed where necessary.
Implementation Group stage			
7. Invite service users and carers identified from 4. above to attend the pre-Implementation Group	Implementation Group	Jul 2015	• Pre-Implementation Group is able to re-constitute as full Implementation Group with active co-production with service users and carers. • A definition of co-production is agreed for Bath and North East Somerset. • Draft 'Making it Real' action plan priorities are agreed.
8. Co-produced and co-delivered 'Making it Real' event.	Implementation Group	Sep 2015	A Making it Real Action Plan identifying the top three priorities for Bath and North East Somerset from the Markers of Progress statements is finalised.

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Integrated Personal Commissioning programme – application form

Please send to england.ipc@nhs.net by Friday 7 November 2014

1. Partners: Which organisations have agreed to join the programme?

Voluntary sector organisations including user-led organisations
Parkinsons UK, British Lung Foundation, Age UK Cornwall, Volunteer Cornwall, Healthwatch Bristol, Compass Disability Services, Voscur, Enham Trust, Autism Somerset, Living Options Devon, WECIL
Clinical Commissioning Group(s)
South Devon and Torbay, Wiltshire, Bristol, Cornwall and Isles of Scilly, South Gloucestershire, Gloucestershire, NEW Devon, North Somerset, Bath and North East Somerset, Somerset, Swindon
NHS Trust(s) or other NHS-funded provider(s)
Local authority (the application should cover only one upper tier council)
Bristol, Torbay, Swindon, North Somerset, Gloucestershire, South Gloucestershire, Somerset, Plymouth, Devon, Wiltshire, Cornwall
Other organisations (see list in section 2 for suggestions)
South West Strategic Clinical Network , Health Education South West, South West Academic Health and Science Network, West of England Health and Science Network, South West Commissioning Support Unit, Avon Primary Care Research Collaborative

2. Sign-off: Who has confirmed support for this application?

Please ask each person to provide their name, job title and organisation, and **to sum up in no more than 50 words** why they support this application. Signatures are not required.

ESSENTIAL: We will only shortlist your application if it has the support of the people listed in this section.
Lead voluntary sector organisation chief executive
Please see attached appendix 1 – endorsement
CCG chief officer(s)
Please see attached appendix 1 – endorsement
Director of adult social services
Please see attached appendix 1 – endorsement
Children's director (if children and young people are included)
Please see attached appendix 1 – endorsement
Health and Well-Being Board chair[1]
Please see attached appendix 1 – endorsement
DESIRABLE: Please confirm who else supports your application and why. It is up to

[1] If possible also please send confirmation in writing that the Health and Wellbeing Board has discussed and approved your application. Your application does not need to list all the organisations taking part in the board, and it may cover only part of the board area.

you to decide who needs to be included; suggestions are listed below.

- User-led organisation chief executive
- Other voluntary sector organisations
- CCG finance director
- NHS Trust (or other NHS-funded provider) chief executive
- NHS Trust (or other NHS-funded provider) finance director
- Other providers
- Local authority chief executive
- NHS England area team director
- Healthwatch chief executive

Please see attached appendix 1 – endorsement

3. Aims and priorities

Why do you want to join the Integrated Personal Commissioning programme?

The South West region has a population of 4.7million spread across 9000 square miles – the largest regional footprint in England. A region with distinct challenges coming from our unique profile with an older than average population and many rural communities. Experience has taught us that systems solutions designed in England's great urban conurbations are not always easy to implement here. We believe that the South West needs to be part of shaping the Integrated Personal Commissioning (IPC), as we want to maximize the potential benefits for people's health and wellbeing in this region and for our local care systems. We have a will to identify implementation solutions at scale and want to be key contributors to the national demonstrator programme.

Yet we know that a will alone is not enough - we are fortunate in this region with having a strong track record of leading integration innovation; 2 of the 14 Integration Pioneer sites are in this region, 3 of the 20 SEND Pathfinders are here too – all of these sites are part of our collaboration (Cornwall and the Isles of Scilly, South Devon and Torbay, Devon and Wiltshire).

Complementary to our local integration experience, as a region the South West has a history of working successfully together. An instance of this can be seen in the regional End of Life network activity. This habit of working together has helped us maintain the highest aggregated regional performance of people supported to die in usual place of residence for some years. All communities here outperform the England average and some (like the area served by North Somerset CCG with 41.42% of people dying in hospital compared to the England average of 50.71%) have an exceptional performance (source PHE's NEoLCIN). We have the proven ability to co-operate effectively sharing developments for delivering personalized care in this region over a sustained period, essential in providing good care for dying people and, we believe, a core element required for the IPC to succeed.

We know co-operation across the region has helped us progress further, faster, for longer already and we think building in sustainability at the outset is critical for implementing the IPC. This is the fundamental reason why we are applying as a region, rather than as individual communities based around our Health and Wellbeing boards. By looking for learning and constantly sharing, combined with the scale of our approach, will allow us to use limited resources available both locally and regionally to maximum impact. Whilst at the same time minimizing the risk for individual partner organizations, critical in these times of austerity.

We are putting co-production at the heart of our programme design and consequently allowing localism

to florish. We are endorsing and encouraging different areas within the region to tackle different elements in ways that meet their local priorities, on a timescale that is realistic to them.

Our regional approach builds on the diverse development strengths of local partners. Somerset's work on the Symphony Project has illustrated the potential released if we work differently through their financial modelling of the health costs of people with multiple long term conditions. Cornwall's Integration Pioneers are now using Symphony data to inform a financial model to fit the Living Well Programme in their Integration Pioneer site. This work is changing the relationship between people, the voluntary and community sector and health professionals. These are just some examples of how different parts of the region already tackling elements of this agenda. We will make it easy for the early adopters to share our learning through our South West IPC network, providing fertile ground for new developments to embed and mutual support to improve the resilience of our change agents to keep going when some parts of the system push against this transformation, as will inevitably happen. Effective networks do accelerate progress and we have chosen to work in this way to ensure we succeed.

Coming together will also enable us to accelerate mainstreaming the benefits, by supporting each other and preventing duplication of development work. It will also prevent a gulf emerging between the early adopters and the rest of the region as everyone is involved to some degree and will be part of the culture change required to deliver IPC.

No single area felt able to cover all groups and all elements of the programme, but collectively we can. This will allow for equitable access for people in the South West faster. We don't want the benefits of IPC to be only available for one group of people in one place - that's not personalized care and it's not transformational change. And we are clear that transformational change is what is needed to mainstream integrated personal commissioning.

What do you hope to achieve?

We want to make significant strides towards embedding the culture change required to truly deliver personalized care. We want personalized care plans for all who may benefit. We want a greater emphasis on preventative support than crisis provision. We also know that to achieve this we need to engage and involve the people, their families and the whole system in true co-production, sharing the risks and the gains equally to ensure sustainability.

We hope to create a social movement for change that will to begin to challenge public attitudes about what is the best way to spend healthcare budgets – away from beds and buildings and onto personalised care and prevention. Our programme aims to help achieve the transformational change set out in the NHS five year forward view published October 2014.

A big part of this change is in how the NHS and local government works with the voluntary and community sector. We see the voluntary and community as equal partners and as a symbol of this stance we have agreed that, if successful in our application, the IPC programme here will be hosted by one of the voluntary sector partners.

Key developments we hope to achieve are:

1. a flexible co-commissioning framework which is tested and fit for purpose;
2. a significant increase in the numbers of people within the workforce that understand, practice and promote personalization;
3. a vibrant network of peer support groups helping to empower people to take more control back over the management of their health;
4. an appropriate brokerage model delivered by the voluntary and community sector and flexible enough to be applied across the region;
5. market development strategies that includes all providers and commissioners and the

wider community. We want to create a space were people, commissioners and providers can come together to co-produce solutions on how to deliver the type of services people want to choose themselves. We also want to tackle some of the longstanding market gaps. We know that finding flexible support for people in rural locations, especially for periodic support (e.g. crisis plan within someone's care plan) is challenging to do. Community support and new partnerships with non-health and care sector employers allowing staff to undertake this work in social and community responsibility initiatives, are the types of creative solutions we seek to explore over the lifetime of this programme;

6. removing the barriers to implementation at scale without 'double-funding' through phased contracting method change;
7. finding methods to allow the controlled release of some of the funding tied up in secondary care that could be more effectively utilized in personalized care support, without destabilizing acute care;
8. an ongoing and rigorous culture of ongoing evaluation and quality improvement driving up standards and ensuring best value from health spending.

We have already identified areas of work that need addressing, but we have not defined yet what all the answers should be. It would be wrong to do so now only two months after the prospectus is published. If we did that would show a lack of co-production. We believe the solutions lie in true co-production and we will invest the time that that takes. The first step will be to bring all partners and local communities together to explore future solutions early in the programme.

We have already made a commitment to work together and we can define what our next steps are. Between now and April 2015 we will continue to work with each and every local area - talking to people and partners at Health and Wellbeing Boards, with Healthwatch organisations and other voluntary and community sector organisations (this engagement work has already started thanks to the help of the South West Forum – see South West Forum IPC PHB handout). We will also increase our engagement with providers.

South West Forum
IPC PHB handout.doc

We will bring senior leaders together with people who have already benefited from personalized care in January at our South West IPC Conference where we will:

- Start the region's social movement for change
- Scope the workstreams needed to deliver the systems change programme, and the governance for the programme – including for agreeing a flexible co- commissioning framework
- Start to define delivery mechanisms in more detail together

We are already identifying first phase sites and are booking practitioners onto a two day residential accelerated learning event on the 7th, 8th and 9th of January to start progressing this work at a micro level. We will start and get integrated plans (and budgets where possible) up and running for different groups of people in multiple, small sites, in different parts of the region. (Not all partners feel ready to taking part in the 1st phase but the majority are – this illustrates our flexible approach in action) This will quickly give us a robust level of data when aggregated across the region to inform the thought leadership programme, which is achievable quickly on a regional basis, whilst maintaining low risk to individual areas as the numbers per CCG/LA is low.

We want to be opportunistic and flexible to grasp opportunities as they arrive and our programme management will allow for that.

How does this fit with local priorities for the NHS and local government including the

joint health and wellbeing strategy?
We are under no illusions that this ambitious programme will be easy to achieve - if it was there would no need for a regional collaboration like ours. We believe our facilitative approach is an innovative way of garnering ideas from the ground up and escalating them to widespread application quickly. From the outset we are focusing on sustainability. We have asked each community (for ease of administration we have defined the area by CCG boundary) to match the scope of the IPC programme requirements against their locally identified priorities. These responses are the core of our regional programme (please see attached appendix 2 for more information by local area) and will immediately interweave achieving local aspirations with successful implementation of IPC .

4. People who will benefit (see prospectus for examples): Which groups will take part and why; how many people do you expect will benefit?

What is already in place?
We have agreed together a commitment to developing the IPC for all people identified in the prospectus. Different areas within the region have identified different groups they wish to prioritize, based on local needs and existing development activity. (Please see appendix xxxx for a breakdown of groups of individuals who will benefit by geographical area).
What will be different within 2 years (by March 2017)?
We are conscious that 30% the population of the South West have one or more long term conditions, all of whom, may potentially benefit from the work undertaken in this programme. However we are realistic in defining this programme as being about developing the required system change to allow true personalization of the health and care system here. Full implementation will go beyond the end of 2017. But by March 2017: • We will have more than 1,000 people, (over and above the number of adults eligible for Continuing Health Care) who will have a personal health budget, or an integrated personal budget. • All people with long term conditions will be offered a personalized care plan and encouraged to take more control over the management of the condition to minimize the impact it has on the things that matter to them.
What are you proposing to do to achieve this?
How will the South West IPC Programme work? A South West IPC Network will be created to oversee the programme. It will use action learning principles and quality improvement methodology. The programme has three core strands, which taken together will deliver sustainable transformational change. They are: **1 – Thought leadership change programme** – launch conference of senior leaders in January 2015 will bring together the whole system to define the scope of system change. This structure of the conference will be to embed co-production at the outset. Input from people who have already benefited from personalisation and their families and carers will demonstrate the benefits. Workstreams supporting necessary change will run from April 2015 including: financial modelling, impact on block contracts, risk sharing strategies, development of the market, growth of peer support and patient activation. Local areas will accelerate implementation by benefiting from each other's strengths using the 'regional expertise time bank'. All areas across the region will be active contributors to this thought leadership change programme to ensure that it is fit for purpose across

the region and to maximise opportunities to share learning and development.

2 – 1st phase roll out of PHBs/integrated budgets for people who may benefit - This will start in those areas that are ready to start implementing now. Support includes training, mentoring, use of quality improvement methodologies and evaluation of impact (outcomes and financial). This series of micro sites in variety of settings, working with different groups of people, in different CCG/LA areas will provide an achievable, low risk place to start. Findings aggregated across the region will provide robust data to inform application at scale quickly, including financial modelling. Sustainability is achieved by 1st phase people and practitioners mentoring 2nd phase roll out sites, and so on. Over the lifetime of this programme, if successful as a demonstrator site, we aim to run 5 cohorts of implementation sites, thereby achieving significant scale by end of 2017. We recognise that different areas are starting from a different place and not all CCG/Local Authority areas are willing to start in the 1st or second phase sites. Areas will join the implementation at a time that is right for them

3 – Social movement for change – communicating the benefits to people, organisations providing care and staff. This element of our programme will promote patient self-management / activation and support the development of peer support networks. Creative use of social media and a focus of demonstrating the difference personalisation can make to people's lives via the use of patient stories will feature highly. We will ensure that this communications work will start early and continue throughout the programme with a constant drip of information. It is via this interactive debate across our communities that we hope to begin to challenge attitudes about what is the best value way to spend healthcare budgets to deliver positive outcomes for people– away from beds and buildings and onto personalised care and prevention.

5. Financial model: How will you develop a financial model which enables NHS and social care money to be brought together?

What is already in place?

The Symphony project in Somerset has provided valuable modelling around the costs of multiple long term conditions.

Ray Heal, as Practitioner Advisor for the South West IPC programme, has developed an information sheet based on people's stories. This is being used by areas to help identify people to initially extend the offer of Personal Health Budgets (PHBs) or integrated personal budgets within the South West's IPC programmes first phase sites, where in year savings are likely to achieved (eg reduction in avoidable emergency admissions).

Information sheet.docx

The South West AHSN within their Integration programme have agreed to work with our 1st phase sites to help ensure cost benefits are captured consistently on all sites so can be aggregated to inform the though leadership work on financial modelling.

What will be different within 2 years (by March 2017)?

We will have a developed a system for identifying the annualized capitated budget for individual patients, and / or categories of patients, based on available data ie HES, social services spend, primary care spend and medications and equipment spend. This combined with Symphony data and ongoing

financial evaluation from first phase sites, will provide aggregated financial data for our systems change programme.

The workstreams concerned with block contacting, market development and risk sharing strategies will have provided models to overcome or minimise the barriers to implementation at scale. Splitting up and decommissioning of block contracts (where appropriate) will attract substantial clinical, financial and legal risk. By tackling this as collaborative, rather than as individual CCGs, this will enable us to share and minimise this risk whilst realising a significant goal in transforming commissioning for the future in support of personalisation and integration (if the perceived benefits are realised). In addition, we hope to achieve a confidence throughout the collaborative in introducing an alternative method to block contracting.

For calculating mental health spend we will work with the local authorities and CCGs to identify the historic split of Section 117 funding (which reflects proportionality split locally, contextualized by local variance in provision) to simplify the process of decision making (a model already developed by Dorset).

For children with complex needs the calculator developed with In Control will be market tested and amended as needed.

What are you proposing to do to achieve this?

The financial modelling workstream, using information gathered via Integration Pioneer sites in the region, the Symphony project and the first phase site financial evaluation work, will oversee the development and implementation of our financial model.

This workstream will be mindful that they need to ensure the sustainability of the financial model beyond 2017.

6. Person-centred approaches: What support will be offered to people in your cohort?

What is already in place?

1) Representatives for all CCGs have participated in personal centred planning sessions linked to the Year of Care model
2) Local Authorities have also developed person centered training programmes for appropriate staff
3) An intensive residential accelerated learning event is booked for January to bring together for the first time people from health, social care and the voluntary and community sector working alongside peer support leaders and people with lived experience who will develop the programme in our first phase sites. This group will be supported on an ongoing basis through mentoring and their own peer support group to promote person centred approaches.
4) There are currently three accredited Year of Care trainers who are contributing to the programme.
5) Work currently developed in partnership with industry to support patients to self-manage by clinical networks and AHSN's will be incorporated into the programme.
6) Work with WECIL on the further development of a web based self-directed person-centred care planning and assessment tool will be included in the programme
7) CCGs and Local Authorities within the partnership are or have developed personalization strategies.

What will be different within 2 years (by March 2017)?

1) We aim to ensure that personalization and integrated approaches to care brokerage and delivery are the norm. Thereby ensuring practice accurately reflects revised and new legislation,

most notably: The Care Act 2014, The Mental Capacity Act 2005, and The Equalities Act 2010.

