Bath & North East Somerset Council

Health & Wellbeing Board

Date: Wednesday, 12th July, 2017
Time: 11.00 am
Venue: Kaposvar Room - Guildhall, Bath

Members: Dr Ian Orpen (Member of the Clinical Commissioning Group), Councillor Vic Pritchard (Bath & North East Somerset Council), Ashley Ayre (Bath & North East Somerset Council), Mike Bowden (Bath & North East Somerset Council), Jayne Carroll (Virgin Care), Mark Coates (Knightstone Housing), Tracey Cox (Clinical Commissioning Group), Debra Elliott (NHS England), Councillor Michael Evans (Bath & North East Somerset Council), Diana Hall Hall (Healthwatch), Steve Imrie (Avon Fire & Rescue Service), Steve Kendall (Avon and Somerset Police), Bruce Laurence (Bath & North East Somerset Council), Professor Bernie Morley (University of Bath), Laurel Penrose (Bath College), Jermaine Ravalier (Bath Spa University), Hayley Richards (AWP), James Scott (Royal United Hospital Bath NHS Trust), Andrew Smith (BEMs+ (Primary Care)), Sarah Shatwell (DHI (VCSE sector)), Jane Shayler (Bath & North East Somerset Council) and Elaine Wainwright (Bath Spa University)

Non-voting member:

Observers: Councillor Tim Ball (Bath & North East Somerset Council) and Councillor Eleanor Jackson (Bath & North East Somerset Council)

Other appropriate officers
Press and Public

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NOTES:
1. **Inspection of Papers:** Papers are available for inspection as follows:

Council's website: https://democracy.bathnes.gov.uk/ieDocHome.aspx?bcr=1

Paper copies are available for inspection at the **Public Access points:-** Reception: Civic Centre - Keynsham, Guildhall - Bath, The Hollies - Midsomer Norton. Bath Central and Midsomer Norton public libraries.

2. **Details of decisions taken at this meeting** can be found in the minutes which will be circulated with the agenda for the next meeting. In the meantime, details can be obtained by contacting as above.

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.

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6. Supplementary information for meetings

Additional information and Protocols and procedures relating to meetings

https://democracy.bathnes.gov.uk/ecCatDisplay.aspx?sch=doc&cat=13505

Health & Wellbeing Board - Wednesday, 12th July, 2017

at 11.00 am in the Kaposvar Room - Guildhall, Bath

A G E N D A

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 - 17 MAY 2017 (Pages 7 - 12)

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

8. HEALTH INEQUALITIES ACTION PLAN (Pages 13 - 28)

The Board's existing Joint Health and Wellbeing Strategy includes a specific aim to reduce health inequalities in Bath and North East Somerset. The Board is asked to consider the attached update report and to:

- note the existing work on health inequalities

- consider some of the current opportunities for strengthening this work and also potential barriers
- consider its future role in relation to this issue.

9. MAKING EVERY CONTACT COUNT (Pages 29 - 34)

Making Every Contact Count (MECC) is about altering how we interact with people through having healthy conversations and learning how to spot opportunities to talk to people about their wellbeing. The attached report seeks the approval and commitment from the Board to implementing MECC locally.

10. MENTAL HEALTH AND WELLBEING CHARTER (Pages 35 - 50)

To receive a presentation regarding the Mental Health and Wellbeing Charter. Members are invited to discuss the Charter and how it could potentially be adopted by the Health and Wellbeing Board.

11. DATE OF NEXT MEETING

To note that the next meeting will take place on Wednesday 6 September at 10.30am.

12. CLOSING REMARKS

The Committee Administrator for this meeting is Marie Todd who can be contacted on 01225 394414.

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HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Wednesday, 17th May, 2017, 11.00 am

Councillor Vic Pritchard (Chair)	Bath & North East Somerset Council
Dr Ian Orpen	Member of the Clinical Commissioning Group
Russ Bennett	Avon Fire and Rescue Service
Jayne Carroll	Virgin Care
Mark Coates	Knightstone Housing
Tracey Cox	Clinical Commissioning Group
Morgan Daly	Director for Communities - Healthwatch B&NES
Councillor Michael Evans	Bath & North East Somerset Council
Teresa Hallett	Bath College
Steve Kendall	Avon and Somerset Police
Bruce Laurence	Bath & North East Somerset Council
Professor Bernie Morley	University of Bath
James Scott	Royal United Hospital Bath NHS Trust
Andrew Smith	BEMs+ (Primary Care)
Sarah Shatwell	DHI (VCSE sector)
Jane Shayler	Bath & North East Somerset Council
Elaine Wainwright	Bath Spa University

Observer

Councillor Tim Ball	Bath & North East Somerset Council

48 **WELCOME AND INTRODUCTIONS**

The Chair welcomed everyone to the meeting.

49 EMERGENCY EVACUATION PROCEDURE

The Chair drew attention to the evacuation procedure as listed on the call to the meeting.

50 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Ashley Ayre – Chief Executive B&NES
Mike Bowden – Strategic Director, People and Communities, B&NES
Steve Imrie – Avon Fire and Rescue Service (Substitute – Russ Bennett)
Laurel Penrose – Bath College (Substitute – Teresa Hallett)

51 DECLARATIONS OF INTEREST

There were no declarations of interest.

52 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There was no urgent business.

53 PUBLIC QUESTIONS/COMMENTS

There were no public questions or comments.

54 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 7 December 2016 were approved as a correct record and signed by the Chair.

It was noted that the Sustainability and Transformation Plan would not now be published until after the general election due to purdah rules.

55 IMPROVED BETTER CARE FUND PLAN (IBCF) - 2017/18 - 2018/19

The Board considered a report regarding the Better Care Fund (BCF) Plan 2017/18 – 2018/19. The report gave a summary of the BCF guidance, policy framework and key priorities. A draft "Delayed Transfers of Care" action plan was also included as an appendix.

The Senior Commissioning Manager, Better Care, outlined the following issues:

- New schemes will be coming on line over the next two years.
- The formal guidance has not yet been published.
- It is important to find a balance between dealing with immediate social care budget pressures and investing strategically in additional preventative services to improve the financial sustainability of service provision over the longer term.

- There are clear conditions of access to the BCF which have to be met in order to access the funding. The BCF must be transferred into one or more pooled funds established under section 75 of the NHS Act 2016. The spending plans must be agreed by the Health and Wellbeing Board and signed off by the relevant local authority and CCG.
- The current BCF performance dashboard showed that the B&NES area was performing well in most areas.
- The priorities for the next two years were outlined including updates from existing priority schemes and new schemes for 2017-19. These included a focus on new assistive technologies.
- There will also be a focus on transformation and redesign of services.
- Funding is to be set aside for providers of care, including to ensure a fair price is paid for care home fees and that the cost of paying the National Living Wage, including for sleep-in cover, can be paid by the care provider.
- The next steps included the development of a detailed iBCF Plan in anticipation of the publication of the detailed implementation guidance, final conditions and supporting submission documentation.

It was noted that an increasing number of care providers are withdrawing from the market. Four care homes (144 bed places) had been lost in B&NES in the last year.

Sarah Shatwell welcomed the recommendations set out in the report and, in particular, the proposals in relation to an increased focus on a strengths based approach, continued investment in social prescribing and the development of a support planning and brokerage service. She felt that social prescribing services can be more joined-up and streamlined with other wellbeing/preventative services. Sarah also emphasised the skills, knowledge and experience that those working in the voluntary, community and social enterprise (VCSE) sector have, particularly in relation to a strengths based approach to assessment and support planning. It was agreed that the VCSE sector has a key role to play, including with those people with complex and acute needs living in the community.

