NHS
Bath and North East Somerset
Clinical Commissioning Group

Seizing Opportunities

A Five Year Strategy

The Operational Plan 2014-16

March 2014

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APPENDICES

Seizing Opportunities – Our Two Year Operating Plan

1. Introduction

This plan details how the aspirations set out in our 5 Year Strategy will be delivered in the first two years of the plan 2014-2016. It needs to be read in conjunction with the full 5 Year Strategy which sets out in much greater detail:

- Our Vision
- Our Priorities
- The National and Local Context
- Our Strategy
- Our Commitment to Quality
- Plans for delivery in years 3-5
- Enabling Plans
- Governance arrangements
- Communication and Engagement

2. Our Vision

When we embarked on our journey to become a Clinical Commissioning Group (CCG), we encapsulated our strategic vision in the statement 'Healthier, Stronger, Together'. Bath and North East Somerset CCG (BaNES CCG) has been established for a year, and this vision is all the more relevant.

We believe that our role as a high performing CCG, is to lead our health and care system collaboratively through the commissioning of high quality, affordable, person centred care which harnesses the strength of clinician led commissioning and will empower and encourage individuals to improve their health and wellbeing status.

3. Context

Our 2-year Operational Plan for 2014-16 and our 5-year strategic plan begin with a strong foundation on which to build future success. We have a track record of working in synergy with our local authority colleagues and have been jointly commissioning integrated health and social care services for many years.

Our 2 and 5-year plans will aim to deliver an ambitious programme of priorities that will mean:

- Empowered individuals, carers and communities who are supported, confident and able to:
  - take increasing responsibility for their own health and wellbeing;
  - manage their long term conditions;
  - be part of designing health and social care services that work for the people that use them.
- Enhanced and integrated primary, community and mental health services, support and expertise working 24/7 with clusters of populations in order to respond to health and wellbeing needs close to home and ensure that hospital admissions are driven by the need for specialist and emergency treatments

- Innovative and widely integrated and utilised pathways of care understood for each long term condition and including self-management, transition, urgent and contingency planning elements as routine
- A focus on the most vulnerable, at risk, frail or excluded citizens as a matter of priority regardless of age
- Local people of all ages who have worked with clinicians and practitioners to design, inform and then have access to information that enables them to be confident in the quality and safety of services and, where they are not confident, to voice and raise concerns easily
- Integrated information and care record systems that facilitate the delivery of integrated health and care services
- Services that represent excellent value for money, measure by quality and effectiveness of outcomes as experienced by the people who use them.

4. Our Strategic Priorities

Through our stakeholder engagement events, we have prioritised what we see as key transformational projects:

- Prevention, self-care and personal responsibility
- Long Term Condition Management (focusing initially on Diabetes to develop a model of care that we will then roll out more widely to other LTCs)
- Musculo-skeletal services
- Interoperability of IT systems
- Urgent Care
- Safe, compassionate care for the frail older people

This operational plan sets out the work we will be undertaking in the first 2 years of the 5 year strategy and consists of a mixture of "business as usual initiatives", pre-existing priorities and initiatives that support our longer term End State Vision for the health and care system in B&NES. The plans build on existing programmes of work and respond to the areas identified where our commissioning activities will have a beneficial impact to the quality of patient care and where efficiencies in the system can be improved. A continued focus on the quality of healthcare in B&NES will remain at the heart of what we do, supported and underpinned by a greater focus on patient engagement and involvement.

We have set out the elements of this strategy in terms of a 2 year operational plan so that it can be presented on one page – see Appendix 1. This plan represents the transitional period where we focus on delivering the plans we already had in train, whilst starting to create the foundations for the transformation work streams. Appendix 2 highlights the specific actions and initiatives over the 2014-16 associated with the 6 transformational projects described above.

5. Better Care Fund

Our commitment to the model of pooled and aligned budgets and common commissioning goals was re-affirmed in April 2013 in a partnership agreement between the CCG and Council. This model covers the whole of our shared agenda but is most fully realised around adult services, including mental health, learning disabilities, physical and sensory disability, carers and our elderly frail population. The Health & Wellbeing Board provides strong local leadership, holding the whole

system to account for improving health and wellbeing outcomes, with a particular focus on prevention and early intervention. For B&NES the Better Care Fund acts as a further enabler and structure to build on and expand existing joint commissioning and provision. Our focus for the future is on further alignment of resources that influence the wider determinants of health and wellbeing.

We have framed our thinking about local whole-system integration in the context of the emerging "House of Care" model for B&NES which we will continue to develop and embed over the next five years. Key components of our integrated system are:

- Step down accommodation
- Support for carers
- Independent living service
- Community Cluster teams
- Social care pathway redesign
- Integrated reablement
- Well-being college
- Social prescribing
- Liaison Services – alcohol, mental health primary care, psychiatric
- Intensive home from hospital support

The Better Care Fund has been a key enabler in developing and enhancing our integrated model of care, being used to secure new service development that have, in a number of cases been piloted and evaluated against key outcomes and, also to increase capacity in key health and social care services, including that are or will be accessible on a 24/7 basis.

We have identified a range of additional projects, using the new contribution from health resources into the Better Care Fund, which enable us to build and expand on the success of these existing schemes to further develop integrated services which benefit service users and their carers and enable more effective use of resources across health and social care.