2) Marked increase in the numbers of people benefiting from personalization to meet the expectation in 'Everyone Counts Planning for Patients 2014 -2018' that everyone with a long term condition has a personal care plan. We will have provided appropriate and tested ways in which primary care can play their part, and enabling GPs to realize the benefits too - freeing up their time from trying to co-ordinate a disjointed system when patients are in crisis, so that they can focus more time on giving personalised care and in shared decision making with their patients.

3) An ever growing network of practitioners (including those with lived experienced) who are able to share learning to continue the cascade roll out of personal centred approaches, towards achieving the goal that all those who could benefit have not just a personal care plan, but support in place tailored specifically to theirs and their families' needs and which includes a crisis management plan.

4) Web based open, dynamic resource bank including people's stories, methodologies, toolkit and learning materials.

What are you proposing to do to achieve this?

1) To ensure that person centered approaches are a cornerstone of the South West IPC Network and feature in all activity.

2) Ensure that existing accredited staff time is focused on the roll out of personal care approaches.

3) Provide the support framework, including training and mentoring for the cascade roll out of sites starting with the first phase sites in Jan 2015 with a new cohort identified and trained every 6 months for the lifetime of the programme.

4) Formalize the 'expertise time bank' to ensure that all areas within the partnership receive an equitable proportion of time focused on their local priorities, to accelerate progress and prevent duplication of development effort.

7. Personal budgets: What will be the scale and pace for rollout of personal budgets for people with health needs, and how will funding be made available?

What is already in place?

1) A commitment by all partners to the principles of personal budgets

2) All participating CCGs have put the processes in place for PHBs to be available for people with CHC and all Local Authorities offer Personal Budgets. See appendix 2 for current numbers of PHBs in place.

What will be different within 2 years (by March 2017)?

1) Children with complex needs and their families will be offered Integrated Budgets across the South West (unless there are overriding clinical or legal reasons why this is not appropriate) as defined in the Children and Families Act 2014 for people with CHC).

2) People with long-term conditions, particularly older people with frailty will be able to request a PHB or Integrated Budget. The rate of roll out to this group of people will different across the region depending on the type of condition and pace of roll out in each area and, of course, individual choice. Local communities will be expected to deliver on the aspirations they are committing to in the IPC programme planning process. The amount of direct support they receive from the programme will be matched to this local commitment.

3) People with learning disabilities with high support needs will have the option of an integrated budget in the areas who have agreed to develop these as a first priority group locally. In other

areas a published commitment to when people with learning disabilities will be able to access this locally will be available.

4) People with significant mental health needs will have the option of an integrated budget in the communities who have agreed to develop these as a first priority group; this will include the development of early intervention support for people entering crisis, to avoid admission, and as the standard offer for people eligible for section 117 after care and/or community treatment orders. In other areas a published commitment to when people with significant mental health needs will be able to access this locally will be available.

Across all groups we will achieve over 1,000 people with personal health budgets who are eligible for adult CHC and over 1,000 other people will have an integrated or health personal budget.

We will have amassed a significant body of evidence, to add to the nationally published evaluation and stories for people who have benefited showcasing the benefits of personalisation and integration. Thanks to the structure of our evaluation we will also provide detailed costings information evidencing financial efficacy, and add to the national and international integration methodology/evidence bank. Through designing our evaluation collaboratively we will aim to produce outcomes and integration measures which can be applied at scale.

What are you proposing to do to achieve this?

The network and phased site cascade approach will provide a support framework to allow a critical mass of PHBs and integrated budgets to develop locally over the course of the programme.

This will be supported by the leadership, financial modelling and evaluation elements of the South West IPC programme – please see sections 5,8 and 12 for details.

8. Leadership and partnership: How will you get key people on board and build capacity in the voluntary and community sector?

What is already in place?

In developing a sustainable region wide programme a lot of initial focus has been on building a broad partnership from across all communities.

Support from commissioners in each area of the region - The timescale of the application process and the requested endorsements has required us to focus on the sign up of all commissioning organisations within the region as a first priority. As you see from the endorsements required in section 2 (attached as appendix 1) we have successfully gained the endorsement of CCGs, Local Authorities and the Health and Wellbeing Boards from all areas within the region. With such large region we have inevitability got some gaps in terms of official sign off and we will continue over the next few weeks to ensure all of the above formally endorse the programme.

Support from voluntary and community sector - We have had several voluntary and community sector partners involved in the initial concept and design of our regional programme proposal and involved local Healthwatch organisations. We have also presented to the South West Forum and started the wider engagement we need to do early to ensure that representatives from the voluntary and community sector are involved in all parts of our programme. We will continue this process. We will continue to build on the work already undertaken around regional brokerage support standards to be implemented and through the CHC personal health budgets project managers in the region to inform future market development.

Support from regional bodies - We have received the formal support from the Peninsula and BNSSSG Area Team's Joint Executive Committee on 3rd November and are hoping to present to the other Area Team's Executive Group to seek their endorsement too shortly. Both AHSNs in the region are supportive of the application. The Peninsula AHSN is providing practical support via with evaluation and is, together with local CLARKS, gathering international research evidence to inform our financial modelling. The

Avon Primary Care Research Collaborative is also supporting our evaluation development and analysis. We are benefiting from the West of England AHSN's Quality Improvement Methodology roll out (Masterclasses for Medical Directors are already being delivered) and we will use this methodology with leaders acting as sponsors for appropriate implementation pieces as the South West IPC programme develops). Health Education South West aims to use the IPC programme as the delivery vehicle for its integration workforce development priority. The South West CSU will ensure that the IPC programme benefits from the CSU's existing work within the region in areas such as, the Patient Voice programme and procurement support and can help with project management support where appropriate. The South West SCN is linking each of networks priorities where applicable to the IPC programme. The structure, as set out in the IPC prospectus, is allowing us to align many existing initiatives; this in itself is building a sense of momentum and accelerating the pace of development. We will continue to act in this way. **Support from primary care and providers** - We have had some involvement in early design from primary care and providers, but this is the area we need to increase our engagement with as an immediate priority now our application is complete. CCG Commissioning lead GPs input from Devon and Cornwall has made sure our planning for delivery is focused and realistic. We have first phase sites identified which will start implementation early. In other areas not ready to implement yet we are working to support local communities get their foundations in place, such as linking with Wiltshire's Primary Care pilot sites for developing integrated working to deliver personalized care planning.
What will be different within 2 years (by March 2017)?
We will have developed a different relationship balance between the statutory sector commissioners and providers and the voluntary and community sector. We will have seen a growth in the brokerage support roll within the voluntary and community sector. We will have greater participation from people with lived experience in the design and delivery of care support. A greater number of operational managers will be confident in how to support and develop further personalization in practice. Quality Improvement methodologies will be used in many and varied settings as a core means of constant improvement in care standards and outcomes. People and staff at all levels will have a greater understanding of the cost of care at a granular level, as an essential prerequisite to driving out savings.
What are you proposing to do to achieve this?
Our IPC programme has been designed with its three core strands (as described in section 4) to ensure we can deliver the sustained partnership necessary to achieve this. We are fortunate that so many leaders within our region are already supporting the South West IPC Programme (as evidenced by the endorsements in appendix 1). We will continue to rapidly build our collaboration further through the launch of the thought leadership change programme in January 2015. The delivery workstreams will work through the detail of specific solutions, such as consistent standards developed for brokerage support services, for sharing with all partners.

9. Co-production and culture change: How will you change attitudes throughout the system, and ensure that people and families lead the new approach?

What is already in place?
The principal of co-production is paramount in the development of the South West IPC programme's approach. From the outset we have asked people with lived experience to join us at our scoping meetings for this application and have opened each session with their stories. Listening to them has

undoubtedly influenced how we have framed our proposals and given us rich ideas for design of delivery.

We are fortunate in having two integration pioneer sites within our region, they are already leading the way in showing the culture change required. Our IPC network assists them in their duty as Pioneers to share in their learning and we will use it to build our system's change solutions. E.g. Living Well's 'Guided Conversation' is changing the relationship between people, the voluntary sector and health professionals. Torbay's history of integration gives so much learning on how to grow and sustain multi-disciplinary, cross-organisational teams.

There are also many other positive pockets of personalization great practice that we can draw together and share. E.g co-ordinated care planning in Gloucestershire and the peer support network (supported by WECIL) in Bristol.

What will be different within 2 years (by March 2017)?

Within the next two years we will also have enshrined the principals and practice of co-production at all levels within the IPC program, supporting our providers and frontline staff to this end and including direct representation of IPC holders on the leadership board.

We will have established a network of people who have benefited from a personal care plan/budget and will have built peer support networks across the region, to provide leadership for increasing personalization in the longer term.

We will have changed the relationship between people and health and social care professionals – making shared decision making common practice.

What are you proposing to do to achieve this?

We pledge to maintain co-production throughout the lifetime of this programme. Here is an outline of some of the ways we plan to honour this pledge:

At a micro level all individual personal plans will be co-produced with the person and the professionals as equal partners. "There will be no decision about me without me" is not just our vision, but is central to our practice. The first phase sites' rapid learning event will have people with lived experience helping to shape and deliver the training. All sites will use tools suitable for personalization and we are delighted that we have the Personal health Budgets national online toolkit to support us. Our evaluation of the programme, led by the South West Academic Health and Science Network, will, of course, include health outcomes for people, along with comparative costings, but it will also qualitative analysis of their experience of care and its impact on their wellbeing, this holistic approach will include the impact on their families and carer's health and wellbeing too (where applicable). An illustration of co-production in action is our decision to include the impact on families and carers in our evaluation , as this comes from the input at our Bristol development session from a peer leader telling their own families story.

Our thought leadership programme will drive both the systems and cultural change required to implement at scale. And will put people and families' experience at the forefront. From the launch conference onwards we pledge to include people with lived experience throughout the design process.

There is already a commitment from a number of organisations including all the Clinical Commissioning Groups, Local Authorities and the Health and Wellbeing Boards within the region. A significant number of third sector organisations are already part of the design process, and we will continue to work on the breadth of voluntary and community sector experience within this programme.

Some practical ways we can help achieve and embed co-production in the programme include:

- Providing training and mentoring for practitioners in co-production of individual plans with people for our implementation sites – we have our 1st cohort training booked for January 2015;
- Our intention to engage with an organization such as "People Hub" to work with the program in

establishing independent user groups to represent the views of the people; and

- Establishing an on line forum for budget holders as in instrument for social change

10. Managing risk: How will make sure that progress is not held up by unforeseen problems?

What is already in place?

Key risks to the programme we can foresee are:

- Maintaining a partnership on this scale
- Achieving individual integrated budgets when budgets are currently held in multiple organisations, with varied legal parameters on charging between NHS and Local Authority services
- Resources are currently tied into block contracts and there is no resource for double funding a transition approach to personalization implementation

What will be different within 2 years (by March 2017)?

We will have used the learning from the South West IPC Programme to support local partners to develop risk and gains sharing strategies which release, in a planned and controlled way appropriate resources from:

- block contracts; and
- secondary care tariffs (particularly 'bad income' from the acute sector – eg excess emergency admissions which impact negatively on Trusts being able to maximize elective work)

which are being spent on personalized care plans supporting people to live well and manage their conditions better.

We will have tested IPC financial modelling and integrated models that will provide evidence of cost implications to inform sustainability beyond 2017 and contribute to national and international evidence of this new commissioning approach.

We will have navigated the legalities around integrated and pooled budgets in order to provide guidance.

We will streamline, and produce clear guidance on the appropriate way to share necessary information across organisations to meet the legislative requirements of the Data Protection Act 2003.

What are you proposing to do to achieve this?

The South West IPC programme has been designed to minimize and mitigate the impact of these the risks from the outset in the following ways:

a) this collaboration has been designed to be flexible allowing all partners to contribute at the pace that is right for them, those areas wishing to forge ahead are free to do so, those wanting to contribute in the network, but are not yet ready to join the implementation programme are supported to get themselves ready working in their local priorities. The partnership is built on valuing localism and sharing learning, this approach we believe is the most likely way of holding this partnership together. The expertise time bank is our regional currency for exchanging practical support as well as sharing ideas. It will ensure resources are shared equitably with local areas accessing the support they really want at the time they need it.

b) The thought leadership change programme will be the method by which we can explore solutions together pooling learning to create and test co-commissioning and alliance frameworks and other tools (e.g. c-quins, pooled budget arrangements). We are mindful that we are asking providers to change without a definite contracting structure in place. By creating a space where leaders from across the commissioning and provider landscape can come together to explore how to manage the market change we aim to engender an honest conversation about what needs to happen and that can be realized, by when.

c) By running several 1st phase implementation sites in different areas we can aggregated data to quickly gather accurate costs with low levels of risk to local budgets due to the small numbers in each place. By targeting certain high cost users first we can drive out in year savings to mitigate any cost pressures.

We welcome the opportunity to be part of the demonstrator sites so that we can work with the national team and be confident that we will be working to a single legal view on the charging legislative impact on integrated budgets. We would seek to test on individual case basis how this works in practice and build up case examples that can be shared.

11. Capacity and resources: What people and other resources will you put in place to deliver Integrated Personal Commissioning?

What is already in place?

The NHS Five Year Forward View identifies the IPC is a means of using existing resources more effectively and we will use this philosophy in resourcing the programme itself.

To that end there are a range of resources already identified within the region to support integration development. We are aligning these where we can to the IPC programme. The prospectus has already acted as a helpful framework to provide a clear focus and direction to a complicated agenda which has hitherto been tackled from diverse angles within our area. We will continue to use the IPC framework to draw in and align existing resources where appropriate and sharing knowledge and ideas via our network.

However we have recognized that the organization of this programme does require some dedicated resources.

We have already got Programme Management time provided via the South West SCN - which is also funding (via its programme budget) the thought leadership launch conference and the first phase site training and Ray Heal as our Practitioner Advisor to mentor the implementation sites.

The Personal Health Budgets team's regional lead Liz Little has an established PHB Project Managers forum whose support and knowledge we will draw on, that has already started working together on developing a regional view on the practical implications relating to personalisation and personal health budgets.

What will be different within 2 years (by March 2017)?

The South West IPC programme will aim to mainstream personalisation, personal health budgets and integrated personal commissioning throughout the region – which reflects a significant change in culture.

Resources will be, or being transferred, to allow many more people in this region to benefit from personalization.

We will have a detailed evaluation of the effectiveness in both health outcomes and cost benefits of the programme.

We will have developed a wealth of practitioners who are trained and can deliver this agenda.

What are you proposing to do to achieve this?
We will establish a Programme Board to oversee the programme and agreements between partner organisations over the deployment of aligned resources held in different budgets. We are developing an expertise time bank to provide a currency for sharing of implementation support between different local areas of the region which cross organizational and community boundaries. We will use the financial model created to baseline existing resource and compare with IPC plan spend on a case basis, using the same format so that this can be aggregated as an evidence base for IPC spend. The baselining will include: existing cost of social and NHS care, medications and equipment spend, spend extrapolated from HES data and primary care and community spend (based on use of appointments), so that whole system impact can be calculated.

12. Learning from results: How will you share your learning and ensure robust evaluation [2]?

What is already in place?
As a consortium, we recognise that sharing learning is the key to the success of an effective network and have mainstreamed it within our approach through the development of a cascade model of training and our commitment to co-production. We already utilise a tried-and-tested collaborative approach through a number of established regional and local forums with proven governance mechanisms that will underpin the dissemination of evaluation and learning throughout the region. An agreement is in place for first phase sites to time bank expertise and knowledge to be used for mentoring future sites. Several of our partners are already signed up to participate in the national evaluation of Personal Health Budgets utilising InControl's Personal Outcomes Evaluation Tool and in addition to this, some partner sites have developed individual evaluation plans to consider the implementation of the personalisation agenda in their localities according to their own priorities. For example, South Gloucestershire CCG has established a plan to assess staff experience, and Bristol CCG has identified that one of their objectives is to assess the merit of Brokerage Services in terms of service provision and costs. Furthermore, we have identified and linked with appropriate experts in the region. A case-based cost-benefits model utilising HES data has already been developed. In addition, utilising quality improvement methodology, the South West Academic Health Science Network (SWAHSN) has supported us to plan an analysis framework across all sites to collect before-and-after aggregate data to assess cost-implementation at scale. We have also established a link with the Avon Primary Care Research Collaborative (APCRC), who are a key partner of the West of England AHSN. APCRC are hosted by Bristol CCG and can advise on approaches to whole programme evaluation through their role as Chair of the West of England Evaluation Strategy Group (WEESG). They are committed to driving the evidence-informed commissioning agenda and one of their core functions is to provide expert advice to NHS and Public Health professionals and researchers around evaluation methodologies, feasibility and dissemination in order to ensure that evidence-informed approaches are embedded into the culture of the NHS. We have secured commitment from APCRC that they can act in an advisory capacity and support the coordination of sites for participation in the proposed national evaluation to ensure a consistent and timely response.
What will be different within 2 years (by March 2017)?
In addition to participation in the national evaluation, it is envisaged that an evaluation and learning

[2] We are currently developing plans for a national evaluation of the programme; more information will be available in due course. All sites taking part in the programme will be expected to take part in the national evaluation.

work stream would look the accelerated learning programme for developing expertise in person-centered approaches for each of the four target groups. Through this work stream, it is intended that the following outputs will contribute to the national evidence-base:

1) An accessible review of the evidence for the approach available in a range of formats.
2) A robust test-of-concept report of the first phase of residential training and recommendations for improvement.
3) A co-produced approach to evaluating the impact of mentoring and support function.
4) Resources developed to enable workforce development initiatives to change practice.