James Scott asked how the priorities had been developed. It was explained that they had been developed from a range of sources including the Health and Wellbeing Board Strategy, the Accident and Emergency Delivery Board and the Your Care Your Way Strategy. James Scott stated that the RUH had some issues in relation to the Home First model and proposals. Tracey Cox confirmed that some of the proposals for the Home First Investments had come from the RUH. It was agreed that these issues would be discussed outside of the meeting.

It was confirmed that the detailed spending proposals would be set out in the final submission.

Tracey Cox noted that the report contained a great deal of detail and that more clarity would be required in the submission in relation to key milestones and decision points to ensure that there is a clear plan for delivery of the proposals and that the investment proposals do achieve improvements in the provision of integrated health and care services.

RESOLVED:

(1) To note the Policy Framework, Context and draft Conditions for the 2017/18 – 2018/19 Improved Better Care Fund.

(2) To agree the priority areas for investment of the Improved Better Care Fund as set out in the report.

(3) To delegate to the Co-Chairs of the Health and Wellbeing Board formal sign-off of the final submission of the 2017-18 – 2018/19 Improved Better Care Fund Plan.

56 **YOUR CARE YOUR WAY UPDATE**

Sue Blackman (Project Lead) and Jayne Carroll (Regional Director of Operations) presented an update on the Your Care Your Way project. A copy of the presentation is attached as *Appendix 1* to these minutes. The following issues were outlined:

- It was noted that the transition of services to Virgin Care had been very smooth with minimal problems. The Board thanked all partner organisations, including Sirona Care and Health, for facilitating such a safe transfer.
- Virgin Care have now taken on responsibility for:
    - Children's Services - such as Health Visiting and Speech and Language services
    - Adult Health and Social Care Services – such as District Nursing and Physiotherapy services
    - Statutory Services – such as adults statutory social care, continuing healthcare and Children's services.
- 1,300 staff had safely transferred on 1 April 2017. A comprehensive 100 day plan is being deployed including review of services, operation procedures and policies.
- Over 90% of teams have attended arrivals events with overwhelming positive feedback.
- There is now a single point of access for queries to enable support to be provided for those needing help quickly.
- Managers have received additional training on systems, support and new values and objectives for the year ahead.
- Virgin Care has continued to engage with stakeholder groups and has proposed an external engagement strategy which was due to be discussed with community champions next week.
- Over 200 new phones have been rolled out to enable staff to access emails on the move. These have been positively received by colleagues.
- All colleagues, carers and subcontractors had received first payments successfully.
- The falls pick up service was launched on 2 May 2017.
- The Service Development and Improvement Plan is being worked on, a review of community hospitals is being carried out and a pathway review of Home First implementation is also being undertaken.
- In the next month the review and redesign of wellbeing services, involving all partners is being launched, mobile phones will be rolled out to the wider workforce and the "Virtual Desktop" environment will be implemented.

The following lessons had been learnt:

- The engagement and the involvement of Community Champions was deemed "gold standard" but there was a need to consider in the next stage how to increase the diversity of the group.
- Internal communications and co-production with staff was as important as communications and engagement with the public.
- Matching the scale of the project with the timeframe for delivery was key.
- Defining the scope of the project should be clear at the outset.
- Strong leadership and project management was paramount.
- Staff feel more connected to their colleagues as a result of their involvement in the project.

Bruce Laurence noted that this was one of the largest and most complex commissioning processes that he had experienced. It had been a very successful transition and presented a real opportunity for system leadership for the Health and Wellbeing Board.

Dr Ian Orpen stated that it was important to build on the connections with GPs and the community teams.

Cllr Vic Pritchard acknowledged the efforts made by all involved in the project to ensure a safe transfer. The Board thanked and congratulated staff for all their hard work on this project and the successful transition.

RESOLVED: To note the update report.

57 **SUGAR SMART COUNCIL**

The Board considered a report regarding the imminent public launch of the Bath and North East Somerset Sugar Smart Campaign. Jameelah Ingram (Public Health Development and Commissioning Manager) and Sophie Kirk (Corporate Sustainability Officer) gave a presentation regarding the campaign. A copy of the presentation is attached as *Appendix 2* to these minutes.

The presentation covered the following issues:

- Today's children are the first generation predicted to die before their parents due to poor diet and inactivity.
- Healthy weight has been identified as a key priority by the Health and Wellbeing Board.
- The recommended average population maximum intake of sugar should be halved (5% dietary energy).
- Reducing the amount of sugar in sweetened drinks by 40% over five years could prevent 300,000 cases of type 2 diabetes and one million fewer people who are obese nationally.
- Sugar sweetened drinks are the biggest source of sugar in pre-school children.
- As part of its Childhood Obesity Strategy the Government announced a soft drinks industry levy in the March 2016 budget which will come into effect in 2018.

- The Sugar Smart Campaign is aimed at reducing sugar consumption across B&NES. It is part funded by Sustainable Food Cities, Jamie Oliver Food Foundation and Sustain, the alliance for better food and farming.
- B&NES will be the first national Sugar Smart campaign reaching both rural and urban areas. The official launch will be in July 2017.
- A Sugar Smart Steering Group had been set up with key partners; engagement had already taken place with schools and businesses.
- The Radstock and Westfield areas had become the new flagship Sugar Smart Neighbourhood.
- There would be a big social media and digital campaign.
- The campaign focus would adopt a needs based, settings approach.

Bruce Laurence stated that consumption of sugar was a major contributor to obesity and also to tooth decay. The broad support of the Health and Wellbeing Board would empower the team to take forward the campaign. He also pointed out the need to encourage the food industry to change their behaviour around the marketing and cost of certain foods.

Sarah Shatwell welcomed the campaign but stated that it was important not to stigmatise particular communities. It was also necessary to understand the attitudes and issues that lead to over-consumption of sugar.

RESOLVED:

(1) To provide strategic support for the Sugar Smart Campaign.

(2) To support key public sector and health promoting organisations across Bath and North East Somerset to sign up to the Sugar Smart Campaign and make pledges to support a reduction in sugar intake.

58 **CLOSING REMARKS/TWITTER QUESTIONS**

There were no Twitter questions.

59 **DATE OF NEXT MEETING**

It was noted that the next meeting would take place on 12 July 2017.

The meeting ended at 12.35 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**12 July 2017**
TYPE	**An open public item**

Report summary table	
Report title	Health inequalities – an update on progress
Report author	Paul Scott (Public Health, B&NES Council)
List of attachments	• Summary of headline progress on targeting inequalities in Bath and North East Somerset
Background papers	'Fair Society Healthy Lives' (The Marmot Review) http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
Summary	The Board's existing Joint Health and Wellbeing Strategy includes a specific aim to reduce health inequalities in Bath and North East Somerset. Following this aim, much of the work that flows from the strategy has a focus on those groups experiencing the worst health outcomes. To build on this platform the Board identified a need to strengthen its understanding of, and approach to, health inequalities through holding a health inequalities inquiry day in 2016. During the event participants used the Marmot review to identify local good practice, gaps, and priorities for action. This report highlights some good practice occurring for each of these priorities. It also reflects on pressures in the system that have slowed progress in focusing on this work in a more strategic way.
Recommendations	The Board is asked to: • note the existing work on health inequalities • consider some of the current opportunities for strengthening this work and also potential barriers • consider its future role in relation to this issue

Rationale for recommendations	The health inequalities inquiry day was held at the request of the Health and Wellbeing Board. The Board has a potential leadership role in challenging and encouraging organisations in B&NES to show how they identify people who are at greater risk of poorer health outcomes, and how they put plans in place to reduce health inequalities amongst these populations.
Resource implications	The context for this work is one of better coordination and focus rather than additional resource, due to the financial pressures facing local organisations. There is limited management capacity in the system to develop this work but some good practice is nonetheless occurring across all the themes of the inquiry day.
Statutory considerations and basis for proposal	The Health and Social Care Act 2012 gave councils responsibility for improving public health and reducing health inequalities in their local population. Clinical Commissioning Groups also have a duty to reduce inequalities between patients in access to, and outcomes from healthcare services.
Consultation	This report is a headline summary of work since the inquiry day rather than a decision or service change and as such has not been subject to wider consultation.
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 Background

1.1 Health inequalities are the differences in health outcomes between groups of people due to social, geographical, economic, or biological factors. Some of these factors such as ethnicity or sex may be fixed. Others, such as the type of employment people have; where people live, study, work and play; or the food people eat, are less fixed. But even when fixed characteristics cause risk, their effects can be modified.