The Better Care Fund Schemes can be categorised into the following groups:

- 7 Day Working
- Protection of Adult Social Care Services
- Integrated Reablement & Hospital Discharge
- Admission Avoidance
- Early Intervention & Prevention

We are confident that in the longer term, by further embedding and developing our model of integrated care, we will relieve pressures on our acute services and help to eliminate the costs that arise from failures to provide adequate help to those at greatest risk. Over time, we expect there to be a reduction in the volume of emergency and planned care activity in hospital through enhanced early intervention and preventative services and improved support in the community

6. National Requirements - Everyone Counts: Planning for Patients 2014/15 to 2018/19

Our plans aim to meet the requirements set out in the planning guidance in respect of delivering transformational change through the 6 models of care:

- Citizen participation and empowerment
- Wider primary care, provided at scale
- A modern model of Integrated Care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence

Whilst maintaining the focus on essentials:

- Quality
- Access to services – convenient for everyone
- Driving change through innovation
- Value for money, effectiveness and efficiency

Whilst we recognise there is a requirement for the CCG to evidence that it is addressing in some way all 6 transformational models of care in order to create a sustainable health and care system in B&NES, our local approach to these areas will be differential based our assessment of where need is greatest and where a focused delivery approach is required.
We will be aiming to make progress in delivering the national requirements in the first two years of the plan as detailed below. The actions identified in Years 1 and 2 have been selected because they are either a national or local priority or because they have been identified as key steps to support delivery towards our 5-year plan.

6.1. Citizen Participation and Empowerment

5 Year Strategic Ambitions:	• Patients and their carers will feel supported to be able to navigate their way around the health and social care system, with access to good information and supported to manage their own care. • Local people of all ages will have worked with clinicians to design, inform the commissioning of services within B&NES • Patients are confident in the quality and safety of services in BANES and, where they are not confident, to voice and raise concerns easily
Operational Actions for Years 1 &2	• Further roll out of the Family and Friends Test • Implementation of Personal Health Budgets from 1st April 2014 and prepare for the move to PHBs to patients with Long Term Conditions • Fully embed the CCG's Patient and Public Involvement Group in commissioning processes

6.1.1 Roll out of Family & Friends Test

In February 2014, we were successfully awarded £120,000 by NHS England to establish a Friends and Family Test Pathway between Primary, community and secondary care with a focus on those patients registered with heart failure

The second wave adoption of the Friends and Family Test (FFT) is proposed to assess the perception of quality of care at all significant touch points on the care pathway for heart failure patients in B&NES using the FFT question plus an additional validated question set underpinning the FFT. This will give an understanding of patient perception of the core domains of patient experience and the core domains of patient health state. The project will be called Heartfelt and will track patients along a care pathway where multiple care provider organisational boundaries are crossed and explore the best ways to test patient experience through the use of the FFT.

Working in partnership, touch points along the heart failure pathway have been identified.

The Touch points are:

- General Practices- Nine BaNES GP Practices are piloting the pathway
- Heart failure Specialist Nurses- Sirona Care and Health CiC
- Cardiology inpatients and some outpatients at the Royal United Hospital.
- Heart failure patients in the Emergency Department at the Royal United Hospital.

Fundamental to the proposal is the use of a real time data capture and reporting system that enables data capture through multiple channels (ipads, telephone contact etc). Real time visibility of results and reports are available and the views are controlled by the permissions allocated to the individual user. The pilot has recently commenced and data will be available shortly

6.1.2 Implementation of Personal Health Budgets

From April 2014 patients in receipt of Continuing Heath Care (CHC) Funding will have the right to ask for a Personal Health Budget (PHB). Working collaboratively with the Local Authority, good progress has been made within the CCG developing robust governance and monitoring processes for implementing Personal health Budgets in line with the NHS England Quality Markers. This will ensure that the safety of patients is paramount.

Administrative and care planning processes have been tested to ensure that the patient experience of PHBs is positive and that PHBs can be delivered cost effectively. The aim is to embed the principles of personalisation.

From April 2015 people with long-term conditions must have a personalised care plan which could include a PHB if the CCG think the individual would benefit.

6.1.3 Embed the CCG's Public and Patient Participation Group

Throughout March 2014 we have been recruiting to the CCG's Public and Patient involvement Group, *Your Health, Your Voice*. Patients and members of the public are being offered two different ways to get more involved in the CCG.

Core members will form a committee of 10 to 15 people who will meet every two months to review the current work of the CCG and ensure that patient voice is at the heart of the CCG's decision

making. The intention is for the committee to be representative of the BaNES population and contain a mix of ages and backgrounds from across BaNES.

Associate members will not be required to commit to regular meetings but will be able to provide feedback to the CCG on a regular basis through e-mail, post and phone. We expect our network of associate members to continually expand as we encourage more people to get more involved in the planning of their local health services.

6.2. Wider Primary Care, Provided at Scale

5 Year Strategic Ambition	• Enhanced primary, community and mental health services will be provided 7 days a week, where required and built around clusters of population of 30-50,000 people • Sustainable model of primary care in B&NES through federated working
Operational Actions Years 1 &2	• Develop a Primary Care Strategy in conjunction with NHS England • Complete a review of primary care based community services • Finalise our plans for the utilisation of the £5 per head monies to support GP manage the over 75s • Develop the practice nurse workforce

6.2.1 Developing a Primary Care Strategy for B&NES

The role of Primary care in B&NES is integral to the delivery of both our 2 year operational plan and five year strategy with a particular emphasis on its contribution to support the delivery of enhanced primary, community and mental health services provided 7 days a week where appropriate. Our strategy assumes the development of community based services around clusters of practice populations of 30-50,000. During 2014/15 we will work closely with NHS England, the newly appointed Wessex LMC and Bath Emergency Medical Services Plus (BEMS+) to develop a primary care strategy in B&NES.