In addition, all sites would be utilising the Personal Outcomes Evaluation Tool at a level appropriate to their stage.

What are you proposing to do to achieve this?

We recognise that a national evaluation of the programme is currently in development and project implementation plans have scope for incorporating the national guidance into our evaluation and learning work stream. However, we also believe that individual elements of the programme will benefit from formative evaluation utilising mixed methods during both the delivery and to establish whether we have achieved our aims and to define what specific lessons can be learnt through this process. We will link with APCRC and the WEESG to advise throughout.

Methodology: Depending on the level of guidance advanced through the national evaluation, we will develop an evidence-based framework for evaluation set against the programme's stated aims and objectives.

We will undertake a rapid evidence appraisal of the literature of the mentoring and support function suggested in our approach and disseminate learning of the cascade approach.

We will work with key stakeholders and to further develop, define and gain buy-in on the theory of change and associated pathways. The evaluation is likely to be a mixed methods longitudinal evaluation with a formative element looking at what works, for whom and in what circumstances (Realist Evaluation – Pawson and Tilley). As this is a programme of work across a wide-range of sites and with personalisation and co-production at its core, it is anticipated that multiple evaluation methods will be explored. It is felt, for example, that an approach such as Experience-Based Design will be a unique and exciting way to evaluate change by capturing the *experiences* of a range of people, rather than just their views on the system processes. This approach deliberately draws out subjective and personal feelings and experiences at key 'touchpoints'.

Analysis: The analytical framework will depend on the final design, however we do expect a mixed methods approach and so the quantitative data will use descriptive and/or inferential statistics, and thematic analysis will be used for the qualitative aspects. The approach will underpinned by the robust financial modelling data that will be generated as a key feature of the programme, and regular monitoring will minimise risks.

Ethics and Governance: APCRC, as our advisor on the evaluation, have a number of core functions which include research governance assurance on behalf of all primary care research across their patch. As such, APCRC will be able to advise the steering group on the final design and whether assurance (research governance) and/or NHS ethics are required. Regardless of whether formal research ethics are required, we are committed to ethical data collection and commit following to good practice guidelines for all ethical and governance issues.

13. Main contact person

We will send all correspondence to the person named below.

Name

Frances Tippett
Job title
Quality Improvement Programme Manager
Organisation
South West Strategic Clinical Network
Email address
Frances.tippett@nhs.net
Direct landline
0113 824 9034 (Tessa Farrow, Administrative Support for the Programme)
Mobile phone number
07825 420546 (please use mobile number to get through direct)

Appendix 1

Endorsements

Voluntary & Community Sector

Steve Ford, Chief Executive, Parkinson's UK

"Parkinson's UK is pleased to lend its support to this bid. Introducing personal health budgets in the region will give people with Parkinson's greater choice and control over their care which, along with a cure and access to high quality services, is exactly what they want."

Dr Penny Woods, Chief Executive, British Lung Foundation

"The BLF are happy to endorse, in principle, the South West Regional IPC Network. The Network looks an excellent vehicle for driving patient empowerment by focusing on the issues that will make a difference to them: supported self-management, opportunities for peer support and person-centred care."

Tracey Roose, Chief Executive, Age UK Cornwall

"I am happy to endorse the South West IPC application, as it will help ensure older people gain from personalised care. This bid compliments Cornwall's Integration Pioneer work, as it is built on the principle of co-production and sharing learning. We are pleased that Cornwall is including older people with long term health conditions in the first phase implementation."

Scott Bennett, Chair, Volunteer Cornwall

"Volunteer Cornwall endorses the South West IPC bid, as it supports personalisation and focuses on changing the culture of care to shared decision making. Voluntary and community organisations have much to contribute and this application recognises the importance of the sector."

Healthwatch, Bristol

"Healthwatch Bristol welcomes the opportunity to support the Bristol CCG application to help build a new integrated and personalised commissioning approach working together to pool budgets around individuals and extending the personalisation agenda.

Healthwatch Bristol is particularly interested in in how Personal Health Budgets and integrated commissioning will be piloted."

Richard Pitman, Chief Executive, Compass Disability Services

"We have worked alongside the Somerset CCG since 2009 during the pilot and supporting service users to access a PHB since in Somerset and the surrounding CCG's. We are working regionally and nationally on PHB development. We would like to support the South West regional collaborative IPC bid."

Wendy Stevenson, Chief Executive, Voscur

"Voscur supports Bristol CCG's proposal because it understands VCS organisations are the bedrock of local communities and are key to empowering people to take ownership of their health. Bristol CCG demonstrates innovative approaches with VCS organisations, which have an important part to play in making personal health budgets a reality."

Peta Wilkinson, Chief Executive, Enham Trust

"Enham Trust fully endorse this regional application for the Integrated Personal Commissioning Programme. As an organisation that delivers support to both social care and health care service users across the South West region, we know that integration of these services and the personal budgets that go with them is essential to improve service user experiences. We are also aware of the disparity between different Councils and CCGs in their progress towards integration and personal budget provision. Joining together as a region will enable best practice to be shared and achieve greater progress. We look forward to involvement in this project."

Campbell Main, Founder, Autism Somerset

"Those affected by autism, a lifelong impairment, uniquely stand to benefit from the cross generational, cross sector, cross agency, person- centred approach to which Integrated Personal Commissioning aspires. Autism Somerset, whose membership includes individuals and their families, Health, Education and Social Care professionals and providers, strongly supports this initiative."

Diana Crump, Chief Executive, Living Options Devon

"We endorse the involvement of Voluntary and Community sector as central to the success of this programme. Living Options Devon (Devon's Disabled Peoples User Led Organisations) is keen to be involved with the SWIPC Programme to ensure service user voice is heard and acted upon during decision making processes."

Anna-Clare Temple, Business and Funding Manager, WECIL

"WECIL believes that a person-centred, integrated approach to commissioning will result in individuals achieving outcomes that are more relevant to them and enable them to exercise greater choice and control over their care and support, leading to an increased level of independence, longer community tenure and greater health and wellbeing."

CCG Accountable Officers

South Devon and Torbay

Simon Tapley, Director of Commissioning

"The CCG working with its partners is keen to build on the success of the integrated health and social care model. Through the Pioneer programme for change and Integrated Care Organisation we view the IPC as an opportunity to take the next steps in offering greater choice and accessibility for personal held budgets with improved outcomes for the individual."

Wiltshire

Deborah Fielding, Chief Officer

"I am happy to support the SW regional bid for the IPC programme. Here at Wiltshire CCG we intend to work with our partners to roll out personalised care plans for people with long term conditions and feel that the integrated approach will enable us to share learning and best practice as it is developed through the collaborative approach to the benefit of our patients."

Bristol

Jill Shepherd, Chief Officer

"Involvement in this programme fits perfectly with the CCGs vision to deliver better health and

sustainable healthcare by working with local people to ensure that they (as patients, carers and families) are at the heart of our decisions. This programme will also complement our successful bid for the Better Care Fund."

Cornwall & Isles of Scilly

Andrew Abbott, Director of Strategy

"I endorse in principle the SW IPC Proposal which will complement our plans for integration and add pace to our intentions to support our service users to have more control over their care needs which we are exploring through our Pioneer status; we are keen to share our learning and benefit from good practice in other areas."

South Gloucestershire

Jane Gibbs, Chief Officer

"South Gloucestershire CCG supports this regional proposal for the IPC programme. The programme goals are aligned with our thinking, and will support existing and future workstreams for personalisation, integrated working, and system change. These are being undertaken jointly with the local authority and partners and are reflected in the principles and priorities of the Joint Health & Wellbeing Strategy. Whilst noting that the final submission will require support from Health and Wellbeing Board, this will not be possible before 28th November."

Gloucestershire

Mary Hutton, Accountable Officer

"We support the South West IPC and would want the CCG to be fully involved in this programme as we feel that this will enable development of managed and sustainable solutions in the most effective manner."

NEW Devon

Rebecca Harriot, Chief Officer

"NEW Devon CCG's commissioning strategy includes a personalised and preventative approach. Therefore we support the South West collaborative approach to the Integrated Personal Commissioning Programme which provides an opportunity to further integrate the systems and processes which underpin personalisation with partner organisations as we collectively work towards delivering improved outcomes and experiences for individuals across Devon."

North Somerset

Mary Backhouse, Chief Officer

"Happy to endorse on behalf of North Somerset CCG."

Bath and North East Somerset

Tracey Cox, Acting Accountable Officer

"On behalf of BaNES CCG and my Local Authority Colleagues, Ashley Ayre, Strategic Director People & Communities and Councillor Simon Allen, Chair of H&WBD, we are happy in principle to support this application."

Somerset

David Slack, Managing Director

"Somerset CCG supports participation in a regional bid on the basis that within this bid we

can have a Somerset pilot project scheme which we develop locally with our identified cohorts. The regional bid will give us the benefit of sharing learning from the other area's projects as we go forward."

Local Authorities – Director of Adult Services & Director of Children Services

Bristol

Mike Hennessey, Director of Adult and Children Social Services

"Engagement in this project will undoubtedly improve the range of options for people with long term and complex conditions and their carers, reducing stress, increasing choice and control and improving outcomes for people. This fits really well with our ambition for integrating care and the broader ambitions of Towards Excellence in Adult Social Care."

Netta Meadows, Service Director - Strategic Commissioning (People Directorate)

"I think that working together to maximise the benefits of Personal Health Budgets and Integrated Personal Commissioning. Engagement in this project will undoubtedly improve the range of options for people with long term and complex conditions and their carers, reducing stress, increasing choice and control and improving outcomes for people. Of course a key benefit would be building on and adding to the range of integrated approaches and services targeted at reducing attendances at Emergency Department and the demand for admission to acute hospital services. This fits really well with our ambition for integrating care and the broader ambitions of Towards Excellence in Adult Social Care."

Torbay

Caroline Taylor, Director of Adult Services

"Torbay supports the regional proposal as the authority is committed to joint and partnership working, has shared learning and considers such approaches key to market development. This will enable a sound infrastructure to support developments by providers in offering choice and accessibility to better informed budget holders; Making the Right Thing to Do the Easy Thing to Do, which is part of our pioneer status approach."

Swindon

John Gilbert, Board Director Commissioning (DCS/DASS)

"I am happy to support this bid for demonstrator status, as it focusses upon a range of cohorts of clients that are a focus for Social care and Health who have high levels of need. Ideally these groups could also help benefit on individuals with learning disabilities and frail older people"

North Somerset

Sheila Smith, Director, People and Communities

"As DASS and DCS for North Somerset Council I confirm my agreement to the proposal. If we are to be successful then there needs to be greater collaboration within the region moving forward."

Gloucestershire

Linda Uren, Director of Children's Services and Margaret Willcox, Director of Adult Services

"We too support the proposal. Greater collaboration is required if we are to be successful."

South Gloucestershire

Peter Murphy, Director for Children, Adults and Health

"South Gloucestershire CCG and South Gloucestershire Council supports this regional proposal for the IPC programme. The goals programme are aligned with our thinking, and will support existing and future workstreams for personalisation, integrated working, and system change . These are being undertaken jointly by the CGG, local authority and relevant partners and are reflected in the principles and priorities of the Joint Health & Wellbeing Strategy."

Somerset

Patrick Flaherty, Chief Executive,

"We recognise the benefits of an integrated commissioning programme and wish to support the proposal."

Plymouth

Carole Burgoyne, Strategic Director for People

"*We are fully committed to the IPC and endorse the regional approach believing this will deliver the greatest benefit across the health and social care community.*

I am responding on behalf of Plymouth City Council as Strategic Director for People covering Children's and Adult's Social Care and on behalf of the Chair of the Health and Wellbeing Board."

Devon

Jennie Stephens, Strategic Director People

"Devon County Council promotes personalised care as a standard offer for social care. it supports the collaborative approach to the development of personalised health and social care proposed by the South West Integrated Personal Commissioning Network"

Wiltshire

James Cawley, Associate Director – Adult Social Care Commissioning and Housing

"Wiltshire Council supports the IPC bid. The Council is an innovator in the commissioning of outcome based services focused on improving personalisation in Wiltshire and support moves to look at improving personalisation through joint health and social care personal budgets."

Health and Wellbeing Board Chairs

Cornwall & Isles of Scilly

Jeremy Rowe, Health and Wellbeing Board Chair

"I endorse the SW IPC proposal which will complement our plans for integration and add pace to our intentions to support our service users to have more control over their care needs which we are exploring through our Pioneer status; we are keen to share our learning and benefit from good practice in other areas."

Devon

Andrea Davis, Health and Wellbeing Board Chair

"The proposal is endorsed because Integrated Personal Commissioning offers an opportunity for those with the most complex needs to benefit from greater control over their condition and their lives, empowering them and their families, to help them achieve better wellbeing, and which is fully consistent with Devon's Joint Health and Wellbeing Strategy."

Torbay

Dr Caroline Dimond Vice Chair HWB (absence of Cllr Chris Lewis)

"I am happy to endorse this approach. Chris Lewis is still away until 10th so as Vice Chair HWBB I hope I can act on his behalf"

Bristol

Martin Jones, Joint Health and Wellbeing Board Chair

"Involvement in this programme fits perfectly with the CCGs vision to deliver better health and sustainable healthcare by working with local people to ensure that they (as patients, carers and families) are at the heart of our decisions. This programme will also complement our successful bid for the Better Care Fund."

Somerset

Christine Lawrence, Health and Wellbeing Board Chair

"As Chair of the Somerset Health and Wellbeing Board, I am happy to support the submission to become a demonstrator site for the IPC. However, due to the short timescales required for this return, I would like to note that this issue has not been discussed by the Board and so I am responding in my role as Chair. Somerset is committed to supporting a personalised approach across the health and social care economy that recognises and values the different contributions of organisations in pursuit of the best outcome for individuals."

South West Strategic Clinical Network

Caroline Gamlin, Medical Director and Chair

"The South West SCN endorses this application. We will continue to support the South West's IPC programme actively from the Quality Improvement Programme team and through aligning to the priorities of the Network groupings. The Integrated Personal Commissioning programme is an illustration of the transformational change that networks can help deliver. The SCN looks forward to helping see the potential of this programme realised in the South West over the next three years."

Health Education South West

Derek Sprague, LETB Director South West

"Health Education South West (HESW) fully endorse this joint application for Demonstrator status. A South West Integrated Personal Commissioning Network will support the development of the best possible programme solution and it is the intention of HESW to be a partner in supporting the programme through education and workforce development initiatives."

South West Academic Health Science Network (SWAHSN)

Dr Renny Leach, Managing Director

"The SW AHSN fully supports the collaborative approach to developing capacity and capability in delivering more personalized care across the south west. This approach aims to accelerate the learning and mainstreaming of best practice and to deliver sustainable change at pace. Bringing a collaborative approach is an exciting opportunity and one where we are very keen to contribute our expertise."

West of England Academic Health Science Network (WEAHSN)

Anna Burhouse, Director of Quality

"The West of England Academic Health Science Network is keen to work in collaboration to support the success of the Integrate Personal Commissioning Programme, supporting its aims and vision by helping to provide quality improvement consultation and support."

South West Commissioning Support Unit

Jan Hull, Managing Director

"South West Commissioning Support Unit (SWCSU) is very pleased to support the regional bid for the accelerated roll out of the Integrated Personal Commissioning programme across the whole South West Region. The SWCSU recognises the potential for transforming individual lives by delivering person centred integrated care to everyone who needs it. Through our existing connections within each locality across the region (for example, through the Patients in Control, Patient Voice, and procurement programmes) and our core support to individual CCGs, we are keen to support the programme to make system change a reality at an individual level, and ensure its sustainability for the long term."

Bath, Gloucester, Swindon and Wiltshire Area Team

Dr Elizabeth A Mearns FRCGP, Medical Director

"This initiative and a network approach looks to be a good way forward."

Peninsula and BNSSSG Area Team Joint Executive Group (JEG)

Minutes and briefing note:

Report to area team
JEG 29th Oct 2014.d

South West IPC
Support Network app

Extract from Monday 3 November JEG meeting minutes:

Frances Tippett attended this session and presented the paper on this issue and programme. It was noted that there is work to be done on building the network particularly in Banes and Glos and therefore this paper will be sent to Ian Biggs.