1.2 Although the health and wellbeing of B&NES residents is above the national average on many indicators, some communities in our district fair significantly worse than others. These differences often start early in life, affect education, lead to different employment opportunities, and lead to poor health and social outcomes in adult life. Local examples of health and social inequality in B&NES are set out in the briefing pack attached with this report.

2 The inquiry day

2.1 An inquiry day was held in May 2016 in Bath. It featured a range of speakers and a chance to hear some experiences of local people and service representatives. Policy objectives from the national Marmot review on health inequalities formed the basis on which good practice, gaps and priorities were explored through a number of workshops. Reflecting the breadth of work needed to tackle health inequalities, invitees to the inquiry day included representation from the council (all directorates, Children's Centres), education sector (eg Bath Education Trust, Bath College), charitable sector (eg Southside Family Project, Bath Rugby Foundation, Julian House, CAB), not-for-profit organisations (eg, Curo, Sirona), the NHS (CCG, RUH, general practices) and all members of the Public Services Board. Around 70 people attended the event.

2.2 The output from the inquiry day was presented to the board in September 2016. The Board asked for a progress update in the summer of 2017.

3 Current actions

3.1 The attached report summarises how some of the local partnerships are addressing inequality for each of the key themes identified in the inquiry day.

3.2 Significant efforts are being made across a number of key programme areas with a view to understanding the needs of our most vulnerable groups and delivering tailored services.

3.3 There had been an intention to set out a more strategic and joined up framework for this work and to include this in our commissioning processes. However, the Your Care Your Way commissioning of community services and the emergence of Sustainability and Transformation Plans has necessarily absorbed a great deal of time and attention. This has meant a lack of space and resource for other cross-cutting work and it has felt impractical to attempt to progress it in this way.

3.4 Consequently, there are almost certainly many more actions not identified in the summary progress report but there has been limited opportunity to ascertain these amidst other priorities and pressures.

4 Recommendations

4.1 The Board is asked to:

- note the existing work on health inequalities
- consider potential opportunities for strengthening this work and also barriers
- consider its future role in relation to this issue

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

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Progress against the six inequality themes identified for the Inquiry Day in 2016.

1. Pregnancy and Early Years

Suggested opportunities identified at the Inquiry Day in 2016

- *Strengthen emotional health and resilience of children and adults (in pregnancy or new parenthood)*
- *Improve access to affordable housing, and housing that is fit for purpose for young families*
- *Join up services: children/adults, transition between services (understanding information sharing), professional relationships*

What we know about young people

We have some good information about children with the worst outcomes from our Children and Young People's Health and Wellbeing Survey. However, we are aware that the limitation of this is that it only surveys children in school. A different approach would be needed to elicit the views and experiences of those not in schools or education and those in youth offending services, many of whom would be at higher risk of poor outcomes. Working with the Off the Record Youth Forum would be a good future action.

Actions we are taking

Our children's early help work is all targeted at those children and young people identified as in need of additional health input or as vulnerable / at risk by universal services. Health visitor and school nursing services prioritise their caseloads by indicators of disadvantage and risk. Those young people not identified through universal services may be slipping through and missing out on early intervention. There is a potential to be more proactive and reaching out to those we know who are at risk / vulnerable – those we know have factors in their family history, or live in certain areas.

Our settings work in the Director of Public Health (DPH) Award programme targets schools that are known to be in areas of high health need. Children's centre and youth services are cited in the areas with highest health needs and provide outreach.

Future actions

The local authority is looking at the use of routine enquiry around Adverse Childhood Experiences (ACES) to target early intervention services. Evidence shows that children who experience a greater number of these ACEs have a proportionately greater risk of poor adult outcomes (including risky behaviours, chronic conditions and early death).

As an authority we are looking at what happens to children who are identified as potential safeguarding cases but who then get classed as NFA (no further action to be taken) to see if early intervention could be given at this point. The use of ACEs and the trauma informed care approach is gaining interest in drug treatment services, the police force and so on.

2. Education and life-long learning

Suggested opportunities identified at the Inquiry Day in 2016

- Optimise the early years preventative work (under 5s), including expansion of nursery places and in particular to work with parents to encourage uptake of free child care available for 2 year olds from disadvantaged circumstances.
- Share current best practice across B&NES and coordinate more effectively the projects and initiatives for the most vulnerable families, their children and young people
- Establish an approach to promoting education and lifelong learning in service clients across all departments

What we know about people

Outcomes for disadvantaged pupils are low at every key stage when compared to similar pupils nationally, and their progress from KS1 to KS2 and from KS2 to KS4 is below both other pupils nationally and similar pupils nationally.

In addition to this, there are a number of other key groups at higher risk of poor physical and mental health, including children who are:

- from black and minority ethnic groups (including migrant families)
- with physical and learning disabilities
- who are - or are at risk of becoming - young offenders
- who are in - or are at risk of entering - the care system
- who are experiencing – or are at risk of - child sexual exploitation
- who are lesbian, gay, bisexual, transgender or questioning their sexuality
- who are being bullied or discriminated against for other reasons e.g. the way they look or their economic circumstances
- Young Carers

Actions we are taking

- Senior HM Inspector invited to attend Strategic Director's meeting with head teachers on 2nd March 2017
- Pupil Premium Review commissioned in maintained schools where the gaps for disadvantaged pupils are significantly larger than the national average

- Actively supporting the engagement of disadvantaged primary school pupils in the Children's University to raise aspirations
- There has been a focus on data training for head teachers, teachers and school governors
- Targeting of support money, for example, for a 'coasting' school to work with an 'outstanding' OfSTED rated school
- An event next week where Head at Bournville Community Primary School, Weston Super Mare to speak to about 20 schools with large numbers of FSM pupils about the good practice they have used.
- Recent funding success for asset-based development work at Foxhill

Future actions

We are running a workshop with local B&NES stakeholders and representatives of Sir Michael Marmot from the Institute of Health Equity in London to explore the issue of educational attainment for disadvantaged children further, informed by insights from around the country.