Practices in B&NES have submitted a bid to the Prime Minister's Challenge Fund to provide extended patients access and progress towards 7 day working and to improve web and telephone access for patients. Practices also propose to work with Skills for Health to fully understand the present skill mix across primary care and develop models for enhancing skill mix to support the move of work from secondary care into the community.

If successful, the CCG will work closely with BEMS+ and Practices to ensure there is on-going synergy with the CCG's 2 and 5 year plans. If the bid is not supported through the national process we will consider what local support can be provided from the CCG and NHS England to make progress in years 1 and 2 towards our strategic ambitions.

In 2014/15 we will also: -

- Review in conjunction with NHS England community based primary care services (Locally Enhanced Services) to ensure best outcomes, quality and value for money
- Work with NHS England to make emerging Local Professional Networks a Success
- Review our approach to engaging with member practices and Clusters to ensure there is an on-going and two way dialogue

6.2.2 Utilisation of the £5 per head monies for over 75s

By the end of May we will have finalised proposals for the utilisation of £5 per head monies to support GPs to manage the over 75**s.** In BaNES, local GP practices have been providing an enhanced Primary Medical Service to nursing homes since December 2011 via a Local Enhanced Service (LES) agreement. The service aims to deliver high quality and pro-active care to nursing home residents, many of whom have multiple and complex needs. The service has been re-commissioned for a further 3-year period and we propose to use part of these monies to fund this service.

Further options under consideration include: increasing primary care support for the community cluster teams with enhanced care planning; regular health checks; frailty scores; increasing the numbers of patients with special patient notes, including end of life care plans, which can be accessed by other agencies; patients to have information packs detailing useful support services and voluntary agencies.

By 1st June 2014, all registered patients over the age of 75 will be contacted by their GP to confirm who will be their named GP.

Our activity assumptions for non-elective activity take account of the impact of the Community Cluster Schemes and our planned work to improve care for people with Long Term Conditions. The impact of the £5 per head per head investment is reflected in our 2 and 5 year activity planning assumptions. In 2015-16 we are assuming an 11% reduction in admissions for over 75's.

6.2.3 Developing Practice Nurses

The CCG Nursing and Quality Directorate is proactively working with the NHS England steering group on the Community Nursing Strategy Prevention and population health work stream. This includes supporting the continued development of practice nurses as part of the larger primary healthcare team working in GP Practices. The aim over the next two years is to identify the workforce planning needs for the future by working in partnership with the universities and to support practice nurses with further training and experience to provide them with opportunities to apply for senior nurse positions, including nurse practitioner level where they will manage their own caseloads.

6.3. A modern model of Integrated Care

5 Year Strategic Ambitions:-	• Enhanced and integrated primary, community and mental health services working with clusters of populations to respond to

	health and well-being needs close to home • Innovative and integrated pathways of care understood for each long term conditions
Operational Actions Years 1 and 2	• Fully embed the Community Cluster Team Model and Active Ageing service and re-designed adult social care pathway • Begin preparations for the re-commissioning of community services • Developing our response to delivering Safe, Compassionate Care for Older People • Delivering SEND reform

Our model for integrated care is articulated fully in our plans for the Better Care Fund (BCF). Building on the model of pooled and aligned budgets and common commissioning goals our commitment to integration was re-affirmed in April 2013 in a partnership agreement between the CCG and Council. The BCF will act as a further enabler and structure to build on and expand existing joint commissioning and provision.

6.3.1 Embedding the Community Cluster Team Model

We plan to embed the Community Cluster Team Model, including the active ageing service and implement a redesigned adult social care pathway during 2014-16 (see BCF). We are considering a range of options to strengthen the primary care support for frail older people using the £5 allocation as set out in Section 5.2.2.

6.3.2 Recommissioning Community Health & Social Care Services

We are planning to undertake a full re-commissioning of community services based on a revised specification. Stakeholders including GPs will be involved in developing the vision and model for the new service which would become operational during 2016.

6.3.3 Safe Compassionate Care for Frail Older People

We have identified providing ***Safe, compassionate care for the frail older person*** as one of the key transformational projects within our 5 Year Strategy. Our 2 Year Operational Plan on a page at Appendix 1, which details the plans for this group of patients.
We have framed our thinking about local whole-system integration in the context of the emerging "House of Care" model for B&NES (see: "Delivering better services for people with long-term conditions – Building the house of care, The Kings Fund, October 2013), which we will continue to develop and embed over the next five years. The Better Care Fund will be a key enabler in developing and enhancing our integrated model of care, being used to secure new service development that have, in a number of cases been piloted and evaluated against key outcomes and,

also to increase capacity in key health and social care services, including that are or will be accessible on a 24/7 basis.

6.3.4 Special Educational Needs Reform (SEND Reform)

We will become responsible for Special Educational Needs Commissioning from September 2014. We have plans to implement the reform of education, health, social care planning to include:

- A Local offer of services for 0-25 age group
- Co-ordinated assessments
- Integrated plans 0-25
- Personal budgets

We are planning to invest recurrently to support the introduction of these reforms in 2014/15. The Joint Planning arrangements are being overseen by the Joint Commissioning leadership Team (JCLT).

6.4 Access to the highest quality urgent and emergency care

5 Year Strategic Ambition	• Deliver a sustainable and resilient urgent care system that ensures that patients are treated at the right time, by the right person in the right setting
Operational Actions Years 1 & 2	• Embed and evaluate the impact of the new Urgent Care Centre, Out of Hours and Homeless Service on the Urgent Care System • Demand and escalation planning - Evaluate and sustain winter pressure scheme initiatives that can evidence a positive impact on our system • Assess requirements and impacts of the Keogh Review • Review and agree Special Patient Notes usage across the local health system

Urgent Care has been identified as one of our transformational work streams within our 5 Year Strategy. We will be building on the successful work already undertaken to further improve and streamline the system and ensure sufficient capacity to respond to increasing demands from an ageing population and an increase in the number of people living with long term conditions.