After discussion, the JEG agreed to:

1. Endorse the approach set out in the paper,
2. AnF will discuss and agree with Ian Biggs who should be the sponsor
3. It was suggested that Lou Farbus may be able to progress participation

directors of adass adult social services

think local act personal

Local Government Association

NHS England

Appendix 2

Clinical commissioning groups and Local Authorities in the South West Region Current position

Clinical Commissioning Group	Current PHB's in situ	Local Authority Personal Budgets
NHS Kernow	9	We are currently mapping with our Local Authorities the number of Personal Budget/ Direct Payments which may be eligible for the Integrated Personal Commissioning in the future
NHS New Devon and Plymouth City	40 (50 in pipeline)	
NHS South Devon and Torbay	47	
NHS Bristol	7	
NHS North Somerset	7	
NHS Somerset	53	
NHS South Gloucestershire	4	
NHS Bath and North East Somerset	8	
NHS Gloucestershire	10	
NHS Swindon	10	
NHS Wiltshire	3 (15 being processed)	

Appendix 3

Clinical commissioning groups in the South West Region Proposed development

Clinical Commissioning Group	Children and young people with complex needs	People with multiple long term conditions	People with a learning disability with high levels of support needs	People with significant mental health needs
NHS Kernow	Phase 1	Phase 2	Phase 4	Phase 1
NHS New Devon and Plymouth City	Phase 1	Phase 2	Phase 3	Phase 4
NHS South Devon and Torbay	Phase 2	Phase 1	Phase 2	Phase 4
NHS Bristol	Phase 1	Phase 1	Phase 3	Phase 4
NHS North Somerset	Phase 1	Phase1	Phase 3	Phase 3
NHS Somerset	Phase 1	Phase 1	Phase 4	Phase 4
NHS South Gloucestershire	Phase 2	Phase 3	Phase 2	Phase 3
NHS Bath and North East Somerset	Phase 1	Phase 2	Phase 1	Phase 4
NHS Gloucestershire	Phase 2	Phase 3	Phase 3	Phase 3
NHS Swindon	TBC	TBC	TBC	TBC
NHS Wiltshire	Phase 4	Phase 4	Phase 4	Phase 4
Current position on sites reported to date	4	3	0	4

Appendix 4

Key Resources identified.

Clinical Commissioning Group	Key Resources:		
NHS Kernow	**Children and Young People:** Project manager linked to multi agency EHC planning,	**Long Term Conditions:** Program manager & Program Lead (limited time)	**Mental health:** Program manager and program lead (Limited time)

<table>
<tr><td></td><td colspan="2">Community paediatrician
SEND Pathfinder
ECH being trialled
Multi Agency resource panel established
Task and finish group established
Local Offer reflects PHB'S
Process for paying PHB's aligned with adult CHC PHB process</td><td colspan="2">Penwith Pioneer , Project plan drafted
Four target groups identified
Potential budget identified
Review of payment methodology underway</td><td colspan="2">Participation in MH PHB Webinars
Project plan drafted.</td></tr>
<tr><td>NHS New Devon and Plymouth City</td><td colspan="2">Long Term Conditions:
Identification of small roll out team for PHB's and IPC programme,
Support from IATC Programme to assist with project management.</td><td colspan="2">People with a Learning Disability:
Identification of small roll out team for PHB's and IPC programme,
Support from IATC Programme to assist with project management.</td><td colspan="2">Mental health:
Identification of small roll out team for PHB's and IPC programme,
Support from IATC Programme to assist with project management.</td></tr>
<tr><td>NHS South Devon and Torbay</td><td colspan="2">Long term Conditions:
Project lead
Integrated team between CCG. and Local Authority</td><td colspan="2">Children with complex needs:
Project Lead
Integrated team between CCG. and Local Authority</td><td colspan="2">People with a Learning disability:
Key resources to be identified</td></tr>
<tr><td>NHS Bristol</td><td colspan="2">Children with Complex needs:
Programme manager
CHC Programme support manager
West of England centre for inclusive living</td><td colspan="2">Long Term Conditions:
Programme manager
CHC Programme support manager
Locality system for identifying priority patients
West of England centre for inclusive living</td><td colspan="2">People with a learning disability:
Key Resources to be identified
West of England centre for inclusive living</td></tr>
<tr><td>NHS North Somerset</td><td colspan="3">Long Term Conditions:
Integrated working relationship with local authority
Budget sharing protocol in situ
Good local authority process in situ for people with LTC that can be adapted</td><td colspan="3">Children with Complex needs:
Integrated working relationship with local authority
Budget sharing protocol in situ
Commitment to SEND roll out ongoing
Multi-agency transitions group</td></tr>
<tr><td>NHS Somerset</td><td colspan="3">Long Term Conditions:
Commissioning Office
Strategic commissioning lead
Existing support services</td><td colspan="3">Children with Complex needs:
Commissioning Office
Strategic commissioning lead
Existing support services</td></tr>
</table>

	Up to 1200 LA personal budget holders have been identified some of whom may be eligible for an integrated Personal Budget.			
NHS South Gloucestershire	**Eclectic approach is being developed for all groups based on a risk stratification criteria:** PHB Project management board GP lead for LTC Director of partnerships and joint commissioning GP clusters working on risk stratification			
NHS Bath and North East Somerset	**Eclectic approach is being developed for all groups with no specific target group with initial focus on Children and People with a learning disability.** Remodelling of existing social care pathway is underway, Project manager and lead nurse funding in situ			
NHS Gloucestershire	**Children and Young People:** Project lead Children's PHB Lead Joint Commissioner for Children Executive support from Director of Finance Gloucestershire County Council, Education department, Health Watch	**Long Term Conditions:** Long term conditions team Gloucestershire County Council Health Watch	**Learning Disability:** LD Clinical Case Manager LD team Gloucestershire County Council Health Watch	**Mental Health:** Gloucestershire County Council Health Watch
NHS Swindon	2 workers identified to support the role out of this programme			
NHS Wiltshire	Eclectic approach is being developed in Wiltshire to be prioritised on risk stratification criteria Commissioning leads and clinical leads in place for people with long term conditions Integrated Community Teams programme currently delivering - 3 demonstrator sites will be up and running before end Dec14 delivering integrated health and community services, further 17 sites established across Wiltshire Current focus on delivering personalised care planning			

Key Partners engaged and committed.

Clinical Commissioning Group	Key Resources:		
NHS Kernow	Long Term Conditions: Cornwall County Council Primary Resource Age UK Cornwall and isles of Scilly, Volunteer Cornwall Disability Cornwall Many other smaller local organisations Cornwall Health and Wellbeing Board Isles of Scilly Health and Wellbeing Board	Children and Young People: Cornwall County Council Parent Carer Council Hear Our Voice (young People Cornwall) Cornwall Health and Wellbeing Board Isles of Scilly Health and Wellbeing Board	Mental Health: Cornwall County Council Voluntary sector provider forum (12 organisations)
NHS New Devon and Plymouth City	**Long Term Conditions:** Project Board (including existing budget holders) Devon County Council Plymouth City Council Project board Enham Trust Living Options	**People with Learning Disability:** Project Board Devon County Council Plymouth City Council Project board Enham Trust Living Options	**Mental health:** Project Board Devon County Council Plymouth City Council Project board Enham Trust Living Options
NHS South Devon and Torbay	**Long term Conditions:** Devon County Council Torbay Council South Devon Healthcare Foundation Trust Torbay and Southern Devon Health and Care Trust Torbay Community Development trust Newton Abbot Frailty Hub (Numerous local support groups)	**Children with complex needs:** Devon County Council Torbay Council South Devon Healthcare Foundation Trust Torbay and Southern Devon Health and Care Trust Torbay Community Development trust	**People with a Learning disability:** Devon County Council Torbay Council South Devon Healthcare Foundation Trust Torbay and Southern Devon Health and Care Trust Torbay Community Development trust
NHS Bristol	**Children with Complex needs:** Bristol City Council Education department Health and Wellbeing board	**Long Term Conditions:** Bristol City Council Health and Wellbeing board West of England centre for inclusive	**People with a learning disability** Bristol City Council Health and Wellbeing board West of England centre for inclusive

<table>
<tr><td></td><td>West of England centre for inclusive living,
Healthwatch
Accelerated development programme</td><td colspan="2">living,
Healthwatch
Have identified over 700 LA budget holders some of which will be eligible for a PHB</td><td>living,
Healthwatch
Proportion of 700 identified personal budget holders will have a Learning Disability</td></tr>
<tr><td>NHS North Somerset</td><td colspan="2">Long Term Conditions:
Local Authority
1 in 4 (mental health charity)
People First (learning disability user lead organisation)
Age Concern
Healthwatch
Identified over 300 adults with a personal budget of which some may be eligible for a PHB</td><td colspan="2">Children with Complex needs:
Local Authority
Multi Agency working group
Healthwatch
Identified up to 130 children for SEND program some of which may have PHB eligibility.</td></tr>
<tr><td>NHS Somerset</td><td colspan="2">Long Term Conditions:
Commissioning Support Unit
Somerset County Council
Compass Disability (Brokerage and support)
NDTI training
Developing e-market
Developing peer support systems</td><td colspan="2">Children with Complex needs:
Commissioning Support Unit
Somerset County Council
Compass Disability (Brokerage and support)
NDTI training
Developing e-market
Developing peer support systems</td></tr>
<tr><td>NHS South Gloucestershire</td><td colspan="4">All Groups:
South Gloucestershire Council
Health and Wellbeing Board
The care forum (South Gloucestershire voluntary sector)
West of England Centre for Integrated Living (Wecil)</td></tr>
<tr><td>NHS Bath and North East Somerset</td><td colspan="4">All groups:
Bath and North East Somerset Council
Integrated health and social care organisations
Peer network
5 Year plan
Direct payment support and advice in situ
Bath HDI</td></tr>
</table>

	PheoniX Age UK Banes Compass Disability			
NHS Gloucestershire	**Children and Young People:** Gloucestershire County Council, Education department, Health Watch	**Long Term Conditions:** Gloucestershire County Council Health Watch	**Learning Disability:** Gloucestershire County Council Health Watch	**Mental Health:** Gloucestershire County Council Health Watch
NHS Swindon	TBC			
NHS Wiltshire	TBC			

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B&NES Health and Wellbeing Board

Integrated Commissioning Intentions:

January 2015

Bath & North East Somerset Council

NHS Bath & North East Somerset Clinical Commissioning Group

Needs Assessment informing commissioning intentions:

- Joint Strategic Needs Assessment (JSNA)
- Analyses of feedback from current commissions across the Local Authority and the CCG in B&NES
- Supporting People & Communities commissioning programme themed reviews
- Service user feedback
- Targeted stakeholder engagement events
- Review and analysis of activity/referral information
- Service mapping, gap analysis and Market Position Statement
- National policy changes resulting in changes in entitlements (e.g. Care Act)
- Research and evaluation (local, national or international) resulting in changes to best practice
- Consultation on the priorities for the CCG 5-Year Strategy 2014/15-2018/19; B&NES Better Care Fund Plan 2014/15-2018/19; Health & Wellbeing Strategy, Children & Young People's Plan and other key plans/strategies
- The Forward View into Action: Planning for 2015/16
- The Good, the Bad and the Ugly (DPH Report 2013-14)

Bath & North East Somerset Council

NHS Bath & North East Somerset Clinical Commissioning Group

Our Shared Priorities

Transformational Work Streams

- Increasing prevention, self care and personal responsibility
- Improving co-ordination of long term conditions (Diabetes)
- Creating a sustainable Urgent Care system

Other Commissioning Work Streams/ Priorities

- The Care Act
- The Better Care Fund
- Re-designing Community Services
- Mental Health and Learning Disabilities Pathways

Bath & North East Somerset Council

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Bath & North East Somerset Clinical Commissioning Group

Our Shared Priorities Continued

Transformational Work Streams

- Commissioning integrated, safe compassionate care for older people
- Re-designing musculoskeletal services
- Ensuring the interoperability of information systems across the Health and Care system

Other Commissioning Work Streams/ Priorities

- Primary Care Co-Commissioning and Development
- Children's and Maternity Pathways
- Children & Young People's Plan delivery, including Early Help Strategy and SEND Reform

Bath & North East Somerset Council

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Bath & North East Somerset Clinical Commissioning Group

Re-commissioning in process, contract award (if relevant*) and/or service in place in 2015/16:

- Expansion of the Independent Living Service, including a targeted service to enhance access to services and support in rural areas for people living with dementia and their carers
- Community health and care services engagement, design and market-testing
- Independent evaluation of the Wellbeing College Pilot and development of Business Case
- Social Care IT system design and implementation following completion of procurement in early 2015
- Advice, information and support for self-funders (requirement of Care Act)
- New integrated Early Help service targeted at families and children in need
- A range of Public Health services

* sometimes, re-commissioning can involve market-testing, pathway or service redesign and it is not necessary or appropriate to undertake a full, open market tendering process

Bath & North East Somerset Council

NHS Bath & North East Somerset Clinical Commissioning Group

Re-commissioning in 2015/16, contract award (if relevant*) and/or service in place in 2016/17-2017/18:

- Community health and care services
- Mental health and wellbeing services, including supported living services
- On-going work to support re-provision of mental health in-patient beds (Hillview Lodge)
- CCG to evidence real term investment increase in mental health services
- New access targets for mental health services
- Children's Centre Services re-commissioned as 2 geographical services
- A range of Public Health services

* sometimes, re-commissioning can involve market-testing, pathway or service redesign and it is not necessary or appropriate to undertake a full, open market tendering process

Bath & North East Somerset Council

NHS Bath & North East Somerset Clinical Commissioning Group

Prevention & Self Care

- Identification of practices with populations with poorer health outcomes with potential to focus on primary and secondary care prevention initiatives
- Targeted and evidence based approaches within CCG's transformational work streams e.g. Diabetes and MSK services
- CQUIN for Self Care - Making Every Contact Count

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Clinical Commissioning Group

Urgent & Emergency Care

- BCF Fund – reducing emergency admissions

  - Review of current plan of 3.5% reduction in 15/16
  - Achievability based on 2014/15 position and current proposed schemes
  - Analysis completed by end January

- Admission avoidance schemes:-

  - Additional support to residential homes,
  - Pro-active weekend GP service

- Resilience Plans – early confirmation of winter schemes for recurrent funding from CCG baseline

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Pathways of Care

- Diabetes
  - Pilot of multi-disciplinary community based teams
  - Greater focus on self care management
- Ophthalmology, Dermatology & Gastroenterology
- Maternity Services specification

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Clinical Commissioning Group

Primary Care Co-Commissioning

- The Forward View into Action sets out increasing role for CCGs in commissioning of primary care
- Co-commissioning to align investment and commissioning decisions with needs of local communities
- BaNES CCG seeking to adopt joint commissioning subject to engagement process with GP practices

CCG's Commissioning intentions:
http://www.bathandnortheastsomersetccg.nhs.uk/publications

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Clinical Commissioning Group

Integrated Commissioning Intentions: Public Health

Bath & North East Somerset Council

NHS
Bath & North East Somerset
Clinical Commissioning Group

Needs Assessment / Strategy development informing commissioning intentions:

Update Joint Strategic Needs Assessment (JSNA)
- Review the young peoples' drugs needs assessment
- Implementation, review and dissemination of the new School Health survey
- Review sexual health needs assessment
- Carry out falls needs assessment

Contribute to needs assessment to inform community services redesign
- Analysis of activity/referral information, outcomes and service user feedback from current commissions
- Targeted stakeholder engagement events
- Review and analysis of service mapping, gap analysis and market position

Research and evaluation resulting in changes to best practice
- Review effectiveness of health checks outreach pilots
- Evaluate the alcohol liaison service
- Support implementation of the REACT research project

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Clinical Commissioning Group

Needs Assessment / Strategy development informing commissioning intentions: (Cont.)

- Consultation and engagement to refresh the following strategies
  - public mental health
  - oral health
  - sexual health
  - Children and young people substance misuse

- Engagement and delivery of the following implementation plans:
  (Tobacco control, Fit for Life, Alcohol, Healthy Weight, Local Food, Suicide Prevention, Public Health Communications)

- Contribute to the development of wider Council policies e.g. economic regeneration and transport

- Develop prioritisation criteria to inform business / investment decisions

Bath & North East Somerset Council

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Priorities influencing current and future commissioning intentions:

- Development of *One Council* approach across the council
- Restructuring in council departments and best use of Public Health capacity
- Meeting the statutory requirements
- Development of integrated commissioning models
- Increasing the focus on prevention, self-care and personal responsibility
- Impact of other partner's commissioning intentions on services in block contracts
- Impacts of welfare changes on mental and physical health of vulnerable groups in our population
- Changes within partner organisations and how responsibilities are shared or led between each of us
- Potential introduction of tariff based system for sexual health services
- Introduction of new NICE or other health guidance (including new immunisations or other public health programmes)
- Introduction of new health legislation (tobacco control, alcohol minimum pricing).