3. Fair employment

Suggested opportunities identified at the Inquiry Day in 2016

- *Ensure a multi-agency approach to engage with and support the work of The Anti-Slavery Partnership locally and regionally*
- *B&NES and its partners to agree definition of a quality job and to work with public sector partners to use our combined leverage to create and monitor delivery of quality jobs*
- *Work with partners to develop a new model of support for employers with a focus on mental health. The model developed will make the best use of local resources and existing Employer networks*
- *Better identification of people needing targeted support and better coordination of job seekers, training providers and employers through a single point of contact.*

What we know about people

- B&NES does better than national average for the gap in the employment rate between those with a long-term health condition and the overall employment rate – (the gap is 7%)
- B&NES does similar to the national average for the gap in the employment rate between those with a learning disability and the overall employment rate (Persons) – although this group still have a 66% gap

- B&NES does similar to the national average for the gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Persons) – although the gap for this group is still 64%
- Worklessness (high rates of long term unemployment) is concentrated in the most deprived wards in B&NES

Actions we are taking

- A number of commissioned programmes are already in place to provide employment support for people with learning disabilities or mental illness.
- A range of employment support activities are also in place for the wider population through DWP, the council, adult social care, Curo, DHI and a number of other organisations.
- A pilot programme of support to promote workplace mental health in SME's was delivered in early 2017.
- A programme of activities was delivered for mental health awareness week during May 2017 as part of strengthening the local approach to workplace wellbeing.
- Council offers have been contributing to and influencing the development of the West of England Employment and Skills Plan
- Delivery of 20 bed spaces of shared housing for young people under the DoD Platform for Life funding programme linked to supporting employment, training or education
- New Employment space, employment training and apprenticeships at Mulberry Park

Future actions

- A virtual employment hub is in the process of being created with additional support for local people, accessed through DWP funding for the West of England. These will include access to support through a new web tool with person to person support from employment navigators.
- Working with employers to improve workforce wellbeing and consequently productivity is an important part of this work.
- Closer integration of health and wellbeing support with employment support will be a key element of the B&NES Wellness Services transformation taking place over the coming year.

4. Healthy and sustainable places and communities

Suggested opportunities identified at the Inquiry Day in 2016

- *Improve access to public transport in less accessible areas*
- *Improve broadband coverage in homes and through free Wi-Fi availability*
- *Ensure delivery of sufficient affordable housing*
- *Change attitudes and stigma towards health and social issues*
- *Improve coordination and awareness of community activities (amongst the public and professionals)*

What we know about people

- There are a lack of affordable homes in B&NES
- Fewer people from lower income households in B&NES say there are plenty of places locally to experience nature
- Some of the areas in the district have higher than the national average number of hot food take aways

Actions we are taking

- A number of council officers have been contributing to work across the West of England to create a Joint Spatial Plan that will set out the vision for housing, employment and travel infrastructure over the next 20 years. The vision includes health and wellbeing, sustainability and narrowing the gap in health and social outcomes. So although this is a high level document it provides an important opportunity to maximise the health objectives so that the subsequent Local Plan for B&NES responds to the JSP and needs to deliver on the health and sustainability objectives.
- One of the key JSP objectives is likely to be the principles of good place-making. This aims to achieve places that are vibrant and enjoyable living and working environments, that are successful in creating economic growth, reducing carbon emissions, improving community health and wellbeing, and that address inequality of opportunity and life chances for all.
- A significant local programme is the redevelopment of the Foxhill housing area. This is one of the most deprived areas in the B&NES district, with high concentrations of social housing, some of which is in poor condition. Curo, the registered housing provider for much of the housing in the area, are in the process of redeveloping the adjacent former MOD site for a mix of market and affordable housing, which will enable Curo to reinvest and regenerate the Foxhill estate. The programme also aims to work in partnership with local organisations to maximise training opportunities, employment support and access to the natural environment surrounding the estate.
- Within BANES the Travelling Community Support Service delivered by Julian House provides an outreach service to Gypsy, Traveller & Boater communities. This service

supports people with specific health and welfare issues as well as developing outreach programmes, both on land and water. A number of successful joint working partnerships have been established with other agencies enabling them to increase engagement with these marginalised communities. The Travelling Community Support has become embedded within BANES and the surrounding local authorities and is well known of, through word of mouth and through social media.

- Two council- wide projects on air pollution are in development:
    - Awareness-raising amongst vulnerable groups in Air Quality Management Areas (AQMAs) of poorer air quality and actions they can take to reduce their exposure
    - Working with schools in Air Quality Management Areas using measurements of the personal exposure to NO2 and PM2.5 to develop exposure reduction advice, promote active travel to school, raise public awareness, and support behavioural change with school children.

Future actions

- Requirement to embed the creation of sustainable and healthy places in the new B&NES Local Plan
- Introduction of a requirement to meet HAPPII compliance for all new housing for older people in the new B&NES Placemaking Plan
- Delivery of a 72 unit mixed tenure extra-care scheme at Lansdown designed to HAPPII standards
- Engagement with sheltered housing providers around the quality of the current affordable housing offer for older people, creating an environment for discussions around refurbishment or redevelopment / re-provision

5. Ill-health prevention

Suggested opportunities identified at the Inquiry Day in 2016

- *Identify sustainable funding for ill health prevention*
- *Address client dependency on health services/lack of community and individual empowerment*
- *Improve transport*

What we know about people

Higher risk or vulnerable groups have been identified and prioritised by a number of partnerships including Fit for Life (Active Lifestyles), the Tobacco Action Network and the Alcohol Harm Reduction Steering Group.

For physical activity these groups include:

- People living in geographical areas of inactivity
- 11-18 year olds (particularly females) – this is the age where levels of activity start to drop
- Families (particularly expectant mothers and those with pre-school aged children)
- Older People
- Those who are carrying excess weight in both children and adults
- Those with disabilities and long term health conditions
- Ethnic Minorities

For smoking, these groups include:

- People with a long term mental illness
- People in treatment for substance misuse
- Gypsy/Traveller community
- Young mums during pregnancy
- Routine and manual workers

For alcohol, these groups include:

- Men
- LGBT groups
- Children subject to adverse experiences eg substance misusing parents, domestic abuse
- Those experiencing mental health conditions
- Those in vulnerable housing situations or homeless
- Those living in more disadvantaged neighbourhoods

Actions we are taking

For physical activity:

Most of the commissioned interventions are targeted, or services are required to provide inclusive provision.

This includes:

- Leisure service contract requires action to be inclusive and address inequalities
- Lifestyle services are for people who meet specific criteria or are prioritised in areas of deprivation
- DPH award focussed on most deprived schools
- Wheels for All - provision for people with disabilities
- Infrastructure development s in areas of deprivation - e.g odd down cycle circuit

- Moving on up targeted intervention for pregnant women
- REACT project for older people

For smoking, much of our commissioned work is targeted at these higher risk groups, however there are also potential gaps in our approach including:

- Young people not in education employment or training (NEET) or with mental illness
- Routine and manual working men
- Ex-offenders
- Unemployed
- Complex families (via connecting families team)
- Ex -service staff
- LGBT community
- People in secondary care (hospitals, specialist services)
- Ethnic minority communities

Future actions

For physical activity:

- further engagement of front line staff to make every contact count
- greater engagement of community members to increase opportunities for activity
- greater engagement of parishes to instigate local activity
- greater provision of outreach to most marginalised communities
- greater promotion of outdoor activity and free opportunities
- development of street play opportunities
- develop link to new NDPP
- increase digital and social media offer

For smoking:

- Work with STP area colleagues to support NHS trusts to achieve a Tobacco Free NHS during 17-18. go completely smoke free estates
- Work with CAMHS service to instigate a clear pathway for smoking cessation support for young people with mental health issues
- Work with the wellness service to ensure holistic outreach service to workplaces/men
- Delivery of training and support to key settings including job centre plus, older people's services and social housing
- Gain a more detailed understanding of smoking prevalence in and support needs of BME groups

- Work with PSHE leads to develop an approach to substance misuse via schools based equalities groups and PSHE leads in schools

For Alcohol:

- Working with the 'Blue Light' services to embed best practice in harm reduction for treatment resistant drinkers
- Targeting identification and brief advice training to priority settings including older people's services, housing and the universities
- Facilitate a meeting with local agencies working with Looked after children to explore needs in relation to substance misuse.
- Work on a co-ordinated approach to health promotion work with the LGBT community - prioritising mental health, substance misuse and sexual health.