6.4.1 Embedding the new Urgent Care Centre, Out of Hours and Homeless Service

From the 1st April 2014, B&NES will have a new integrated urgent care service provided by Bath Doctors Urgent Care. This represents a significant change to the location and delivery of local urgent care services as the GP led health centre at Riverside will be replaced by an Urgent care Centre at the front door of the RUH. During 2014/15 we will aim to ensure that these new service arrangements are fully embed and evaluated.

In 2014-16, we aim to review the role of the minor injury unit, and to continue to explore opportunities to develop ambulatory care pathways across primary and secondary care. Agreement has been secured on the use of the 70% threshold monies. In 2014/15 these monies will be invested in the RUH to support continuation of their successful application in 2013/14 in enhancing front door support to A&E (see section related to access). Other developments are detailed in our Operational Plan on a Page – see Appendix 1.

6.4.2 Demand & Escalation Planning

During 2013/14 the CCG has led a more robust approach to Demand and Escalation planning across our local health and care system. This has been part of our response to managing winter pressures. During 2014/15 we will identify those initiatives that can evidence a strong impact in supporting local providers to manage winter pressures and support through headroom monies where appropriate.

6.4.3 The Keogh Review- Urgent and Emergency Services

In January 2013, Professor Sir Bruce Keogh announced a comprehensive review of the NHS urgent and emergency care system in England. During 2014/15 the Urgent Care Working Group will begin to assess the implications of the emerging proposals from this review and their impact on the future of urgent care provision in B&NES and surrounding areas.

6.4.4 Special Patient Notes Project

Special Patient Notes (SPNs) provide specific information relevant to a patient with complex health and social needs. These are seen as an important mechanism for sharing information between providers of care but there problems currently with the way these are developed, accessed and maintained. We have agreed to establish a Task and Finish group to develop phased project plans, scope the SPNs already in place, develop guidance on the purpose and content of SPNs, data cleanse existing SPNs, incentivise practices to increase the use of SPNs and develop processes to share SPNs across services and the urgent care system.

6.5 A step-change in the productivity of elective care

5 Year Strategic Ambition:	• Innovative pathways of care will be in place with self-care and personalised care planning at their core • To deliver more cost effective and where appropriate community based pathways
Operational actions Years 1 and 2	• Review of 3 key elective pathways • Establish referral management support service across B&NES

6.5.1 Review of Key Pathways of Care

In 2014/15 we will be reviewing ophthalmology, pain management and the fibromyalgia (rheumatology) pathways. Our objective is to reduce activity pressures in these areas on acute services and find more effective community based approaches to supporting patients.

6.5.2 Reviewing and Redesigning Musculo-skeletal Services is one of the transformational work streams within our 5 Year Strategy. We are planning to develop proposals for an integrated Musculo-Skeletal service, working with existing providers, on an incremental basis but with a consistent aim to maximise quality, and achieve a step-change in productivity.

6.5.3 Referral Support Service in B&NES

We will be establishing a Referral *Support* Service for BaNES, a 'one-stop-shop' for selected secondary care referrals from GP surgeries that will benefit patients, GP practices and commissioners. It will have a number of benefits, whilst supporting the concept that GPs maintain independent, clinical judgement:

- Support fully informed patient choice.
- Support the aim of *'right clinic, first time'.*
- Reduced administrative burden in practices.
- Provides a rich source of referral information that supports pathway usage and policy development, and its implementation.

6.6 Specialised services concentrated in centres of excellence

We will continue work with NHS England on the commissioning of specialised services to ensure that service delivery and changes consider the whole of the patient pathway and not just the specialised service aspects and to understand the potential impacts of specialised commissioning service developments on our local providers.

During 2014/15 we expect to contribute to the following service issues working through the BGSW Specialised Commissioning Collaborative Forum.-

- Vascular Services Re-configuration
- CAMHs
- Cystic Fibrosis services
- Radiotherapy
- Spinal Surgery

We have recently received the "Plans on a Page" of the Strategic Clinical Networks and we have reviewed these to ensure there is alignment with our plans. For 2014/15 and will need to continue to consider how we secure on-going representation to these fora within our capacity constraints.

6.7 Meeting Other National Requirements: -

6.7.1 Information & Innovation

Interoperability of IT systems is one of the key transformational projects within our 5-year strategy. The CCG recognises the potential benefits that arise through exploiting clinical data and makes a clear reference to this in the IM&T strategy. During 2014/15 work to complete the Data Strategy will develop across the three themes of Routine administrative data, User data & My data. While the linking of hospital and GP data through care.data has been paused, we are maximising the use of similarly combined data for risk stratification and population profiling. This is now in place across all practices in the CCG and represents a valuable asset in understanding the health of the population. Contractual levers are included with robust Information Schedules and Data Quality Improvement Plans in place with local providers ensuring their use of NHS Number.

The main acute trust has access to digital records in approximately 50% of practices in BaNES. A web portal is being developed in collaboration with the RUH to allow practices to view a limited set of data, starting with patients who are fit for discharge.

The current social care record does not enable the use of the NHS Number as the primary identifier. However, by April 2015 Sirona Care and Health will move to a single, integrated care record by April 2015. 2014/15 BCF non-recurrent funding will be used to support the transition of the adult social care record to this single, integrated record, which is likely to be that currently used by acute and about half of primary care providers.