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Service Redesign Priorities

- Contribute to the Community health and care services redesign (engagement, design and market-testing for lifestyle services and integrated 0-5 services)
- Review and redesign of adult weight management services
- Complete school nursing review against new guidance
- Implement revised approach for work in settings - e.g. workplace health, educations settings
- Review use of public health capacity across the council
- Support strategic approach to Public Health workforce development including Make Every Contact Count

Bath & North East Somerset Council

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Clinical Commissioning Group

Re-commissioning in process, contract award and/or service in place in 2015/16:

- Coordinate the transition of 0-5 commissioning responsibilities from NHSE to the Local Authority from October 2015
- Review, re commission or extend the following services:
  - Sexual health vending
  - HIV Support Service
  - Small grants programme
  - Weight management for teenagers
  - Home safety equipment scheme
- Co - commission the following services:
  - Wellbeing college (adult commissioners)
  - Self-harm improvement project
  - YP drug treatment services (childrens commissioner)
  - Adult drug treatment services (adult commissioners)

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NHS England

Working with the CCG to :

- Meet all commitments laid out in ‘The Mandate’
- Commissioning to provide new Mental Health service targets
- Securing a major expansion of personal health budgets
- Provide women with a choice of Midwifery Services (following the national review)
- Urgent and emergency care review of local services

NHS England

With the CCG there is the opportunity to co-create new models of care including;

- Multi specialty providers
- Integrated primary and acute care systems
- Models of enhanced health in care homes

NHS England

Delivering a new deal for Primary care through;

- Attracting more GPs to the workplace
- Premises and infrastructure improvement
- Prime Ministers Challenge Fund

NHS England

Enabling change through;

- Increasing the use of technology to help people use care services
- Further roll out of Electronic prescribing
- Practices providing online access to medical records
- Practices providing online access to appointments

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NHS Bath and North East Somerset Clinical Commissioning Group

healthwatch Bath and North East Somerset

MEETING	B&NES HEALTH AND WELLBEING BOARD
DATE	21/01/2015
TYPE	An open public item

Report summary table	
Report title	B&NES Health and Wellbeing Network – Making Every Contact Count
Report author	Ronnie Wright (0117 958 9333)
List of attachments	None
Background papers	The full meeting notes, presentations and handouts are available at http://www.thecareforum.org/page134.html Further information about the approach is seen at http://www.makingeverycontactcount.co.uk/
Summary	What can be learnt from the ideas within the national Making Every Contact Count initiative, as discussed through the Network, and how might we take these ideas forward at a local level.
Recommendations	The Board is asked to: • Note the outcomes of the meeting • Consider possible next steps in relation to Making Every Contact Count
Rationale for recommendations	Making Every Contact Count is a national approach which can support and empower staff to take advantage of opportunities which arise in their contact with others to raise people's motivation to make changes and choices that might improve their lives. This links closely to the Health and Wellbeing Strategy objectives particularly in relation to staying healthy, through reduced alcohol use, and improving the quality of people's lives through better mental wellbeing.
Resource implications	NA
Statutory considerations and basis for proposal	NA
Consultation	NA
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

The Making Every Contact Count workshop was held on 5 November 2014 and 32 people attended. The meeting was organised by Healthwatch Bath and North East Somerset in partnership with B&NES Council public health and Active Lifestyles & Health Improvement teams and Sirona Care and Health Healthy Lifestyles service.

1. Understanding better how to motivate people and encourage behaviour change are issues which have been raised through a number of previous Health and Wellbeing Networks. Additionally how we might all make the most of each contact with have with people has been seen by many as an important way of increasing the effectiveness of all services. With that in mind this meeting took the form of an interactive workshop looking at Making Every Contact Count.

2. Making Every Contact Count is about how to take most effectively the opportunity to help people - service users, family, friends and colleagues - improve their own health. It is about providing simple, brief lifestyle information and being able to signpost people to existing services where appropriate. It is not about adding to workloads. It is not about becoming experts in other services. It is about feeling empowered to help other people to know how they can improve their own health and wellbeing, and doing this effectively.

3. As well as an introduction to the idea of Making Every Contact Count the session also looked at the strategic context for this work including the local Fit for Life strategy. Participants discussed some of the key health messages in relation to a number of issues including physical activity, mental health, smoking, healthy eating and alcohol. Participants also looked at stages of behaviour change and using the brief intervention approach of 'Ask Advise Assist'.

4. At the end of the session, people were asked to identify if there were any comments they wanted to make about the training or next steps in relation to the training, or if they had any anything to add in relation to the day. In summary they said:

    - B&NES wide Making Every Contact Count group
    - More information and support in signposting people to services
    - More consideration should be given to free and informal opportunities for exercise – including giving staff time to exercise at lunch time

5. In addition to these suggestions it has also been felt that further support through motivational interviewing training is something which organisations would find beneficial and this is an option that could be further explored. It would also be welcome to consider how this approach might be shared more widely with providers. There are interesting examples from other areas which have implemented Making Every Contact Count.

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

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

healthwatch Bath and North East Somerset

MEETING	B&NES HEALTH AND WELLBEING BOARD
DATE	21/01/2015
TYPE	An open public item

Report summary table	
Report title	Director of public health annual report 2013-4: The Good, the Bad and the Ugly.
Report author	Bruce Laurence (01225 394075)
List of attachments	DPH report hard copies to be circulated at meeting. Report available on BaNES website at: http://www.bathnes.gov.uk/services/public-health/director-public-health-report
Background papers	N/A
Summary	It is a statutory responsibility of the DPH (to write) and the Council (to publish) an annual report on the public health. This is to present the latest report to the HWB in its capacity as the body overseeing the population's health and wellbeing. .
Recommendations	The Board is asked to note the publication of this report and comment on its contents and format.
Rationale for recommendations	No specific recommendations, but areas of work highlighted fit well with the health and wellbeing strategic priorities.
Resource implications	Nil specifically, but the report highlights some of the areas of work on which the council spends parts of the public health budget
Statutory considerations and basis for proposal	N/A
Consultation	The report specifically represents the view of the director of public health and is not subject to formal consultation, but this year a particular effort was made to represent a wide range of other views including from members of the public and elected members from different parties.
Risk management	N/A

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Finding out more about health and the things that affect it

Find out more statistics about the health of people living in Bath and North East Somerset from the council's searchable Joint Strategic Needs Assessment (JSNA). It's designed to be the single portal for facts, figures and intelligence about our local area, its communities and its population. It has been developed to be used by anyone who has an interest in or makes decisions about Bath and North East Somerset. It works as an on-line 'wiki' resource, that can be updated more easily to reflect the flexible and ever changing nature of our local communities.The JSNA is still in development, so please bear with us if things fall over, don't work or look silly (we're working on making tables better) - if you spot something doing any of those things, please drop us a line - *research@bathnes.gov.uk*. You can find it at *http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/about-jsna.*

To find out more about the priorities that we and our partners have set for improving the health of people in Bath and North East Somerset look at the Health and Wellbeing Board's Strategy at *http://www.bathnes.gov.uk/services/neighbourhoods-and-community-safety/working-partnership/health-and-wellbeing-board* . The priorities are not an exhaustive list of everything that the Council and NHS are doing to meet local health and wellbeing need; but rather a small set of priorities for the Health and Wellbeing Board to really focus on and make a difference in the coming years. The priorities identified are set out in the next column.

THE HEALTH AND WELLBEING BOARD HAS IDENTIFIED THE FOLLOWING PRIORITIES

Theme 1
Helping people to stay healthy

- Helping children to be a healthy weight
- Improved support for families with complex needs
- Reduced rates of alcohol misuse
- Create healthy and sustainable places

Theme 2
Improving the quality of people's lives

- Improved support for people with long term health conditions
- Reduced rates of mental ill-health
- Enhanced quality of life for people with dementia
- Improved services for older people which support and encourage independent living and dying well

Theme 3
Creating fairer life chances

- Improve skills, education and employment
- Reduce the health and wellbeing consequences of domestic abuse
- Increase the resilience of people and communities including action on loneliness

Bath & North East Somerset Council

Report of the Director of Public Health 2013-14
The Good, the Bad and the Ugly

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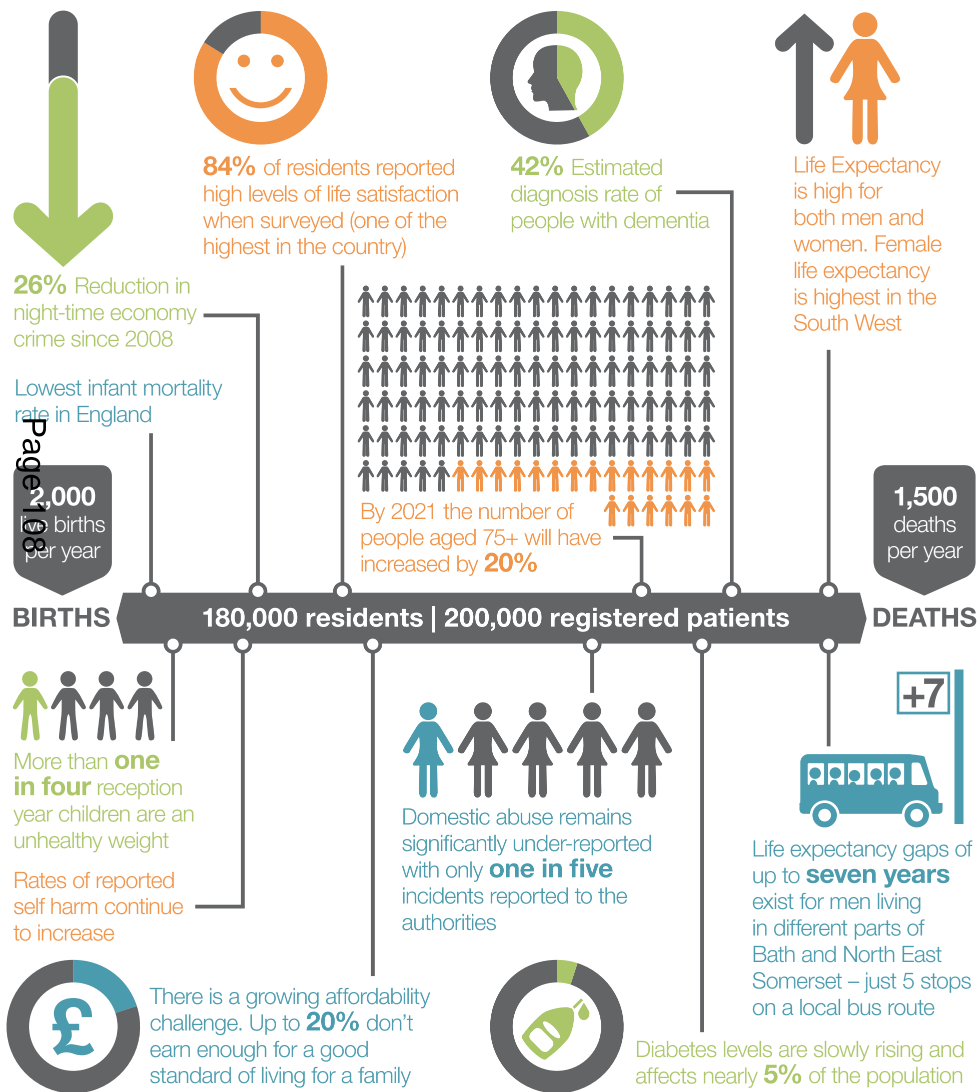

For more information please visit the Joint Strategic Needs Assessment (JSNA) at www.bathnes.gov.uk/jsna

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10 Vox pops: hearing from local people about what health and wellbeing means to them

12 Moving towards a smoke-free world

13 **Case study:** The benefits of giving up smoking

14 Staying well – a profile on diabetes

15 **Case study:** Free NHS Health Check

17 **Case study:** SHINE Health in Pregnancy Group

18 Five ways to wellbeing in Bath and North East Somerset

20 The five ways to wellbeing

21 Child poverty and its impact on physical and mental health

25 **Case study:** Early years Director of Public Health Award

26 Director of Public Health report indicator set

27 Understanding how things that are unhealthy impact on disease

28 Finding out more about health and the things that affect it

Acknowledgements

I would like to thank all the colleagues within the Public Health team and the Council who contributed to this report, in particular Joe Prince and Natalia Urry for their help with data analysis. Thanks also go to the people who shared their experiences and the organisations who worked with them: Sirona Healthy Lifestyles Service, the Health in Pregnancy Service, Playful Families and the Widcombe Acorns Pre-school. I appreciate the efforts of Ryan Smart, apprentice at Somer Valley FM, and station manager Dom Chambers, who helped me get some insight into what being healthy and happy means to local people and am grateful to the following for sharing their thoughts: Al Hannan, Frank Asante, Tanya Kingman, Carrie Edgeworth, Pam Beaver, Kelly Parsons, Georgia Butler, Patrick Edgeworth, Joe Alexander and Carol Smart. And most of all, I'd like to thank Justine Womack for her central role in the production, designing, and editing of this report.

Foreword

Welcome to the 2013-4 Director of Public Health Report. This year I want to show you some interesting and varied examples of how we are working within Bath and North East Somerset Council and with a wide range of partners, to improve the health and wellbeing of residents across Bath and North East Somerset.

Why did I call this 'The Good, the Bad and the Ugly' – apart from bringing back the memory of a great film…

The Good is the enthusiastic way in which the Council has taken on wide new responsibilities for the public's health after last year's NHS reorganisation. An example of this is in the section on 'healthy places to live', which shows how good health can be built into the way we plan our towns, villages and transport systems and how this can have just as much impact as the NHS with its surgeries and its hospitals. The good is also the long life expectancy and high levels of physical and mental health and wellbeing that the majority of our residents enjoy compared to other parts of England as illustrated in some local statistics presented in the report. And, of course, how good are our wonderful towns and villages and the beautiful natural environment that we are so lucky to share?

The Bad is the very significant set of health challenges that still afflict us, and in particular those illnesses and disabilities that are not due to bad luck, but that are avoidable if only we all had the means, the knowledge and the will to lead healthier lifestyles. This is illustrated by the sections on diabetes and smoking. I firmly believe in the value of supporting people of all ages to take charge of their own health and that of their families. This support can take many forms but the benefits of wise investment will be felt by individuals and by our society now and into the future. Pulling up the roots of disease is so much more satisfying than tasting its bitter fruits!

The Bad is also the flip-side of our excellent longevity, which are the consequences on health and social services of an aging population, against a difficult national economic picture. And then on a global scale there are big environmental challenges that we face like climate change and pollution.

And what about the Ugly? This is embodied in the persistent and unacceptable levels of health inequality that we have throughout the UK, exemplified in Bath and North East Somerset by the seven year difference in male life expectancy between the highest and lowest ranked wards. We put a spotlight on child poverty, the effects of which can last throughout life, and which, despite the commitment expressed by successive governments has been a stubborn problem, shaming in such a wealthy country as ours.

The report contains much more besides. We have included examples of local people working to overcome their difficulties, and have asked councillors and members of the public to give their views on health and wellbeing and how we might make a difference here and now.

The Joint Health and Wellbeing Strategy, developed last year, symbolises the way in which different partners across Bath and North East Somerset work together to safeguard and improve health, and most sections of this report link to one or other of its priorities. You can follow links at the end of the report to this strategy and also to a wealth of local information. I have also included an interesting chart showing the most important underlying causes of illness and death in the UK, most of which can be modified by individuals or by communities working together.

I have aimed to give a balanced picture of our highs and lows, and some insight into the many factors that influence how well we feel, how healthy we remain and how long we live. As a public health worker my role can be to work with anyone in Bath and North East Somerset whose actions somehow impact on their own health, that of their family or of the wider community, and if that sounds like it might include you, you are surely right. So whether you agree with what I have written, or don't like it at all, please contact me if there is anything that you would like to say.

Dr Bruce Laurence
Director of Public Health

Views of elected members on what is different about Public Health being in the Council

Councillor Martin Veal

"Health is something that is important to all of us although we don't always give it much thought until we are ill ourselves or affected by the illness of someone close to us.

"Having public health come back into local government provides fresh opportunities to encourage people to take their health seriously and create places and communities that promote it.

"The importance of a good start in life is often talked about and we know that the early years, families and schools play a critical role in establishing behaviours that will have a significant impact on children's health in later life. I am excited by the potential we now have to build the confidence of parents and communities to get that healthy start right.

"A key part of that is getting children and young people active. Team facilitated sports and games help both children and adults to build friendships, social networks, give people a sense of belonging and help to break down social barriers. We have a strong culture of sports clubs in the area and continue to work with the school sports partnership to continue to ensure high quality sport and physical activity opportunities are delivered within schools."

Councillor Simon Allen

"It's interesting to hear in this report what being healthy and happy means to some of the people living here. What they have to say reflects the fact that so many things affect our health, such as where we live, what the environment is like, our access to work, facilities and transport and how connected to other people we feel.

"Local councils have responsibilities in all these areas, which is why it makes sense for the job of improving health to sit with us. But we know that we can't do this on our own, which is why working with so many partners in the NHS and voluntary sector through the Health and Wellbeing Board is so important.

"Although we know that broadly speaking people in Bath and North East Somerset are pretty healthy compared to those in other parts of the country, we also know that not everyone is experiencing it in the same way and we know that there are some real threats to all of us, such as the challenge of not becoming overweight and inactive.

"It's why we put such a significant emphasis on creating high quality work opportunities, healthy places for people to live and work with good transport links that support being active and supporting children and families to ensure a positive start and build resilience to address the pressures of modern life. It is these pressures which can affect our mental health and lead to patterns of unhealthy behaviour developing.

"The opportunities for us to build a new way of thinking about being healthy and well into all the things that we do are significant."