Making Every Contact Count (MECC)

- MECC is about making the most of the opportunities to make a difference to people's health and wellbeing. By supporting people to make changes to their lifestyles it is possible to prevent ill health, improve health and reduce health inequalities.
- MECC encourages a wide range of workforce to initiate very brief healthy conversations around core elements of lifestyle behaviours such as stopping smoking, increasing physical activity, reducing alcohol consumption, maintaining a healthy weight and diet and promoting mental and emotional health and wellbeing.
- We are working across the Sustainability and Transformation Plan (STP) footprint to roll out MECC to ensure a consistent and system wide approach. Using national evidence and local learning we will be working with partner organisations to implement MECC in an effective and sustainable manner.

6. Inequity in access to health services

Suggested opportunities identified at the Inquiry Day in 2016

- *Have a greater focus on populations that experience extreme exclusion to better understand their health needs and be able to determine whether they attend health services*
- *Improve transport to access healthcare services*
- *Address the long length of time that people with low to moderate mental health needs have to wait for a mental health needs assessment*

What we know about people

Local and national work suggests that health services and preventative programmes are less well used by men and those from disadvantaged areas or routine and manual trades. Age, sexual orientation and ethnicity can also play a role, depending on the kinds of services involved. For example young people might be more likely to use urgent care services rather than general practice, but less likely to take up offers of screening or health checks.

Actions we are taking

There are numerous examples of services and projects aimed at marginalised or vulnerable groups across many different health and social services locally – too many to mention here. This is reflected in the Health and Wellbeing Strategy and the CCG five year Strategic Plan. The transformation ambitions between health and social care commissioners and Virgin care also reflect these ambitions, though it is too early to judge progress in targeting services towards those most in need.

However, we don't yet have a framework of actions, aimed at the key groups with the worst outcomes and metrics to help judge the effectiveness of progress.

Uptake of the national child and adult vaccination programmes are regularly explored in a B&NES multi-agency immunisation group. As a result of the work of this group, work has gone on over the year to support a number of general practices in B&NES with lower uptake of childhood immunisations to increase their uptake.

An urgent transport service has been implemented as part of the early home visiting service in primary care to ensure patients can be transported to the RUH early in the day so that they can be assessed and hopefully returned home the same day.

Future actions

- A workshop is being planned for late November to identify what can be done collectively to reduce the differences we see between different population groups in the uptake of identified screening and immunisation programmes
- For a number of reasons, adults with learning disabilities are less likely to attend routine screening appointments than the general population. Work is ongoing to find out what the specific barriers are, and to make access to breast and bowel screening appointments easier

- The public health team based in the B&NES, Gloucestershire, Swindon and Wiltshire NHS England team are appointing project officers in each local authority area for a period of one year to help identify, understand, and address inequalities seen in the uptake of screening and immunisation programmes.
- Access to transport for hospital care is subject to a substantial review across the 12 CCGs in the South West.

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MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**12 July 2017**
TYPE	**An open public item**

Report summary table	
Report title	Making Every Contact Count (MECC)
Report author	Zoe Clifford. Tel: 01225 394071
List of attachments	None
Background papers	LGA. 2014. Making every contact count: Taking every opportunity to improve health and wellbeing. [Online] Available from: https://www.local.gov.uk/sites/default/files/documents/making-every-contact-coun-e23.pdf NICE (2014). Behaviour change: individual approaches. Public Health guidance PH49. [Online] Available from: https://www.nice.org.uk/guidance/ph49 PHE & HEE, (2016). Making Every Contact Count (MECC): implementation guide. [Online]. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/495087/MECC_Implementation_guide_FINAL.pdf
Summary	Making Every Contact Count (MECC) is about altering how we interact with people through having healthy conversations and learning how to spot opportunities to talk to people about their wellbeing. This paper seeks the approval and commitment from the Board to implementing MECC locally.
Recommendations	The Board is asked to: a. Note the approach to implementing MECC b. Comment on the suggested key principles for local implementation: • A focus on MECC Level 1: very brief intervention / healthy conversations. • Delivering MECC Plus to include the wider determinants • A phased approach with identified target audiences • A model of cascading the training/learning c. Provide high level support and commitment to MECC
Rationale for recommendations	This will provide a consistent and wide spread approach to low level behaviour change through the use of very brief healthy conversations. It provides the opportunity to reinforce messages about health and wellbeing and signpost to the relevant services is used.

Resource implications	Financial resources have been identified and secured from external funding (Health Education South West). Staff time is required to attend and/or deliver training.
Statutory considerations and basis for proposal	The MECC Consensus Statement (PHE, 2016) recommends that the MECC approach should be applied across all health and social care organisations. Signed by a wide range of organisations, including Health Education England, Local Government Association and Care Quality Commission, it describes the commitment to the MECC approach as a way of supporting positive behaviour change.
Consultation	The following have been consulted about the approach outlined in this report: • Bath and North East Somerset, Swindon and Wiltshire Sustainability and Transformation Plan Prevention and Proactive Care sub group • South West MECC Steering Group • Public Health England • South West Workforce Development Group. •
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. Background

1.2 Making Every Contact Count (MECC) has been defined as “an approach to behaviour change that utilises the millions of day-to-day interactions organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations” (PHE & HEE, 2016).

1.3 MECC encourages organisations and staff to develop a different way of working with people to address health and wellbeing. Telling people what to do is not the most effective way to help them change. MECC is about altering how we interact with people through having healthy conversations and learning how to spot opportunities to talk to people about their wellbeing.

1.4 MECC encourages workforces to:

a. Take a holistic people-centred approach to service delivery.

b. Initiate very brief healthy conversations around core elements of lifestyle behaviours such as stopping smoking, increasing physical activity, reducing alcohol consumption, maintaining a healthy weight and diet and promoting mental and emotional health and wellbeing.

c. Be competent and confident to raise health issues.

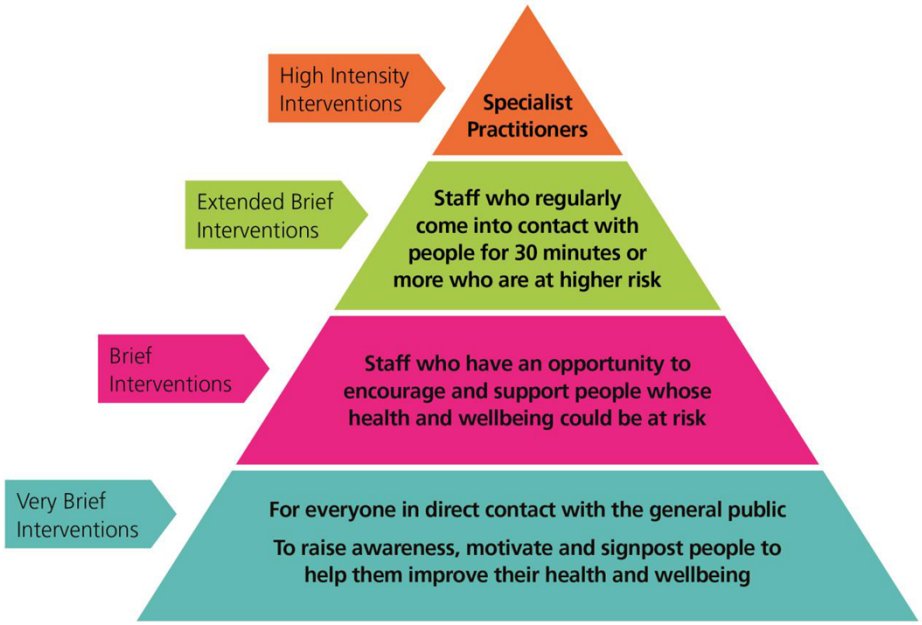
d. Know about local services and how to signpost people to help them to access them, where appropriate.

1.5 To be fully effective, a ‘whole system’ approach is necessary in which all staff working with the public signpost and provide information on a wide range of services that can improve people’s health. These include leisure and recreation, welfare benefits advice, housing, social care, routes to employment, education and training, home safety and so on (LGA, 2014).