Improvements in local Information Systems and improvements in how we use Information Management and Technology will directly lead to improvements in patient care. Our community health and social care provider Sirona will work in partnership with our GP practices to review patients in a multi-disciplinary setting. The outcome of these reviews, including any decisions or referrals made will be digitised and made available in the health record available to both the GP and health and social care partners. This will ensure a consistency of care across the primary and community sectors.

Building on this, we have identified the sharing of Special Patient Notes as a key intermediate step on the path to full interoperability. During 14/15 we will develop the route to the sharing of this specific patient information between primary care and all other relevant providers using a single IT system.

Technology Libraries – Sirona Care & Health is working with a number of partners including Bath Institute of Medical Engineering to offer technology to support people with dementia to maintain independence. The launch of the library was held on 3rd April 2013 and an independent website went live on 12th July 2013 to showcase the products available (http://memorytechnologylibrary.co.uk).

We have piloted the use of telecare in the management of heart failure patients for a small group of patients. Public health colleagues are reviewing the evidence base to determine where we might wish to invest in telehealth and telecare to maximise the benefit for patients.

In addition to the Nurse Technology Fund bid for FFT, in February 2014 we submitted two other expressions of interest bids to the Nurse Technology Fund. Supported by us, the BaNES practice nurses and practice managers worked hard to identify shared priorities across all practices in order to improve patient experience and care. The bids were for

1: SurgeryPods to support improved health checks
2: Dopplex Huntleigh Ability to support the early identification peripheral arterial disease

6.7.2 Access to services – convenient for everyone

We are planning to deliver all the NHS Constitution Targets in 2014-16. There have some areas of performance concern in 2013/14 regarding 4 hour waits, ambulance response times, mixed sex accommodation breaches and some waiting time targets for access to treatment for cancer patients. Appendix 2 details our performance in delivery of the NHS Constitution in the current year.

The Urgent Care Working Group will lead and manage movement towards delivery of system wide operational resilience plans with capacity and management systems supporting flow across the whole of the urgent care system. These changes will impact on waiting times in the emergency department and the use of beds, including the need to accommodate patients in mixed sex accommodation.

New penalties are being introduced for poor performance in delivering the Category A targets by the ambulance service. We are investing in an enhanced service to support the non-conveyance of patients, where appropriate and to deliver improved performance for the Category A targets to meet locally agreed trajectories across the 2 years of the contract. These improvements will also contribute to a reduction in attendances at the emergency department.

We have recently undertaken a review of the impact of non-recurring allocations made in 2013/14. We are committed to investing the threshold monies, i.e. 70% of the marginal tariff and £966K of proposals have now been assessed as being required all year round. A number of the schemes for which funding has been agreed from 2014/15 will support 7 day coverage. These include additional Emergency Department Consultants; support for the Older Person's Unit; Surgical Admissions Unit; medical ambulatory care; critical care and the Assessment and Consultant Evaluation Unit.

Our plans for the Better Care Fund will enable continuation of 7-day hospital social work services & the core reablement service, which is focused on hospital discharge both of which are currently s256 funded. Implementation of the Community Cluster model will see further enhancement of 7-day services to support discharge, including the District Nursing Service and the Access Team. Patients requiring an urgent response regarding potential admission to the "virtual ward" will be seen within two hours by a member of the Multi-Disciplinary Team (MDT). Patients requiring planned interventions will be seen within 24 hours. The expanded integrated reablement service funded from the BCF will operate from 07:00 hours to 23:00 hours, seven days a week. The emergency response replacement care service for Carers is accessible 7-days a week and established protocols are in place and recognised by emergency services and primary care.

During 2014-15 we are funding increased capacity in the out of hours emergency response service for social care, including the Approved Mental Health Practitioner service in light of the significant increase in activity over the past 12-months, which we are now satisfied is a longer-term trend. This service interfaces with the adult social care services provided by Sirona Care & Health and Avon & Wiltshire Mental Health Partnership NHS Trust.

6.7.3 Outcomes and Ambitions

Everyone Counts is a commitment from NHS England to improving outcomes in five key domains:

1. Preventing people from dying prematurely, with an increase in life expectancy for all sections of society
2. Making sure that those people with long-term conditions, including those with mental illnesses, get the best possible quality of life
3. Ensuring that patients are able to recover quickly and successfully from episodes of ill-health or following an injury
4. Ensuring that patients have a great experience of their care
5. Ensuring that patients in our care are kept safe from harm and protected from all avoidable harm

The domains have been translated into a set of specific measurable outcome ambitions that will be the critical indicators of success, against which progress can be tracked. Our trajectories for the first two years of the plan are detailed in Appendix 3 – Measures of Success.

6.7.5 Parity of Esteem

A current system weakness common with many other health and social care communities is that we think of people with mental health problems in B&NES as opposed to thinking about the mental health of people in B&NES.

To respond to the Parity of Esteem requirements set out within *Everyone Counts* the challenge for the CCG, our local providers and other stakeholders is to consider more widely the mental health of people in B&NES through our strategies, planning, contracting and performance management . This approach will require:-

- Workforce development plans to show how providers will change their skill mix and support training for staff
- The assessment of someone's mental health and offering psychological support should become routine
- Mainstreaming prevention, promotion and self-management

This change of approach will require a cultural and operational shift driven through commissioning processes. Our 2 year operational plan includes a number of service developments that evidence our intent to have a greater focus on parity of esteem.