Councillor John Bull

"Health is a big component of overall wellbeing and happiness for all of us.

"Apart from freedom from pain or mental anxiety, good health requires as little uncertainty as possible about things that can cause our quality of life to deteriorate. There are many of these, which are known in the technical jargon as the social determinants of health. They recognise that how healthy we are is affected by where we live, the resources we have, our education and our access to meaningful work. They are all aspects of society in which local authorities play a critical part, which is why I am so delighted that this is now recognised through our responsibility for public health. It means we have the opportunity to influence improvements in health through education, the environment, licensing, planning, leisure and transport.

"By being proactive in these areas the Council can help to improve all our prospects whether in relation to tobacco, alcohol or drug addiction, obesity, fitness or mental health."

The importance of **WHERE WE LIVE** for our **HEALTH AND HAPPINESS**

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What do you think about the area in which you live?

Does it look nice, is it safe, can you get to school, college or work easily? Is your house dry and can you afford to keep it warm? Does it have a kitchen big enough to cook in? Is there room to store a bicycle? Can your children play safely outside? Do you have any green space nearby where you can sit and think and enjoy nature or grow things? Can you get around easily by walking, cycling or public transport and not only by car? Is it easy for older people to get around or get help or meet people easily? Is it easy for you to meet people or join activities, are people friendly?

This might seem like a very long list of questions with no connection to places people normally associate with health such as GP surgeries and hospitals, yet all these make a big difference to how healthy and well we are. People generally enjoy walking, but if it is not accessible and easy they are less likely to actually do it. Likewise, if people cannot buy healthy, affordable food easily, they are less likely to cook well for themselves and family.

How healthy is Bath and North East Somerset to live in?

Although people in Bath and North East Somerset are generally healthier than the average for England, there is still plenty to do. About 13% (3,700) of children live in poverty, and between 10-14% of all households experience fuel poverty (a need for well insulated, heat-efficient homes). The high cost of private and rental accommodation contribute to poverty, which in turn is bad for health and wellbeing. In 2013 house prices were 40% higher than the national average, which is particularly concerning when residents earn (on average) less than those in the South West and nationally.

Only 30% of adults living in Bath and North East Somerset consume the five pieces of fruit and veg a day recommended for a healthy diet, a recommendation that has recently increased to seven pieces. Rates of obesity are rising in adults in Bath and North East Somerset even though they are still lower than national rates. In the 2013/14 school year, 23% of reception aged children were overweight or obese, higher than national and >

Healthy food growing and preparation taking place at the Community Farm, an organic not-for-profit farm, which aims to reconnect people with the land where their food is grown.

CASE STUDIES
Helping Bath and North East Somerset become a healthier place to live

Getting around Bath and North East Somerset can be active and fun!: Bath Two Tunnels Circuit is attracting people from all over the South West to cycle or walk all or part of the 13 mile circular route. People can enjoy art, light and music installations while cycling or strolling through the tunnels. Bath and North East Somerset Council also supports people to 'go by bike' by providing cycling training in schools and free adult training. Regular cycling sessions are also open to members of the public at the Odd Down Cycle Circuit. For more information about these and other cycling schemes see the Council website at: *http://www.bathnes.gov.uk/services/parking-and-travel/cycling/go-bike*

Bath Area Growers (BAGS): Bath Area Growers is a network of community food growing groups in Bath many of whom have set up communal orchards, veg plots, and agricultural projects and work with vulnerable people.

Food For Life Partnership in Bath and North East Somerset: The majority of schools in Bath and North East Somerset (57out of 78) are enrolled in the Food For Life Partnership (FFLP) programme which raises food awareness amongst children and engages them in food growing, cooking and composting activities. A national evaluation of the FFLP programme showed that following their participation in FFLP programme, the proportion of primary school children eating five or more pieces of fruit and veg a day increased by 28%.

regional levels. Physical activity is crucial in addressing obesity and supporting more residents to gain a healthy weight.

That's why Bath and North East Somerset Council is working with local people to help to continually improve the places where people live.

What is a healthy community?

A healthy community is a good place to grow up and grow old in, which supports social interaction. It is one which makes it easy for people to be healthy both physically and mentally. The key to this is good urban design. This includes good access to local services and facilities, green open space, safe places for play and food growing, and where it is easy to walk and cycle to work, school or activities. It helps children and young people to grow and develop, as well as being adaptable to the needs of an increasingly elderly population and those with dementia and other disabilities.

What are we doing to create a healthy Bath and North East Somerset?

Bath and North East Somerset Council is working to influence these wider factors that affect our health and wellbeing in a whole range of ways…

Public health and Planning colleagues are working together to ensure that health and wellbeing is improved through all our planning processes. So for example, when council plans for major redevelopments are looked at, they will be judged on how 'healthy' they are. Questions such as "Is the development designed to promote active lifestyles?" and "has consideration been given to designing for all ages?" will be asked. Public health staff will also comment on pre-planning applications for major developments locally to see that developers have thought about cycling and walking routes, play and recreation areas, allotments, housing for people of all ages and vibrant, well connected neighbourhoods.

Council colleagues, including those in Transport and Planning, have been working with partners such as Sustrans to make Bath and North East Somerset more accessible on foot and by bike. The local area is becoming well known for the way it is connecting up key city attractions and green spaces through new cycling and walking paths. The Council's Transport Plan for Bath 'Getting Around Bath' also promotes walking and cycling, and sets the vision for a 'walking friendly city'.

Only 30% of adults living in Bath and North East Somerset consume 5 pieces of fruit and veg a day. This percentage is lower in poorer parts of our community.

Bath and North East Somerset is developing a local authority-wide food strategy to promote healthy, sustainable and local food in their area. The aim is to get healthy, affordable food to all our people and to transform their food culture to one that improves health and wellbeing, environmental sustainability and the local economy. Numerous successful food projects are underway in Bath and North East Somerset relating to healthy eating, communal food growing, cooking and growing skills and local food markets.

Strategic Director of Place Louise Fradd said: "Planning colleagues have always had an interest in developing healthy places, and with public health colleagues now working alongside us within the Council, this has enabled a renewed emphasis on this."

A new development in Ralph Allen Yard provides well designed housing with low running costs, a community space, cycle storage and proximity to shops and bus routes.

The new civic centre in Keynsham will be among the most energy efficient office developments in the country.

CASE STUDIES

Helping Bath and North East Somerset become a healthier place to live

This Council's Food Forum: The Council food forum has an important role supporting schools, colleges and early year settings to increase the quality and uptake of lunchtime meals and to reduce the amount of unhealthy food that children consume within educational settings. The Food Forum develops and delivers a range of award schemes to promote healthy eating including the Food For Life Partnership Award, the Director of Public Health Award, SHINE And HENRY awards. The Food Forum has also supported the implementation of the School Food Plan, including support to implement universal free school meals for all key stage 1 primary school children from September 2014. This will help to reduce cost for all families and help children to be healthy and ready to learn.

Eat out-Eat well award: Delivery of the 'Eat-out, Eat-Well' award by the Council and Sirona supports food outlets and catering businesses to provide a wider range of healthy food options and to reduce the level of trans-fats, salt and sugar provided in their foods.

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Your voice

WE ASKED PEOPLE IN THE AREA TO TELL US WHAT BEING HEALTHY AND HAPPY MEANS TO THEM.

Al Hannan

Age: 45-59
Area: Midsomer Norton
Vocation: Secondary School Teacher

“Being healthy and happy means not being ill but feeling energetic and being able to live life to the full. This is definitely a big step in being happy and having a sense of wellbeing. Not only being physically healthy but mentally and emotionally happy as well. All of these things work together.

I feel happy today but not every day but it would be nice if that was a more consistent thing.

The biggest problem with being healthy and happy is the amount of stress and pressure that people are under from work or family or whatever. Just having enough time to exercise would be a good thing. I like cycling but it a few near misses with cars has put me off.I can't afford to get run over because of my job and family.”

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Georgia Butler

Age: 18-29
Area: Haydon
Vocation: Unemployed

“For me, being healthy is about eating a balanced diet, and not too much junk food, as well a being able to keep fit.

I notice I get out of breath quickly because I don't get much exercise. It's probably due to the fact that I moved house and am unemployed and I'm at home and because I'm at home I eat lots more. Being active gives you more energy and when you have more energy you go out and do more things with friends which in turn makes you happier.”

Patrick Edgeworth

- *Age: 16*
- *Area: Paulton*
- *Vocation: Student*

“Playing organised sport such as football is key to me being health and happy because I enjoy it and it keeps me fit. Free or cheaper access to the local gym would help me be healthier and happier because money is tight.”

Tanya Kingman

Age: 30-44
Area: Midsomer Norton
Vocation: Sales Assistant

“Being fit, having good overall health and not feeling ill all the time are essential to being healthy and happy. The normal things would help people be healthier and happier such as giving up smoking, keeping fit, eating well and keeping on top of your finances. I would like to see nicer places to keep fit such as warm swimming pools and cleaner and more up to date gyms.”

“The biggest problem with being healthy and happy is the amount of stress and pressure that people are under from work or family or whatever.”

Carrie Edgeworth

Age: 45-59
Area: Paulton
Vocation: Seamstress for Mulberry

“I don't really know what being healthy and happy means. I'm not either of these things at the moment

I would be happier if it was easier for my children to move into their own home but at the moment this is unachievable due to housing prices in the area and the lack of full time employment for them to earn a good wage.”

Frank Asante

Age: 30-44
Area: London (works in the area)
Vocation: Pharmacist

“Being healthy and happy means a lot. It depends on how you see life. In your mind you have to be mentally healthy, and your body physically fit as result of eating healthily and exercising. Happiness comes from the simple things in life and is affected by your outlook and attitude to life. People need to look after themselves by avoiding emotional and physical stress and getting help with any medical issues they develop.”

Carol Smart

Age: 30-44
Area: Farmborough
Vocation: Nursery Assistant

“Health is not something you can buy. Exercising more and having more relaxation time would help people to be healthier and happier because mental health is just as important as physical health. It's important not to over analyse things and have achievable expectations as well as being satisfied and enjoying happy times and memories.”

Joe Alexander

Age: 18-29
Area: Stoke St. Michael
Vocation: Unemployed

“Being healthy is not having to go to the doctor's all the time as well as eating properly and getting exercise. Being happy is being content with what you are doing in life, including your job, being able to afford the things you need and having things to do in your local area. It would help if people had more things to do in their area. I used to live in London and there were lots more things for people my age to do than there are here. I would like to see more venues developed to attract more bands.”

Pam Beaver

Age: 60+
Area: Corston
Vocation: Retired

“I'm retired and if I'm well I can do a lot of things I couldn't when I was working. You can only be happy and healthy if you are well, have close friends and eat and exercise properly. However, it would help if doctor's surgeries were open longer hours to enable people who work to get there.”

Kelly Parsons

Age: 18-29
Area: Radstock
Vocation: Complementary Therapist

“Keeping fit and staying relaxed is essential for me to be healthy and happy. I think people need help to motivate them to stay healthy and people to talk to about problems they have. Keeping people emotionally and mentally healthy is really important.”

“Keeping fit and staying relaxed is essential for me to be healthy and happy.”

Moving towards
A SMOKE FREE WORLD

PROVIDING SUPPORT FOR PEOPLE TO QUIT SMOKING IS A KEY HEALTH PRIORITY

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In Bath and North East Somerset 83% of people don't smoke, which is much better than the national average. This is great news but nevertheless there are still 23,000 adult smokers and for those that do smoke giving up is the single biggest thing they can do to avoid becoming ill or dying early, which is why it remains a key health priority for the Council.

As well as providing support for people to quit, protecting other people from second-hand smoke is really important, which is why our end goal is a world where no one smokes.

A ban on smoking inside any public buildings was introduced in 2007 and in February 2014 a ban on smoking in cars in England, when children are passengers, was approved in an amendment to the Children and Families Bill.

Protecting children

But it's also a problem outside, which is why in Bath and North East Somerset we've introduced a scheme to encourage adults not to smoke where children are playing through clear signs in 61 playgrounds across the area. This is also important because children start smoking by copying adults and we know that 65% of people who smoke start before the age of 18.

We're keen for all other places where children and young people play and hang out to encourage a no-smoking approach outdoors such as schools and children's centres.

And there's plenty of evidence that people support smoke-free outdoor spaces. A recent survey in the South West by Smoke Free South West on attitudes to a ban on smoking in High Streets found that the great majority of non-smokers (84%) and even more than half of the smokers asked (52%) felt that a voluntary ban was either 'very acceptable' or 'fairly acceptable'.

Schools and colleges do a great deal of work to prevent children taking up smoking, ranging from making their sites smoke free, providing peer-led and other health promotion sessions as part of the curriculum. Recognising that smoking isn't the norm is an important message for young people, which is why Bath College has been trying to get this

Bath College students with their message

CASE STUDY | KEN, ST MUNGO'S

The benefits of giving up smoking

Ken, who works for St Mungo's, recently trained to become a Stop Smoking Advisor to help others after giving up because of health and financial reasons. He said: "I decided to stop smoking because my breathing was difficult, and I would become breathless walking up a small incline and used to wheeze at night. My energy levels were very low, my mood was not good for most of the time and I would spend £50 per week on smoking.

"I gained 2 stones when I first stopped smoking, but then lost all of that, and another stone, and now exercise regularly which is something I never thought I would manage to get to do again.

"I work in mental health and now have clients that have stopped smoking as well, which means they feel they are doing something really positive for themselves and get back some health and energy that they may not have had previously.

"For clients on certain types of medication, it can even mean a decrease in their medication as the effectiveness increases after stopping. This can mean less sedation, and other side effects for them. All in all stopping smoking has made a massive difference to my life."

> "I would become breathless walking up a small incline and used to wheeze at night."

across through its 'seven out of ten students don't smoke' campaign, which aims to change common perceptions about smoking habits (http://www.citybathcoll.ac.uk/index.php?id=9668).

E-cigarettes

Many people will have noticed or read about e-cigarettes or 'vaping', which provide inhaled doses of vaporised nicotine but without the toxic chemicals that go with it in cigarette smoke. We don't know how many people are using them in our area but what we do know is they are mainly used by current and former smokers, and only about 0.5% of people who have never smoked in Great Britain have tried the product. They are becoming an increasingly important way of people giving up smoking and reducing the harm to their health from cigarettes.

But like lots of things, it's complicated. There's also a concern that smokers will use both e-cigarettes and conventional cigarettes and delay giving up completely and that they might make smoking in public places more acceptable again and even introduce some of the next generation of children to smoking. E- cigarettes already come in a variety of flavours likely to attract children.

One of the biggest concerns is the impact of children copying adults and particularly the effect of aggressive marketing campaigns. This is why the Children and Families Bill included a ban on their promotion to under-18s.

Other services

Illegal tobacco and hand-rolling tobacco are both big issues in the South West, which is why the Council-funded Smoke Free South West has mounted local campaigns against both these in addition to supporting national campaigns including Stoptober and No Smoking Day.

In addition to our range of actions to prevent smoking we offer a range of specialist support to help people quit including support through GP surgeries, pharmacies, maternity services, mental health services and through Sirona Healthy Lifestyles service.

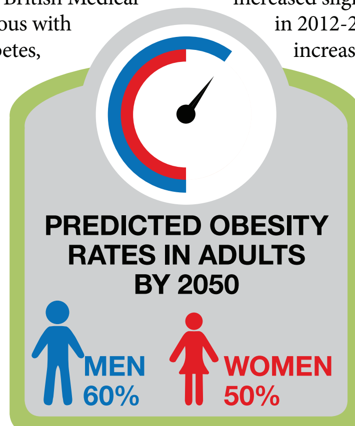
For more on burden of disease risk factors, including smoking, turn to page 27

STAYING WELL: A PROFILE ON DIABETES

WITH MORE PEOPLE AT RISK OF DIABETES, HELPING PEOPLE MAINTAIN A HEALTHY WEIGHT IS CRUCIAL

Diabetes is rapidly becoming one of the biggest threats both to the health of our residents and also the viability of our local health services. This is equally true across most of the UK and indeed many other countries. A third of adults in England are on the verge of type 2 diabetes, according to a recent study in the British Medical Journal. The implications are serious with one in ten progressing to full diabetes, which can cause death and disability, including heart disease, stroke, kidney disease, blindness and amputations, if not well controlled. Fifty per cent of people already have complications when they are diagnosed with Type 2 diabetes and 10% of the NHS budget is currently being spent on it.

The latest figures for Bath and North East Somerset show there are 7,460 people aged 17 years and over registered with diabetes. It is estimated that there are a further 3,259 adults in the Bath and North East Somerset Clinical Commissioning Group GP Practice population with undiagnosed diabetes. The level of diabetes in 17 year olds and over has been steadily increasing locally, regionally and nationally. In this area it has increased slightly from 4% in 2008-2009 to 4.6% in 2012-2013 and is expected to continue to increase, by approximately 150-200 people per year adding up to a 34% rise from 2005 to 2025.



People with diabetes in NHS Bath and North East Somerset are 44% more likely to have a heart attack, 32% more likely to have a stroke, 73% more likely to have a hospital admission related to heart failure and 44% more likely to die in any given year than the general population in the same area.