1.6 Evidence shows that brief interventions on healthy living are cost effective and produce effective behavioural change outcomes (NICE, 2014). MECC is a way of making a difference for the population on a large scale by all frontline staff embedding prevention in their day to day work with clients/patients. Very brief healthy conversations with service users by frontline staff could equate to thousands of healthy behaviour change opportunities each year and yet take up very little staff time.

1.7 Very brief healthy conversations form the bottom layer of the behaviour change intervention pyramid (see figure 1) and is sometimes referred to as MECC level 1. MECC can also take place at the next level up on the pyramid where more of a brief intervention takes place.

Fig 1: Behaviour change intervention pyramid.



Behaviour change interventions mapped to NICE Behaviour Change: Individual approaches/PH49
Behaviour change interventions diagram by Health Education England – Wessex Team

1.8 MECC Level 1: Very brief intervention / Healthy conversations is a very brief intervention can take from 30 seconds to a couple of minutes. It enables the delivery of information to people, or signposting them to sources of further help. It may also include other activities such as raising awareness of risks, or providing encouragement and support for change.

1.9 MECC Level 2: Brief intervention involves oral discussion, negotiation or encouragement, with or without written or other support or follow-up. It may also involve a referral for further interventions, directing people to other options, or more intensive support.

1.10 MECC Plus: It is recognised that partner organisations such as local authorities may adopt a broader definition the MECC approach, which we have referred to here as MECC Plus. This may include conversations to help people think about wider determinants such as debt management, housing and welfare rights advice and to direct them to services that can provide support.

1.11 A South West review showed that commitment to MECC was not universal and several areas had no activity (Kelly and Wills, 2015). It was evident that there was widespread training in behaviour change interventions for particular workforces. For example those who may work with individuals with drug and alcohol problems, as part of smoking cessation or weight management pathways, for specialist community public health nursing teams and pharmacists.

1.12 The review recommended that a brief introduction to MECC should be a mandatory part of induction for all staff to raise awareness of the importance of key public health messages and highlight the importance of prevention.

1.13 The vision now in the South West is that all health and social care organisations and relevant partner agencies will be aware of, adopt and embed MECC principles. This means that, whenever appropriate, the opportunity to reinforce messages about health and wellbeing and signpost to the relevant services is used.

2 LOCAL IMPLEMENTATION

2.1 Bath and North East Somerset, Swindon and Wiltshire (BSW) are working together across the Sustainability and Transformation Plan (STP) footprint to roll out MECC to ensure a consistent and system wide approach. Using national evidence and local learning we will be working with partner organisations to implement MECC in an effective and sustainable manner.

2.2 The suggested general principles for the implementation are:

a. Promoting healthy conversations - Focus will be on everyone being able to deliver MECC Level 1: Very brief intervention / healthy conversations.

b. Delivering MECC Plus – the wider determinants of health will be included in delivery.

c. A phased approach with identified target audiences - Focus on MECC engaging with older people (aged 65 and over) as a targeted population group initially with flexibility to widen this focus locally to meet local need. The second phase will extend the target audience to those age 40-64 and linking to the One You campaign. Local areas may choose to focus on additional population groups.

d. Offering flexible training options based on a cascade model of training

2.3 MECC training will be cascaded (see figure 2). A small number of people will be trained as MECC trainers and accredited. They will deliver training to identify MECC champions. These champions will act as main points of contact about MECC in their organisations and cascade the information to colleagues and these champions will cascade in-house MECC training.

Fig. 2: Cascaded MECC training

2.4 To fully embed MECC so that it is effective and sustainable we ask that all participating organisations identify suitable people to champion the intervention and to cascade the MECC learning. These staff will receive MECC training and support.

2.5 Organisations may also wish to identify staff to become MECC trainers. The MECC train-the-train course consists of two half days and one full day of training and will be free to participating organisations.

3 SUPPORTING RESOURCES

3.1 Funding has been made available from Health Education South West until March 2018 for each Sustainability and Transformation Plan footprint to implement MECC. Locally this funding will pay for a MECC co-ordinator, a small grant scheme for the voluntary and community sector and additional MECC train-the-trainer course

3.2 A MECC Co-ordinator will be in post from September 2017 and will cover the Bath and North East Somerset, Swindon and Wiltshire Sustainability and Transformation Plan area. They will work with twelve large organisations across the area to support and assist with embedding MECC within organisations to ensure efficient and effective implementation and delivery. They will be able to deliver MECC training and support in-house trainers and champions.

3.3 A small grant scheme will be available to the smaller voluntary and community sector organisations to assist with implementing MECC. This is aimed at removing some of the potential barriers for these particular organisations and may be used to back-fill staff, pay travel expenses or room hire for training. The grants will be available from the end of the summer.

3.4 There is currently a small pool of MECC trainers who can cascade the training to MECC champions. Additional MECC train-the-trainer courses will be ran in the autumn of this year. There is also a free e-learning package which all staff can access.

4 MEASURING SUCCESS

4.1 A South West evaluation of MECC implementation will take place between September 2017 and June 2018. Evaluation findings will inform the future implementation of MECC.

5 RECOMMENDATIONS

5.1 The Board is asked to:

a. Note the approach to implementing MECC
b. Comment on the suggested key principles for local implementation:
    - A focus on MECC Level 1: very brief intervention / healthy conversations.
    - Delivering MECC Plus to include the wider determinants
    - A phased approach with identified target audiences
    - A model of cascading the training/learning
c. Provide high level support and commitment to MECC

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

Logo created by Pete Savin – Graphic Designer

Mental Health and Wellbeing Charter

Bath and North East Somerset (B&NES)

1st Published – August 2016
Revised – April 2017

This Charter was created by New Hope volunteers in collaboration with people who have used services for their mental health, family, friends and supporters, volunteers, 3rd sector and statutory groups in B&NES

In Memory of Andrea Morland
(Senior Commissioning Manager, Mental Health, B&NES)
"It's not about competing it's about working together, to serve people in the best way possible… not silos of organisations but a group of people with solid working relationships that give people the support they need".

Introduction

The Mental Health and Wellbeing Charter provides a clear set of principles to guide people who require mental health support on their wellbeing journey. Alongside the 'In Practice' document it promotes a shared approach between those using services, their families, friends, groups and professionals to support each person's unique mental health needs..

We have worked with over a 100 people who have received support for their mental health, to create the Charter and the 'In Practice' document. The aim of the Charter is to inform those who work with people with mental health issues about the key areas which support wellbeing.

The Charter supports the key aims of New Hope which are to '*affect positive change in treatment and support services'* and to *'give service users and carers a* voice' and the 'Bridging the Gap'(3) report which currently underpins mental health commissioning strategy. One of the key findings of the report was the impotance of *'statutory services and other support networks working together to optimise support for the individual'*.

The Charter has been informed by the B&NES Crisis Care Concordat (4) and the Care Quality Commission 'Right here, Right now'(5) report of June 2015 and the projected transformation of mental health services highlighted in the 'The Five Year Forward View for Mental Health'(6) .

The creation of the Charter ran alongside the consulting process for 'Your Care Your Way'(7) . In 2017 it was written into the B&NES Mental Health and Wellness Commissioning Pathway and has recently received funding for the development of a Peer Evaluation Tool using the Charter as a framework.

The Charter will sit alongside the AWP Friends, Family and Carers Charter(8), created by carers support group Keep Safe, Keep Sane and Avon and Wiltshire partnership Trust (AWP).

There are two parts to the Charter

Part 1 : The Charter (Page 16)
The Charter highlights the 10 Guiding Principles that reflect the support people need for their mental health and wellbeing. Local organisations are invited to sign up to these principles.