These include:-

- Establishment of a Well-being College in 2014/15 – jointly commissioned between the Local Authority, Public Health and CCG.
- The establishment of Peer Support Workers in Acute Mental health settings
- Piloting of an on line counselling service for Young People
- Investing recurrently in mental health liaison support in the RUH
- Rolling out social prescribing

Our 2014/15 investment plans include a total investment of £0.469m directly in mental health related services, with a further £0.340m in supporting dementia related projects and further investment in integrated projects addressing mental and physical health needs.

7. Our Commitment to Quality

Quality is integral to everything we do as a CCG and we are committed to providing a culture of continuous improvement and innovation with respect to patient safety, clinical effectiveness and patient experience. As reflected in both A *Call to Action* and *Everyone Counts*, we will ensure that quality is central to our local plans. This commitment is underpinned by sustained and effective collaboration within primary, community and secondary care and in partnership with other agencies and organisations and with the public

Improving quality is a wide-ranging agenda and in order for it to be implemented efficiently and effectively it is essential to maintain awareness with regards to the diversity of health and care in BaNES. We will build on developing trust between partners and the public with a willingness to share good practice whilst learning from adverse experience and enhancing our knowledge and skills. Learning from the Francis Report, Winterbourne View and the Berwick Report reminds us that improving quality is as much about our behaviours and attitudes to our patients as it is about ensuring services improve.

7.1 What is quality

Quality may be defined as the continuous improvement in effectiveness, experience and safety of health and social care services for the people of Bath & North East Somerset (BaNES) provided within available resources. The three subdomains of quality are:

7.2 Patient Safety

The first dimension of quality must be that we do no harm to patients. This means ensuring that within the services we commission the environment is safe and clean and that avoidable harm such as excessive drug errors or rates of healthcare associated infections are reduced. To achieve this aim we will work, in partnership, and listen to our patients and staff to ensure that commissioned services are provided by the right people with the right skills that are in the right place at the right time

7.3 **Effectiveness of care** (which encompasses cost effectiveness, equality and diversity),

This means understanding success rates from different treatments for different conditions

7.4 Patient/ service user/ carer experience (accessibility, acceptability and appropriateness)

Quality of care includes the compassion, dignity and respect with which patients are treated. It can only be improved by understanding patient satisfaction with their experience and to achieve this, consideration is given to a wide range of information

7.5 Quality Strategy and Delivery Plan

The CCG Quality Strategy and Delivery Plan for 2014-2016 is aligned to this Operational Plan and contains more detailed milestones on how we will achieve our goals. Our quality objectives for 2014/15 and 2015/16 are set out in our Operational Plan on a Page at Appendix 1.

Our commitment to quality is central to the CCGs values and we will not tolerate sub standard care. Over the next two years we will build on existing strengths to :

- Adopt a person-centred approach that includes treating individuals, including children and young people, their family and carers courteously and with compassion, involving them in decisions about their care, keeping them informed and learning from them
- Focus on continually improving the quality of services
- Be credible, creative and ambitious on behalf of our local population
- Work collaboratively and be respectful of others
- Be alert to the needs of all our population, particularly those who are most vulnerable
- Establish a positive, open and fair and lifelong learning culture
- Ensure that the values underpinning equality, diversity and human rights are central to our policy making, service planning, employment practices and community engagement and involvement
- Achieve continuous improvements in person centred care which is safe, effective, timely, efficient, equitable and that outcomes are measurable and that areas of variation are reduced
- Operate with integrity and trust
- Ensure staff are properly inducted, trained and motivated and there is a high level of staff satisfaction and opportunities for innovation
- Empowering staff with responsibility and freedom to deliver safe care

7.6 The Patients' Experience

Public and Patient Engagement (PPE) is a core priority for the CCG and is integral to its quality and patient safety responsibilities because it is about the quality of care and the experience that patients have of the NHS whilst receiving care. The CCG is committed to achieving a modernisation and re-shaping of services for BaNES and is engaged in the NHS England's '*The NHS belongs to the people: a call to action'* with further events planned. Consultation with the public over each proposed change is at the very core of all new service proposals and a 'Your Health, Your Voice' Group has been established

Engaging with individuals including children and young people and delivering equality, diversity and human rights is embedded throughout the work of the CCG and this partnership is integral to achieving our objectives. Our participation activities will take into account barriers associated with language, age, access to information and disability etc. We will plan our participation to ensure it reaches people who find it more difficult to get their views heard as well as being mindful of those disadvantaged and minority groups such as Gypsies and Travellers for instance to ensure services which suit their circumstances are, where possible, specifically tailored for them

7.7 Quality in Commissioned Services

The CCG commissions services from a number of providers and is associate commissioner, working in partnership with the lead CCG for others. The Quality, including patient safety, patient experience and clinical effectiveness of provided services is assured through quality schedules, commissioning for quality and innovation indicators (CQUIN), monitoring of the quality impact of cost improvement schemes and site visits of our major providers

Our Quality Strategy details how we respond to the Francis Report. We work with our providers through the appropriate mechanisms to support them in implementation of the Francis Report and the Compassion in Practice and Berwick recommendations in particular:

- Learning from complaints.
- Requirement for candour.
- Nurse training in compassionate care, leadership and culture re-enforcing values and standards.
- Ensuring the right staff, with the right skills in the right place and supporting a positive staff experience
- Each patient to have an allocated named nurse for each shift.
- Healthcare support workers to be distinguishable from registered nurses.