Diabetes is a condition in which the amount of glucose >

CASE STUDIES

Free NHS Health Check

Everyone aged 40 – 74 who does not have a related pre-existing condition will be invited for a NHS Health Check once every five years. The free Check is to assess a person's risk of developing heart disease, Type 2 diabetes, kidney disease and stroke. It takes about 20 – 30 minutes and includes simple tests to check cholesterol, blood pressure and Body Mass Index (BMI). Last year in Bath and North East Somerset over 6,000 people took up the offer of a free NHS Health Check. They are now armed with the information and support they need to reduce their risk of developing heart and vascular problems.

A further 12,000 people will be invited for their NHS Health Check this year. People are given personalised advice on how to lower their risk and maintain a healthy lifestyle. Treatment or medication may be prescribed to help people maintain their health.

Michael, 48, from Bath, describes how he discovered he had diabetes because of his Health Check:

"In January I received an invitation from my doctor's surgery to attend for a free NHS Health Check. I thought it would be a good idea to go along so I made an appointment to see the practice Health Care Assistant. She was very helpful. As a result of attending I was told that I could have diabetes. At first I found it very hard to believe as I didn't feel ill. She reassured me and arranged for me to see a nurse who helps people who have diabetes. I had more tests and it was confirmed that I do have Type 2 Diabetes. Since then I have been supported by the surgery and I have made changes like eating more healthily and increasing the activity I do. The changes I have made along with the tablets I take now have helped me take to control and manage my condition. When I last had a check-up in May my blood test results were very good. I'm very glad that I went along for the NHS Health Check as I might have become very unwell otherwise. Now I am able to keep control."

(sugar) in the blood is too high because the body can't use it properly. The reason behind it is linked to the production of insulin, a hormone which helps the glucose enter the cells where it is used as fuel for the body. Type 1 diabetes, where the body can't produce insulin, isn't preventable. It usually appears before the age of 40 and only accounts for about 10% of people with the condition. During pregnancy, some women have such high levels of blood glucose their body is unable to produce enough insulin to absorb it all, this is known as gestational diabetes.

Type 2 diabetes, which is the one mainly responsible for the great increases of recent years, develops when the body either can't make enough insulin or the insulin produced doesn't work well enough. It is very much linked with being overweight although in a small number of cases people of normal weight can develop the condition.

The number of people who are obese in England has more than doubled in the last 25 years, with a particularly high rate of increase in England. And it is set to get much worse with 60% of men, 50% of women and 25% of children predicted to be obese by 2050.

There has been considerable debate about what's behind the massive increase in weight but there is general consensus that it is a combination of increased availability, and therefore consumption, of high fat, high sugar foods such as processed food and fizzy drinks as well as lack of physical activity and people living more sedentary lifestyles.

There is increasing concern that it is taking over from tobacco as the leading cause of preventable illness and death and there have been calls for regulation of the food industry, particularly on products targeted at children. These controls include stricter regulation of how food is advertised, the way nutritional information is provided and raising the standard of food including reducing salt, saturated fat and levels of sugar.

A considerable proportion of the council's budget already goes on promoting more physical activity both through planning and transport infrastructure and commissioning facilities and programmes to enable people to build it into their every-day lives.

The sheer scale of the problem and impact on local health services is why the local clinical commissioning group has made diabetes, including preventing it through maintaining a healthy weight, one of their top 6 priorities.

HELPING PEOPLE STAY HEALTHY

CASE STUDIES

SHINE Health in Pregnancy Group

The Health in Pregnancy Service describes the positive progress made by one of the mums in the Paulton maternity weight management group:

"I met Ann when she was 14 weeks pregnant. Ann already had 4 children, having her eldest when she was 17. On meeting Ann she was very anxious about our visit and her pregnancy. We talked through the risks associated with a high BMI. Ann felt very guilty that her weight may lead to complications for her unborn child. Nice recommends that women with a BMI> 30 should aim to maintain a healthy weight gain of between 5-9kg. We discussed how this could be achieved by sticking to 2000 calories (2200 third trimester) and knowing your food groups. I explained to Ann that by doing 15 minutes of exercise 3 times a week building up to 30 minutes 7 times a week, not only does this help her to maintain her weight it also helps to build her stamina in preparation for labour. We recommend that women walk and, if possible, swim.

"For every woman the most enlightening information I give is regarding portion control! I asked her to put into a bowl the amount of pasta she would have on her plate. To say she was a little surprised when I then weighed out a 35g portion was a bit of an understatement! A handful of pasta, rice and veg is roughly equivalent to 35g.

"I made 4 further visits to Ann who embraced the opportunity to make changes and quickly saw the benefits. In addition to her maintaining a healthy weight gain we also looked at ways of improving her confidence and self-esteem. I encouraged her to join children centres to meet other mums and build up a circle of friends that will support her.

"Ann had a normal delivery of a healthy boy and managed to maintain a healthy weight gain in pregnancy. I received a text 5 weeks post-natal saying she was now 123kg, 5kg below her initial booking weight."

> **"To say she was a little surprised when I then weighed out a 35g portion was a bit of an understatement! A handful of pasta, rice and veg is roughly equivalent to 35g."**

The Paulton Maternity Weight Management Group

5 Ways to Wellbeing
in Bath and North East Somerset

HAVING A NETWORK OF SOCIAL CONNECTIONS OR HIGH LEVELS OF SOCIAL SUPPORT HAS BEEN SHOWN TO INCREASE OUR IMMUNITY TO INFECTION, LOWER OUR RISK OF HEART DISEASE AND REDUCE MENTAL DECLINE.

How happy and well people feel is an important part of life. In recent years there has been a growing interest in the science of well-being and happiness and the factors that affect it, with increasing recognition of the importance of our relationships and resilience in the way we respond to things that happen to us.

Happiness includes the fluctuating feelings we experience everyday but also our overall satisfaction with life. It is influenced by our genes, upbringing and our external circumstances - such as our health, our work and our financial situation. But crucially it is also heavily influenced by our choices - our inner attitudes, how we approach our relationships, our personal values and our sense of purpose.

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And improving how happy we are has an important impact on our physical functioning. Harvard School of Public Health examined 200 separate research studies on psychological wellbeing and cardiovascular health and found that optimism and positive emotion provide protection against cardiovascular disease, slow progression of heart disease and reduce risk, by around 50%, of experiencing a cardiovascular event, such as a heart attack.

Having a network of social connections or high levels of social support has been shown to increase our immunity to infection, lower our risk of heart disease and reduce mental decline as we get older.

Recent research has shown that an eight week mindfulness meditation class can lead to structural brain changes including increased grey-matter density in the hippocampus, known to be important for learning and memory, and in structures associated with self-awareness, compassion and introspection.

But being happier is easier said than done. Poor mental health is influenced by genetic factors as well as changes in life circumstances such as divorce, bereavement, illness, unemployment, financial pressures and housing worries as well as uncertain and stressful work environments.

These pressures not only influence psychological wellbeing, but may also contribute to relationship strain, less leisure time for those in work, and less money to spend on healthier foods and leisure activities for those out of work.

One in four people will experience a mental health problem during their lives and at any one point one in six is living with a common mental disorder. Mental health problems have not only a human and social cost, but also an economic one. The overall cost to the UK is estimated at more than £110 billion a year. The costs of mental illness are currently greater than the costs of crime and are projected to double over the next 20 years.

Based on the Office for National Statistics survey of wellbeing, residents in Bath and North East Somerset experience some of the highest levels of recorded wellbeing in the country. However, estimates also suggest that 16% of the working age population have a common mental illness, and levels of reported anxiety (41% feeling anxious yesterday) are higher than regional and national levels. There are also significiant variations in different sections of the community. For example, younger and older people report higher levels of wellbeing, while Black and Minority Ethnic communities; those with poor reported physical health and the unemployed experience lower levels of wellbeing.

84%

of residents reported high levels of life satisfaction when surveyed

IMPROVING QUALITY OF PEOPLE'S LIVES

Poor mental health covers a range of problems including: depression, anxiety, obsessive-compulsive disorder, phobias, eating problems, bi-polar disorder, schizophrenia, and personality disorders. Symptoms can include: panic attacks, self-harm and suicidal feelings.

The life expectancy of those with serious mental illness in the UK is 12-13 years lower than the national average; with death rates from heart disease, strokes and cancer at a level experienced by the general population in the 1950s, and not improving. Additionally people with serious long term mental illness do not usually get to live in the most affluent areas and suffer poorer income, employment and housing prospects.

Although a whole range of factors determine an individual's level of personal well-being, evidence indicates that the things we do and the way we think can have the greatest impact on improving mental health. 'Bridging the Gap' peer research on people with mental health issues accessing community activities and groups in Bath and North East Somerset found that connections with other people and the ability to do things that people are interested in is essential to feeling better about themselves and interacting with the world.

But although participating in activities can promote wellbeing it can be harder for some people to join things because of a range of practical factors including cost, family responsibilities and lack of transport options. In our local survey people with mental health difficulties identified practical barriers such as cost and transport as more important than any lack of confidence that they might have.

There is increasing evidence that being physically active and having good general well-being protects against both dementia and mental health problems like depression and anxiety in later life. It seems that it does this by increasing people's sense that they can achieve things and cope and serves as a distraction from negative thoughts.

In order to make it easier for people to access the kind of courses and volunteering opportunities that enable them to connect with others, participate, learn and be active, the council is setting up a Wellbeing College. People can be referred or phone up themselves and discuss what they're interested in doing and have help joining up to a course that interests them. By working with a range of providers, the College will connect people up to subjects ranging from mindfulness to dancing, gardening to IT skills. >

The 5 Ways to Wellbeing

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Keeping in touch with

family, friends colleagues and neighbours, at home, school, work on in your community are all essential for our wellbeing. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

Why not: Meet people and enjoy the view at the Bath Skyline Walk. Children can check out the woodland play area off Claverton Down Road, near Ralph Allen School http://www.nationaltrust.org.uk/bath-skyline/

Give

Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with people around you.

Why not: Find out about volunteering opportunities with the Volunteer Centre at http://www.vol-centre.org.uk/

Keep learning

Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.

Why not: Join up for an evening class by looking at the options for adult learning at colleges in the area at www.bathnes.gov.uk/services/schools-colleges-and-learning/learning-16/adult-learning

Take notice

Be curious. Catch sight of the beautiful, remark on the unusual Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

Why not: Look at the Mental Health Foundations Be Mindful website for ideas of how to take notice of what's around you http://bemindful.co.uk/

Be active

Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly pick a physical activity you enjoy and that suits your level of mobility and fitness.

Why not: Cycle through the Two Tunnels and connect up with this 13 mile circular route from the centre of Bath that takes in National Cycle Route 24 and National Route 4. The route also takes riders of the spectacular Dundas Aqueduct on the Kennet & Avon Canal. www.sustrans.org.uk/ncn/map/route/bath-two-tunnels

CHILD POVERTY

> *To be poor in an essentially wealthy society is a very particular and stigmatising experience, and children are well aware of this.*
>
> *Through Young Eyes: The Children's Commission on Poverty*

A child's start has a huge impact on their health and wellbeing throughout their life. The resources available to the family they live in play a big role in that start.

While Bath and North East Somerset is considered a fairly affluent area, it hides a very different economic picture for many people living here, which is particularly hard on children. The amount of money people have affects the type and size of housing they live in, what food they eat, their ability to take part in different activities and whether they have the same kind of life as most other people in the area they live in.

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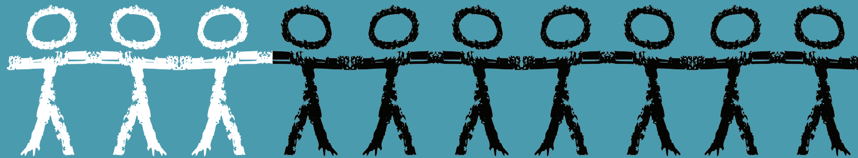
It has a big impact on children's physical health but also how they feel. Children from poor families are more likely to die in their first year of life, have higher rates of accidents, are more likely to miss school as a result of illness and are nearly three times as likely to suffer mental health problems.

A recent report found children themselves say they worry about whether their family can pay for things they need, that it affects their sleeping and studying at home and how safe they feel in the area they live. They also experience bullying due to visible signs of poverty and difference.

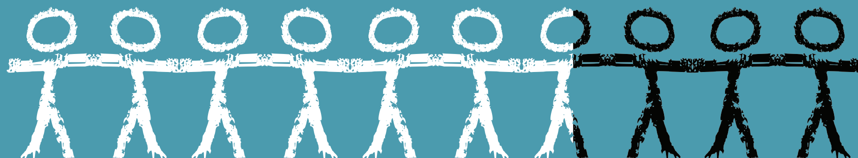
Child poverty is not necessarily something that stays the same over time. Some families are persistently poor for long periods of time, others only occasionally, whilst some families move in and out of poverty. Poverty is also not something that fits neatly into defined classifications. Families who are just above the eligibility for benefits may also live in considerable poverty and face additional costs.

Poverty can be such a destructive force because of its long-term grip on families and communities, holding them back generation after generation.

In 2012/13 in Bath and North East Somerset...



Young people from low income families achieving 5+ GCSE A*-C (including English and Mathematics): 31%



Young people not in receipt of Free School Meals achieving 5+ GCSE A*-C (including English and Mathematics): 66%

Child poverty in Bath and North East Somerset

According to the End Child Poverty report, about 12% (4,056 children) of children in Bath and North East Somerset live in poverty. This compares to 14% in North Somerset, 17% in West Somerset and 11% in Wiltshire. 13% of all children in Bath and North East Somerset (16% in the South West, 20% in England) were in low income families in 2011.

There are dramatically different proportions of children living in poverty or in families on low incomes across different parts of Bath and North East Somerset. It can be particularly hard for those children living in poverty or on low incomes in more affluent areas because their circumstances are so different from their peers.

Child poverty is estimated to cost £44 million in Bath and North East Somerset.

The impact on children living here

In 2012 11% of children in primary schools and 8% in secondary schools were eligible for Free School Meals. Although this is lower than the national picture, children eligible for Free School Meals (FSM) in Bath and North East Somerset performed significantly worse in the Key Stage 2 Reading, Writing and Mathematics attainment measure at the expected level compared to their non-FSM peers – 54% and 82% respectively (2012/13). FSM pupils are also more likely to make unhealthy or risky lifestyle choices, according to the Child Health and Wellbeing Survey 2013. A higher proportion of the secondary school pupils eligible for the Pupil Premium (PP) responded that they felt afraid of >

CASE STUDIES

Playful Families

Bath and North East Somerset commissions a range of Community Play services for 5-13 year olds including Playful Families; group play sessions requested by families or professionals working with them. They explained how the experience has helped two fathers to learn to understand the importance of play and support improved attachment with their children:

"A father of three children who was living in a hostel due to his substance misuse and had no access to his children (who were on a child protection plan) and very low self-esteem was referred by another voluntary agency. He was then allowed weekly access to his children at the Playful Families group. Play workers continued to support the father including making successful housing applications and he was awarded custody of the children.

"Another father whose 6-year-old son had foetal alcohol syndrome struggled with his son's behaviour and energetic play and would end up watching TV or not taking him out. His play was aggressive and often violent towards his father. At the Playful Families group, we brought in some fancy dress clothes; the boy dressed up as a Ninja turtle and then started dressing up his father in a pink beaded head dress, a superman cape and a cowboy scarf. The boy thought this was very funny and his father let him completely lead this play without interruption and stayed dressed like that. This was a fantastic outcome as the child's behaviour was calm and methodical and Dad allowed him to be in control showing trust."

"Playful Families went on to support the father with making successful housing applications and he was awarded custody of the children."

going to school because of bullying at least 'sometimes'. It was 34% compared to 23% of non PP pupils.

The differences in educational attainment continue to show a stark contrast between young people from low income families and their peers.

What Bath and North East Somerset Council is doing to try to reduce the health impact of poverty on children

Tackling child poverty requires action targeted at both the children themselves, and at their wider environment, including their families, and their whole communities. Action to give families the resources they need include welfare support, improving pay and increasing employment, reducing the costs of working, increasing access to affordable housing. It also involves building children's resilience to deal with poverty as best as possible and trying to improve the child's future outcomes and so reduce the intergenerational transmission of poverty. Interventions focussing, for example, on improving educational attainment and health outcomes for disadvantaged children may fall into this category of intervention.

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Bath and North East Somerset Council is taking a multi-pronged approach to trying to support children who are growing up in poverty through an economic strategy aimed at growing employment opportunities, developing healthy and sustainable places for children to be brought up in where there are places to play outside, good schools, supportive communities and accessible leisure activities for children of different ages.

The Connecting Families team in the council works hard to intervene early to take action to try to prevent negative future outcomes by providing intensive home-based professional family support and tailor-made packages to meet the individual requirements of all the families we work with.