Part 2 : 10 Guiding Principles 'In Practice' (Pages 5-14)
The 'In Practice' document provides a framework and local examples of best practice to enable staff and other supporters to understand, reflect and develop a supportive network which addresses the Guiding Principles of the Charter.

- **Family and friends** – to create an enhanced shared approach and improve communication between the people they support, professionals and other supporters
- **Services** - To continue improving partnership working, so that support is coordinated and consistent wherever people are on their path, especially at the critical times of discharge and crisis, therefore highlighting and hopefully eliminating the gaps in services that people can fall through.

What we did

All the following elements were co-produced by volunteers with lived experience of receiving support for their mental health and staff from a number of local statutory and 3rd sector groups. We (New Hope and St Mungos);

- Worked collaboratively with Healthwatch (9) (Care Forum) and the Council in the form of 'Making it Real'(10) to establish a framework for the Charter and In Practice document and to establish the most effective way of obtaining feedback.
- Ran two pilot focus groups to establish a first draft of the Charter and 'In Practice' document.
- Ran ten focus groups and informal conversations with over 100 people who had received support for their mental health and individuals feedback via an online survey.
- Collated all the feedback and created the final Charter and In Practice document
- Organised a celebratory event to launch the Charter where all organisations working with people who need support for their mental health are invited to sign up to the principles of the charter

The logo - New Hope volunteer, Pete Savin Graphic Designer, created the logo. .

The logo illustrates a feeling of openness and transparency and welcomes everyone using the Charter in B&NES to express what they need to have the best quality of life possible

The tree symbolises support and safety. The birds are people who use services, who fly onto the tree and are supported and nurtured until they are ready to fly off in the knowledge that the tree is there if needed.

The sunrise brings hope, bringing light and a sense of new beginnings to challenging times. The image is fluid with the movement of the sunrise, birds, leaves and branches illustrating that our lives are not static and services need to be dynamic to support people.

Within this eco-system, at all stages, people are supported to increase their understanding and self-awareness

MENTAL HEALTH AND WELLBEING CHARTER
BATH & NORTH EAST SOMERSET

Key Terms

Service User
We deliberately haven't used the term 'service user' because we feel it can define someone as the passive recipient of services, rather than a person with skills and abilities, who also has a mental health diagnosis. We want the Charter to emphasise the person as a whole., reflect the positive work in B&NES to reduce stigma and as a challenge to tokenistic service user representation. We see service users as people.

Supporter or Carer (different stages of a person's journey)
In the Charter we've used the term 'supporters' to mean family, friends, volunteers and professionals who support someone with their mental health. 'Supporter' reflects the dynamic and empowering relationships people require on their mental health journey. We recognise at times people do need care, it is essential for wellbeing and can be lifesaving. However, as a result of focus group feedback people felt the term 'carer' can be disempowering and could suggest a static state of being.

The idea of Charter was introduced and led by Caroline Mellers, initially as a St Mungo's and New Hope volunteer. Caroline has a personal and professional background in mental health, having used crisis, and inpatient services. She worked for the District Health Board in New Zealand as a service evaluator and now works with a number of local statutory and 3rd sector organisations in B&NES.

If you would like more information on the Charter or would like to replicate it in anyway, please contact Caroline Mellers (caroline.mellers@mungos.org, 07525 594606 or Ralph Lillywhite(ralph.lillywhite@mungos.org, Tel: 0782 511 5775

Launch Event Organisations and individuals signing up to the charter at the launch event in May 2016.

Organisations and groups who have signed up to the principles of the Charter include:

Avon and Wiltshire Partnership Trust	Keep Safe Keep Sane
Bath College	B&NES Mental Health Commissioners
Bath Mind	Missing Link / Next Link
Bipolar UK Bath	New Hope
Carer's Centre	S.E.A.P.
DHi	Second Step
Fresh Arts	Sirona
Healthwatch	Soundwell
Hope Space	St Mungo's
Julian House	The Mayor of Bath

My Support My Way

Principles

- I understand the different support available to me. It is clear where and how I can access it.

- I have the opportunity to plan my unique care and support. This support changes as my needs change.

In Practice

1) I am involved in planning my support, aware of the timescales and this is regularly reviewed with my supporters. I know at what point services may reduce or stop.

   Best Practice example - "When I accessed Talking Therapies, they clearly defined the programme of support and what would happen at the end of this period so I felt supported".

2) I am supported at home, however there are other options available.

   Best Practice example - "I stayed in the Wellbeing House for a few days it gave me some space to clear my mind away from home".

3) I do not need to repeat my story unnecessarily as organisations work together effectively.

   Best Practice example - "It was useful that the Complex Intervention Team were able to access the records of Social Services when my partner was unwell. As this really helped them understood his needs and I did not have to repeat information at a time of stress".

4) I am supported to navigate the best possible, timely support on my mental health journey. Assessments are kept to a minimum so I do not experience unnecessary distress especially at times of transition.

   Best Practice example - Talking Therapies take into account that I might be unwell. I am able to say how I feel every session by filling in a feedback form. They also called me to make sure I was OK when I missed a session".

5) I understand what happens if I leave services and need to re-access them. I have a support plan that includes ways of staying well.

   Best Practice example – "Second Step are developing a Move On Tool Kit so people feel supported when they leave the service. It will also inform people of how they can contact the service once they have left and where else they can go for support".

6) I have one mental health plan that is transferable and takes into account my physical and mental health needs.

Best Practice example - "One joined up plan would have been really useful, as staff on the inpatient ward might have known to support my daughter to keep taking her epileptic tablets. The discharge part could include informing supporters on the possible side effects of new medication.

7) I'm supported to access and remain in education, work, and volunteer roles.

Best Practice example - "Sirona's Work Development Team spoke with the Occupation Health Department at my work about when I would be able to return to work. They also helped me identify barriers to my wellbeing".

8) My age, culture, race, religion, disability, gender identity and sexual orientation are not a boundary to receiving the best support I need.

Best Practice example - BGEN Message "My age, culture, religion, disability, gender and sexual orientation are not a boundary to receiving the best support I need" If I need support I can contact BGEN Bath.

Feeling Safe and Supported

Principles

- I have supportive people around me, who understand my needs and who can enable me to get help early to avoid a crisis.

- I have one agreed plan that supports my wellbeing and helps keep me safe if I become unwell.

In Practice

1) I have one agreed plan everyone follows that supports me when well, unwell or in crisis. This is regularly updated to ensure vital information is not missed.

   Best Practice example - "I knew my client was distressed. I was able to refer to their plan and found the names of their beloved pet to start a conversation".

2) I feel safe and supported in my relationships with my supporters, the type of support and boundaries are clear.

   Best Practice example - "I felt that no one was listening to me, until a member of the Intensive Team really listened to my concerns and helped me develop a plan of action that I felt would work".

3) When I am too unwell to keep myself safe, plans or interventions and support are always in my best interest. This takes into account past discussions and experiences with my supporters.

   Best Practice example - "I wasn't well enough to say what worked for me in the past, my care co-ordinator spoke to my supporters to find this out. The information is now recorded in my plan so if I am unwell again it is available, and can be shared with the other supporters".

4) I am supported to have equal access to activities.

   Best Practice example - "I wouldn't need staff support if I had peers/friends who understood my condition and needs. I really like the development of peer mentors, within AWP and St Mungo's who would be proactive in supporting people like me achieve this".

5) I feel informed and understand different medication options, side effects and the potential alternatives that are available to me.

Best Practice example - "I was able to discuss my concerns about medication and physical side effects with my psychiatrist and integrate this with my plan for wellbeing".

6) I know how to report concerns I have about my treatment and support.