Through their Quality Account our key providers of secondary, community and mental health and learning disabilities health care have demonstrated a commitment to improving outcomes for BaNES patients, in relation to improving patient experience, reducing admissions and further reducing avoidable harm. The CCG will work closely with its providers of health care to ensure that they achieve this commitment to our population and that the local action as required within the implementation plan for 'Compassion in Practice' National Nursing, Midwifery and Care Givers strategy is reflected in the services we commission

The quality schedules into which each year we will build increasingly Specific, Measurable, Achievable, Realistic and Timely (SMART) Quality and Outcome measures and the Commissioning for Quality and Innovation (CQUIN) indicators allow for early identification of failing services and specialities and the mechanisms for early identification is via the contractual mechanism in the first instance and then on to the CCG Quality Committee and Commissioning College and the CCG Board or more rapid escalation if required

The CCG also liaises with others in the system such as Care Quality Commission (CQC) and where there are significant concerns about the quality of services, these may be shared. In certain and unusual circumstances it may be necessary to decommission services that do not provide a high quality service and to reinvest in services that do meet the requirements

7.8 Improving Patient Outcomes

It is essential when reviewing services and then deciding priorities that the CCG draws upon data from a variety of sources, both hard (quantitative) and soft (qualitative) data, and to triangulate this data to obtain a rounded view of quality. This analysis will also include identifying where there is unwarranted variation in quality within the BaNES area compared to comparator areas elsewhere.

7.9 Examples of recent initiatives with expected patient outcome measures

7.9.1 Compassion in Practice

In February 2014, the CCG was successfully awarded £15,000 by NHS England to set up a staff development project designed to improve compassion in practice. Providers have worked collaboratively to deliver a programme that will be accessed by Health Care Assistants (HCAs) and support staff working at the Royal United Hospital (RUH), Royal National Hospital for Rheumatic Diseases (RNHRD), Dorothy House Hospice and Sirona Care & Health. This will be achieved through:

- A suite of Master Classes – aligned to the End of Life Care Pathway
- Facilitated Action Learning Sets – to support more focussed discussion on topics within a smaller group size, will allow for broader depth of learning, discuss applications to own practice and provide a network of facilitated supervision of practice.

Outcome measures include

- Evaluations of the Master Classes
- Evaluations of Action Learning Sets
- Pre post evaluation questionnaires of HCAs, Support Workers and managers to establish impact of learning and effect on care provision
- Care plans and documentation will be evaluated by staff groups from the Action Learning Sets

7.9.2 Commissioning for Quality and Innovation (CQUINS)

The CCG is working with providers to review essential service standard and to set goals for quality improvement as part of the Commissioning for Quality and Innovation (CQUIN) framework for 2014/15. Our CQUIN focus for 2014/15 is:

- End of Life Care
- Heart failure
- Sepsis Management
- Antimicrobial prescribing
- Care of frail older person

Our proposals for the Quality Premium are detailed in Appendix 2. These include the national requirements with our local proposals for:

- Reducing the potential years of life lost from causes considered amenable to healthcare
- Improving access to psychological therapies.
- Reducing avoidable admissions.
- Friends and Family Test rolled out.
- Improving reporting of medication-related safety incidents.
- Assessing actively ageing people for frailty and adding them to the frailty register if appropriate.

7.9.3 Safeguarding Vulnerable Children, Young people and Adults

Working with partner organisations and health providers to protect vulnerable children, young people and adults is a key priority for BaNES Clinical Commissioning Group. Some patients and members of the public may be unable to uphold their rights and protect themselves from harm or abuse. They may have greatest dependency on our services and yet be unable to hold services to account for the quality of care they receive. In such cases, we have particular responsibilities to ensure that those patients receive high quality care and that their rights are upheld, including their right to be safe.

The CCG Adult and Children's Safeguarding service is designed to ensure that the B&NES population are in receipt of safe, high quality services. Integral to this is assurance for people who use services, and their carers that the delivery of services is based on the following themes:

a. Strategic clinical leadership
b. Quality care
c. Partnership working
d. Robust contract management

We are working with our partners including local police, social care, education, care homes and other local statutory and voluntary organisations and with our GP practices and other health care organisations to strengthen arrangements for safeguarding adults and children in BaNES. Within the CCG, Children's and Adults' safeguarding issues are considered in detail at the Serious Incident, Complaints and Safeguarding Committee which reports to the Quality Committee and, in turn, to the CCG Board.

We are the major commissioner of local health services for the BaNES community and therefore responsible for safeguarding quality assurance through contractual arrangements with all provider organisations. All BaNES CCG contracts for commissioned services include safeguarding adult and children standards

Acknowledging that the Local Authority remains the safeguarding lead, the CCG Safeguarding Action Plans also considers work that the CCG can usefully achieve by pooling resources, producing joint policy and procedures, and working together where it makes sense and is appropriate to do so.

7.9.4 We have identified our safeguarding priorities for 2014/15 and 2015/16:

We will ensure that BaNES CCG continues to meet all its statutory safeguarding children responsibilities and is compliant with the NHS England Accountability and Assurance Framework, and that the safer recruitment processes are complied with

Working with both children and adult health and social care services and families, we will develop strengthened strategies in health and in partnership for helping children and families cope with transition and change and minimise the risk of harm occurring during transition

We will work with GP Practices in strengthening their engagement with safeguarding children and adults processes by:

- Developing a training programme in partnership with NHS England Area Team

- Support the implementation of the general practice-based domestic violence and abuse (DVA) training support and referral programme (Identification & Referral to Improve Safety-IRIS) which has been funded by the CCG in partnership with the Police and Crime Commissioner

Prevent: is one of the four elements of 'Contest', the government's anti-terrorist strategy. The Adult Safeguarding Lead has been working with Providers to ensure they all recruit named Prevent leads. Prevent is now included in the National NHS Contract for 2014/15 and has accordingly been added to the Adult Safeguarding strategy.