In Bath and North East Somerset, Sirona delivers the Health Visiting and School Nurse service. Their role is to deliver the Healthy Child Programme. This means a universal offer of regular checks and screening for all children and young people, with further support offered to any children with identified

needs, or from vulnerable families. The health visiting service also delivers the Family Nurse Partnership (FNP) to all parents who are 19 and under. The FNP is an intensive, preventive, nurse-led programme for vulnerable, first time, young parents. FNP has one of the best evidence bases for preventative early childhood programmes, with evidence of impact on a range of health and social outcomes. The local FNP team are supporting 82 first time mothers currently.

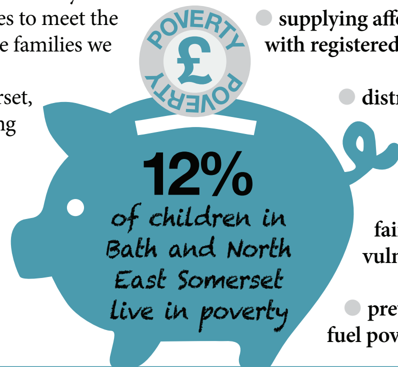
The School Improvement and Achievement Service is committed to supporting schools in improving outcomes for all pupils including the most vulnerable and becoming good or outstanding as judged by OFSTED.

The Director of Public Health award enables nurseries, children's centres, schools, colleges, and other settings to identify their own health priorities and take actions that will promote physical and mental health and wellbeing among children, families and communities throughout Bath and North East Somerset.

With people experiencing greater financial pressures, the council's Family Information Service and Citizens Advice Bureau have produced a new Managing Your Money folder.

Low-cost housing options and the promotion of a fair living wage make it easier for residents to 'make work pay'. This is very relevant in Bath and North East Somerset where the average wage is lower than the national average and the cost of living high. Estimates suggest that over 20% of the working age population may not be earning a 'living' wage, suitable to maintain a good standard of living (JSNA, 2013).

The Council transferred its housing stock to Curo in 1999, which is responsible for:



- **supplying affordable housing in partnership with registered housing providers**
- **distributing affordable housing fairly to those with greatest need**
- **distributing loan and grants fairly to improve the homes of vulnerable people**
- **preventing homelessness and fuel poverty.**

Early years Director of Public Health Award

HOW ONE PRE-SCHOOL GOT CHILDREN GROWING AND EATING THEIR OWN FOOD AND TRAVELLING UNDER THEIR OWN STEAM

Widcombe Acorns Pre-school children

The Healthy Early Years Certificate and the Healthy Outcomes Certificate for Early Years were launched in September 2013 to early years settings (childminders, pre-schools, nurseries, children's centres and reception classes) to work towards the Director of Public Health Award alongside schools and FE colleges, making this a seamless 0 – 19 years programme. The main health priority for early years locally is to support babies and young children to establish and maintain a healthy weight.

Widcombe Acorns Pre-school is working towards the Healthy Outcomes Certificate for Early Years. They are focusing on increasing the opportunities for all children to be involved in a variety of planned growing/gardening experiences in order to meet their healthy eating outcome and to increase the number of children actively travelling to the pre-school. They said:

"Being on this programme has encouraged us to really think about how we could improve gardening experiences for the children in our care to enable them to think about healthy eating.

"We started by asking an ex-parent, who works as a gardener, if she would be willing to give us some of her time to work directly with the children with support from the team. She started to come in regularly to run gardening activities. The children planned what we would grow using resource books and the internet.

"The results are amazing already, the staff team feel empowered and are now confident in leading regular planned gardening opportunities and the children feel ownership of the area and what is grown, tending and watering, and then harvesting and eating the food once it is ready, we have even cooked many different foods on the fire outside.

"We also chose to look at active travel because we had noticed that more children were being driven in to pre-school this year. We started by looking at where our children lived (the majority being within walking distance), we sent out a survey asking parents their preferred method of travelling to pre-school, and how many times per week they were likely to use their cars.

"We followed this by having a display of different containers; they were labelled with various methods of travelling – walking, cycling, car, train, bus, scooter, bike and push chair, we encouraged the children to place a button in the container that corresponded to how they had travelled in that day.

We wrote to the parents and gave the reasons why their children would benefit from being more active in the mornings, how they may settle better, be more alert, how they are more ready for their day ahead with fresh air, a good chat, and some physical exercise.

"We quickly saw a difference in how many children were travelling in under their own steam.

"Having a whole setting approach has improved our confidence and our practice, and has certainly motivated the children, parents/ carers and staff team!"

Public health indicators:

although many of our health outcomes are good in Bath and North East Somerset, we've identified areas where more work needs to be done

Public health outcomes framework and other key indicators (as at August 2014)

PHOF Reference/ Source	Period	Indicator Description	England	South West	Bath and North East Somerset
Health Improvement					
2.02ii	2012-13	Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth	47.2%	49.3%	59.7%
2.04	2012	Under 18 conceptions (females 15-17, rate per 1,000)	27.7	24.8	18.0
2.06i	2012-13	Excess weight (overweight and obesity) in 4 to 5 year olds	22.2%	22.9%	23.2%
2.06ii	2012-13	Excess weight (overweight and obesity) in 10 to 11 year olds	33.3%	30.9%	26.4%
2.07i	2012-13	Hosp admissions, unintentional and deliberate injuries 0 - 4 years per 10,000	134.7	142.1	184.4
2.07i	2012-13	Hosp admissions, unintentional and deliberate injuries 0 - 14 years per 10,000	103.8	103.9	120
ChiMat	2012-13	Hospital admissions as a result of self-harm (10-24 years old)/100,000	346.3	442.5	456.1
ChiMat	2011-13	Alcohol specific admissions to hospital aged under 18s per 100,000	42.7	51.2	68.2
2.13i	2013	Proportion of physically active adults	55.6%	57.7%	61.4%
2.14	2012	Smoking prevalence	19.5%	18.5%	16.7%
2.15ii	2012	Successful completion of drug treatment - non opiate users	40.2%	39.5%	33.5%
2.20i	2013	Cancer screening coverage - breast cancer	76.3%	78.9%	73.9%
2.22iv	2013-14	Take up of the NHS Health Check Programme – health check take up	49.0%	45.4%	51.1%
Healthcare and premature mortality					
4.04i	2010-12	Under 75 mortality rate from cardiovascular diseases (per 100,000)	81.1	67.9	62.7
4.05i	2010-12	Under 75 mortality rate from cancer (per 100,000)	146.5	136.8	130.0
4.06i	2010-12	Under 75 mortality rate from liver disease (per 100,000)	18.0	15.2	16.1
4.10	2010-12	Suicide rate (per 100,000 population)	8.5	9.8	8.7
4.14i	2012-13	Hip fractures in over 65s (per 100,000)	568.1	555.5	576.8
Inequalities					
Marmot	2006-10	Inequality in male life expectancy at birth (years)	8.9	7.0	5.7
Marmot	2006-10	Inequality in female life expectancy at birth (years)	5.9	5.0	4.5
1.01ii	2011	Child poverty, under 16s	20.6%	16.2%	13.1%
1.02i	2012-13	% of Reception Year FSM pupils achieving a 'Good Level of Development'	36.2%	36.8%	28.7%

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KEY: Significance to comparable England figure

Significantly better · *Not significantly different* · *Significantly worse* · *Significance not available*

Health Protection

PHOF Reference/ Source	Period	Indicator Description	England	South West	Bath and North East Somerset
3.03x	2012-13	MMR take-up age 5 (2 doses)	87.7%	88.7%	88.5%
3.03xiv	2012-13	Population vaccination coverage flu aged 65 years and over	73.4%	73.4%	75.5%
3.04	2010-12	People presenting with a late stage HIV infection	48.3%	49.4%	50.0%

KEY:

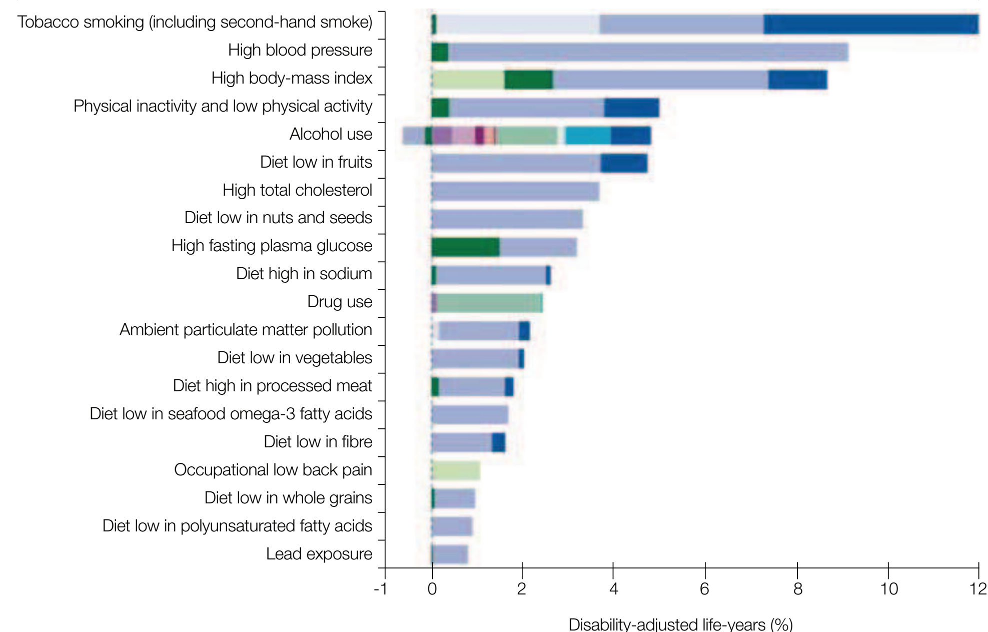
<90% target · *≥75% target* · *<75% target* · *<25% to 50% target*

SOURCES | **PHOF:** http://www.phoutcomes.info/ | **ChiMat:** http://www.chimat.org.uk/
Marmot: http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx

Understanding how things that are unhealthy impact on disease

This chart shows the key things that influence our health in relation to their impact and the diseases they cause. Most of them are things that we can do something about and can influence in our own lives.

Burden of disease from 20 leading risk factors



KEY:

Cancer · *Cardiovascular and circulatory diseases* · *Chronic respiratory diseases* · *Cirrhosis* · *Digestive diseases* · *Neurological disorders* · *Mental and behavioural disorders* · *Diabetes, urogenital, blood, and endocrine* · *Musculoskeletal disorders* · *Other noncommunicable diseases* · *HIV/AIDS and tuberculosis* · *Diarrhoea, lower respiratory infections, and other common infectious diseases* · *Neglected tropical diseases and malaria* · *Maternal disorders* · *Neonatal disorders* · *Nutritional deficiencies* · *Other communicable diseases* · *Transport injuries* · *Unintentional injuries* · *Intentional injuries*

SOURCE | The Lancet, Volume 381, Issue 9871, 2013, 997 - 1020
http://dx.doi.org/10.1016/S0140-6736(13)60355-4

Bath & North East Somerset Council

NHS
Bath and North East Somerset
Clinical Commissioning Group

healthwatch
Bath and North East Somerset

MEETING	B&NES HEALTH AND WELLBEING BOARD
DATE	21/01/2015
TYPE	An open public item

Report summary table	
Report title	A briefing regarding the work of the B&NES Local Safeguarding Children Board (LSCB)
Report author	Reg Pengelly – Independent Chair
List of attachments	N/A
Background papers	None
Summary	This is a briefing on the work and future scrutiny of the LSCB
Recommendations	The Board is asked to note this report and make any recommendations for additional scrutiny
Rationale for recommendations	The work of the LSCB contributes to the safety and wellbeing of all children in Bath & North East Somerset
Resource implications	None for this Board
Statutory considerations and basis for proposal	The Local Authority has statutory responsibility for establishing a LSCB and a number of partner organisations are under a legal duty to support and contribute to its work and function
Consultation	N/A
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance

THE REPORT

1. INTRODUCTION

1.1 This report provides a brief summary of the work of the Bath and North East Somerset Local Safeguarding Children Board (LSCB).

1.2 The Statutory Guidance issued under the Children Act 2004, (Working Together 2013) provides for the establishment of LSCB's. The primary purpose of the LSCB may be summarised as: to monitor and coordinate the activities of a number of partner organisations so that children are safeguarded and their welfare is promoted.

The guidance makes it clear that:

a) The Local Authority is responsible for establishing a LSCB
b) The LSCB should be independent. It should not be subordinate to, nor subsumed within, other local structures
c) The Chief Executive, drawing on other LSCB partners and, where appropriate, the Lead Member will hold the Chair to account for the effective working of the LSCB
d) The Chair's Annual Report is the key mechanism for demonstrating accountability

1.3 In determining the effectiveness of arrangements, Ofsted's inspection framework, in its description of 'good', refers to:

"*The governance arrangements enable LSCB partners (including the Health and Well-Being Board and the Children's Trust) to assess whether they are fulfilling their statutory responsibilities to help (including early help), protect and care for children and young people.*"

2. GOVERNANCE, RELATIONSHIPS AND ACCOUNTABILITY

2.1 As a multi-agency partnership, each of the agencies subject to the duty to cooperate with the LSCB is responsible for the effectiveness of the LSCB; the Independent Chair is held accountable by the CEO of the Local Authority. The relationship between the LSCB and the Health and Wellbeing Board and the Children's Trust, is therefore one of <u>mutual</u> challenge and holding to account. It should not be, or be perceived to be, one of linear accountability. The purpose of this report is therefore to brief members of the B&NES Health & Wellbeing Board on the work of the LSCB and to confirm the relationship as one of mutual challenge. So far as the Children's Trust Board is concerned, specific challenges are tabled each year and it is proposed that a similar arrangement should be in put in place for the Health and Wellbeing Board from 2015.

2.1 The accountability of the Independent Chair and of the LSCB has been subject to a recent review and it has been agreed that this will take place in two stages:

1) An annual Scrutiny Panel will be established from senior members of the participating agencies including the Lead Member. The Panel will review the Annual Report and report their view of the effectiveness of the LSCB and the quality of the report to the B&NES Chief Executive
2) 360 degree appraisal process to triangulate information about the performance of the Chair by way of a "360 degree" appraisal process

By this means a rich assessment of the performance of the LSCB and the Chair will be available to inform continuous improvement. This process will commence in 2015.

3. THE WORK OF THE LSCB

3.1 2014 has been a busy and productive year for B&NES LSCB. In particular, a great deal of work has taken place to strengthen the ability of partners to hold each other to account and this has led to the restructure of our meetings so that at least half of the available time is occupied by a thematic review. The first such meeting took place in December, at which multi – agency processes for child protection were reviewed in considerable depth. About 330 referrals about safeguarding concerns are received by the Local Authority each year and at any one time approximately 120 Child Protection Plans are "live". These numbers are consistent with, or slightly lower than the national average and less than those of statistical neighbours. Outcomes from this meeting included a commitment from members to strengthen robust assurance within their organisations and the need for clearer categorisation of cases. Both outcomes can be reasonably expected to improve protection for children and to provide clarity for their families.

3.2 Local Health Services and the Police have been subject to inspections of their safeguarding children arrangements during the past year. Whilst opportunities for improvement have inevitably been identified, both services have received overall favourable judgments of their competence. Safeguarding inspections by Ofsted of the Local Authority and LSCB are anticipated within the next few months.

3.3 Nationally, there has been significant interest in the field of safeguarding children following further revelations arising from the Jimmy Savile investigation and the apparent failings of several Local Authorities to protect children from sexual exploitation, notably in Rotheram. This has led to the development of a local Child Sexual Exploitation Strategy, which is coordinated with similar arrangements across the Avon and Somerset Police area. In particular, recent revelations arising from the police "Operation Brooke" trials, serve to remind us all that this particular risk to the young and vulnerable, is not exclusively confined to inner cities.

3.4 A Communications Group was established with a view to improving the promotion of safeguarding and the work of the LSCB to families and the workforce. One very important aspect of this work is engagement with children and young people and several useful references have been undertaken during the year. The Communication Group was also responsible for holding a highly successful and well-attended Stakeholder Event in November, on the topic of Early Help.

4. COLLABORATION

4.1 Throughout the past year, the Independent Chair of the LSCB has been meeting with the Independent Chair of the Safeguarding Adults Board (SAB) with a view to exploring opportunities for collaboration between the two Boards. This has led to a specific proposal for collaboration across particular areas of business and for a Joint Development Day to be held in early 2015 to determine how to take this proposal forward. The LSCB Chair has since been appointed as the Independent Chair of the SAB with effect from the stepping down of the current Chair in June 2015. This promises for an exciting year of exploration and further development across both Boards.

5. CONCLUSION

5.1 As the Independent Chair, I am pleased to report my view that the B&NES LSCB is an

effective and vibrant partnership of committed agencies, which continues to achieve many positive outcomes for children. Moreover the LSCB is equally committed to improve, as evidenced by a ready embrace of our new thematic meeting arrangements.

5.2 Members of the Health and Wellbeing Board are asked to note this report. I will be pleased to present my Annual Report that will provide a more detailed assessment of the performance of the LSCB, later this year. My last report for 2013/14 including information about the current work programme may be found at the Bathnes.co.uk, Local Safeguarding Children Board website.

Reg Pengelly
Independent Chair
Bath & NE Somerset LSCB

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