Best Practice example - "I rang the Patient Advice and Liaison Service (PALs) when a staff member didn't get back to me about an important health issue. I was impressed when the team resolved the issue quickly and I had an apology from the member of staff 3 days later".

7) I can have a facilitated meeting between my supporters and services to share concerns and agree appropriate action.

Best Practice example - "My psychiatrist encouraged me to bring my friends, who were supporting me, along to a meeting to discuss how we could all work together, this really helped".

8) I understand confidentiality is used to protect my personal details and not to create boundaries to care. At times of risk information may be shared and I will be informed of this.

Best Practice example - "After attending the B&NES confidentiality conference I felt comfortable to speak to my manager with issues of confidentiality".

9) I have the opportunity to be supported by people with lived experience.

Best Practice example - "I feel supported by people from Fresh Arts to express myself creatively. The facilitator and other participants are peers with lived experience".

10) I live in a safe environment that meets my needs.

Best Practice example - "A patient was really worried about going back to their accommodation as they had no phone, buying them a phone removed the stress of not being able to ask for support in a crisis. (Move on Worker, on an inpatient ward)

Insight into my Mental Health

Principles

- I am empowered to gain insight into my mental health and explore what either supports or hinders my wellbeing.

- I am supported to view my life as a whole, with my mental health as a component.

In Practice

1) I have the opportunity to create my own plan to increase my understanding of what keeps me well.

   Best Practice example - "I attended a Wellness Recovery Action Plan course at the Wellbeing College. I was able to create my own plan, which I can add to as I learn more about my wellbeing".

2) I am recognised as an expert in my wellbeing and supported to enhance this via self-understanding and awareness.

   Best Practice example - "St Mungo's Bridges to Wellbeing believed we were able to facilitate our own group, with training and support it turned out we are".

3) I am supported to integrate my mental health as part of my life rather than it controlling my quality of life.

   Best Practice example - "Joining Tiny Monuments has led me to join other creative groups and build a peer (friends) network. I now run groups, have gained skills and confidence and as a result I'm much more stable. The support from Creativity Works has been invaluable".

4) I am supported in understanding any trauma that has impacted on my mental health to strengthen my resilience and self-understanding.

   Best Practice example - "My psychologist was able to slowly help me understand aspects of my trauma and how it linked to my having psychosis. I have now been well for 10 years."

5) I am empowered to explore what triggers affect my mental health and what steps can be taken to reduce my distress.

   Best Practice example - "I worked with the Recovery Team to come up with proactive ways to help me understand and manage my triggers".

6) I have the opportunity to learn from people with lived experience.

Best Practice example - "I had a diagnosis of personality disorder. To increase peoples understanding and ability to provide really good support I now deliver training on it".

7) I am encouraged and supported to identify what steps I can take to improve my wellbeing.

Best Practice example - "I was supported to become a volunteer. This really helped my confidence to get ready to go back to work after being off for a long period of time".

Supportive Staff and Organisations

Principles

- I can access organisations which support their staff using a clear set of principles, training and procedures.

- I am supported by competent, compassionate and respectful staff who understand my unique needs at every stage of my journey.

In Practice

1) Managers provide support and opportunities for staff to reflect on their work to improve clients' experience.

   Best Practice example - "I really liked being asked my opinion about staff for their appraisal, I felt really listened to and believe it can really help staff to be the best they can. It also made me think about the service I should receive."

2) Managers understand the qualities of a supportive therapeutic relationships so people feel really heard and understood by staff.

   Best Practice example - "My Plan (Bristol) includes a tool designed by a team of staff and those using services to support the co-production of care plans. It's for people ready to be discharged and those at high risk of requiring more intensive support. (AWP pilot in Bristol)".

3) Staff coordinate with other organisations involved in a person's support to ensure the pathway and sharing of information is effective and seamless.

   Best Practice example - "DHI and Curo supported me and, with my consent, shared information about me. This made moving into my property quick and less stressful".

4) Staff provide opportunities for people to develop and maintain their peer support network and links to community activities.

   Best Practice example - "I used the Hope Guide to help find a peer led group that would support my interests in a safe and supportive environment"

5) Organisations are encouraged to develop and share best practice in innovative ways.

   Best Practice example - "Creativity Works facilitates meetings every 6 weeks with the Creative Perspectives group. This gives members a voice and enables them to successfully run the groups themselves".

6) Staff appraisals include feedback from colleagues, clients and carers.

Best Practice example - "I really liked being asked by St Mungo's to give feedback for staff appraisals".

7) Trained peer evaluators are part of the process for assessing how effective services are.

Best Practice example - "I heard that a manager say they provided staff with reflective practice sessions that encouraged dialogue around cases studies. I think this would really help staff to understand the needs of people experiencing a crisis".

8) All records are written in the knowledge that they may be viewed by people using the service. The process to request this information is clearly explained.

Best Practice example - "I was an evaluator in New Zealand. The unique perspective of people using services was heard alongside the views of family, staff, management and other organisations. This was seen by many as the missing part of the puzzle and supported a 360º view of the complexity of mental health".

Advice and Information

Principles

- I can speak to people who have the knowledge and expertise to advise and help me to get the support I need.

- I have access to clear and practical information that supports my wellbeing and ability to be independent.

In Practice

1) I have access to independent advice and support as needed.
Best Practice example - "The Hope Guide is really useful to help me find a group. It would be even more useful if there was a central website with all available information, this site could be developed with people who use services".

2) Advice and information empowers me to make an informed choice on what is available locally. This includes support for filling in forms and accessing the benefits system.
Best Practice example - "CAB at the One-stop-shop is where I always go for advice on anything related to benefits or finances. They are always really helpful".

3) The advice I receive takes into account issues that might stop me getting the best information, such as my age, culture, race, religion, disability, gender identity and sexual orientation.
Best Practice example - "B&NES Council is working in collaboration with GPs to understand the needs of recently arrived refugees".

4) Information is available to meet my individual communication needs including: large print, web based, interactive technology, different languages (including sign language).
Best Practice example - "Age UK provide large print options on their website". ? Are interpreters available in services?

5) Organisations clearly explain what support they are responsible for providing and how this links with the support provided by others.
Best Practice example - "The Intensive Team gave me a leaflet with all their information including how the team worked and the time frame their support would run for. I felt better supported as I understood the team".

6) I receive up to date, accurate information on services, groups and one-to-one support available, especially in times of first onset, transition or additional stress.

Best Practice example - "My GP told me about Talking Therapies, I booking online or by phone is simple, and when I left a message they got back within 24 hours".

"It felt like the information I need was locked in a safe and I didn't have the combination. One place which details all available support can be lifesaving".

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9. Healthwatch – Your spotlight on local services
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Mental Health and Wellbeing Charter

The 10 Guiding Principles followed in Bath & North East Somerset

To support mental health and wellbeing

My Support, My Way	• I understand the different support available to me. It is clear where and how I can access it. • I have the opportunity to plan my unique care and support. This support changes as my needs change.
Feeling safe and supported	• I have supportive people around me, who understand my needs and who can enable me to get help early to avoid a crisis. • I have one agreed plan that supports my wellbeing and helps keep me safe if I become unwell.
Insight into my mental health	• I am empowered to gain insight into my mental and physical health and explore what either supports or hinders my wellbeing. • I am supported to view my life as a whole, with my mental and physical health as components.
Supportive staff and organisations	• I can access organisations which support their staff using a clear set of principles, training and procedures. • I am supported by competent, compassionate and respectful staff who understand my unique needs at every stage of my journey.
Advice and Information	• I can speak to people who have the knowledge and expertise to advise and help me to get the support I need. • I have access to clear and practical information that supports my wellbeing and ability to be independent.

This Charter was created by people who have received support for their mental health
For more information on the Charter and the 'In Practice' document please visit
www.newhopebanes.org