There is also continued engagement with Public Health to ensure the Joint Strategic Needs Assessment (JSNA) appropriately identifies the needs of the whole population including those with Learning Disabilities and that these needs are incorporated into the commissioning strategy. This ensures the CCG will continue to implement the important requirements of Transforming Care: a national response to Winterbourne View Hospital

8. Financial Plan 2014-16

8.1 Financial Strategy

Our financial strategy, as set out in our 5 year strategy document, 'Seizing Opportunities', is designed to support the achievement of our priorities for the local health and care community whilst meeting all our statutory financial duties and targets. The key elements of the strategy are, in summary:

- realistic, risk based financial planning and management
- use of clinical intelligence, comparative data and procurement mechanisms to continually test whether resources are well directed
- effective use of the resources, levers and incentives available to us, including investment, disinvestment, transitional funding, and emerging contractual and payment flexibilities
- a proactive and collaborative approach to designing and delivering change, sharing risk and gains equitably

8.2 2014/15 and 2015/16 Financial Plan

The tables below provide a summary of the financial plan which supports delivery of our 2 year operational plan for 2014/15 and 2015/16. The 2014/15 plan also constitutes our proposed budget for the year. It should be noted that further non-material detailed adjustments will occur as contract values are confirmed and other minor issues resolved.

	2014/15 Plan		
	Recurrent £000	Non-recurrent £000	Total £000
Sources of Funds			
Commissioned Services Allocation	(211,985)	0	(211,985)
Running Costs Allocation	(4,655)	0	(4,655)
Other Anticipated Allocations	0	(3,062)	(3,062)
Total Sources of Funds	(216,640)	(3,062)	(219,702)
Applications of Funds			
Commissioned Services	166,492	4,169	170,661
Primary Care & Prescribing	29,206	960	30,166
Running Costs	4,654	0	4,654
Reserves	9,094	1,930	11,023
Total Applications of Funds	209,446	7,059	216,505
Planned Surplus	(7,194)	3,997	(3,197)

	2015/16 Plan		
	Recurrent £000	Non-recurrent £000	Total £000
Sources of Funds			
Commissioned Services Allocation	(215,589)	0	(215,589)
Running Costs Allocation	(4,178)	0	(4,178)
Other Anticipated Allocations	0	(3,197)	(3,197)
Better Care Fund Allocation	(3,345)	0	(3,345)
Total Sources of Funds	(223,112)	(3,197)	(226,309)
Applications of Funds			
Commissioned Services	171,812	1,975	173,787
Primary Care & Prescribing	30,626	618	31,244
Running Costs	4,176	0	4,176
Reserves	11,319	3,519	14,838
Total Applications of Funds	217,933	6,112	224,045
Planned Surplus	(5,179)	2,915	(2,264)

The plan assumes the following, in accordance with the planning requirements of 'Everyone Counts':

- income in accordance with the notified resource allocations for commissioned services and running costs
- running costs expenditure within the notified allocation, including delivery of a 10% cost reduction in 2015/16
- in 2014/15 a net decrease on Acute Services contracts of 1.2% against the 2013/14 recurring forecast out turn, comprising a 4% efficiency target and 2.8% inflationary uplift. In 2015/16 the net decrease is assumed as 1.1% due to provider inflation of 2.9%
- an equivalent net decrease on the majority of Non-Acute based contracts of 1.8%, with efficiency targets at 4% and inflation recognised at 2.2%
- non-demographic growth for Continuing Health Care and Prescribing within the nationally recommended range
- a planned surplus of 1% (£2.197m) in 2014/15 with an additional £1.000m relating to maintaining the additional surplus generated in 2013/14. In 2015/16, a planned surplus of 1% (£2.264m) with the £1.000m released within the position and assumed as non-recurrent investment capability
- headroom set aside for non-recurrent investment at 2.5% in 2014/15 (£5.300m), with 1% of this to support transformation including preparatory work associated with the Better Care Fund. In 2015/16 we are only required to hold headroom of 1% (£2.189m)
- general contingency of 0.5% (£1.099m) in 2014/15 and 1% (£2.263m) in 2015/16
- £5 per head to support practices in transforming the care of patients over 75
- CQUINs funded at 2.5%
- increased demand due to population growth of 0.77% in 2014/15 and 0.66% in 2015/16
- the additional investment required of the CCG to create the full value of the Better Care Fund in 2015/16

We have assessed the impact of the above assumptions and of our QIPP and investment schemes on activity for each provider to ensure contractual and system-wide activity plans are consistent. Where we anticipate activity changes, the financial impact is based on a costed assessment of the movement in activity.

8.3 Investment Plans

Within our plans we have set aside monies for investment in unavoidable cost pressures and to support delivery of our commissioning priorities. We have a robust Prioritisation and Investment Framework and scrutiny process to ensure approved investments meet key criteria relating both to alignment with our operational and strategic priorities and to deliverability.

We approved investments, as summarised at Appendices 4 and 5, under the following headings through this process:

- non-recurrent proposals suitable for funding from headroom
- previously committed or otherwise unavoidable investment
- recurrent proposals delivering quality and/or value for money improvements

We also concluded that it would be prudent to hold uncommitted recurrent and non-recurrent sums to meet emerging in-year investment priorities, including seasonal pressures in urgent care and proposals which were not fully developed for consideration at plan stage.

We have recognised other sources of investment in our plans, as follows:

£5 per head of population for GPs – this has been set aside in our 2014/15 plan and we will agree plans for its use with our GP practices which fairly reward extra work undertaken in support of the over 75s which delivers measurable benefits. We will focus particularly on implementing the accountable lead professional role and in reducing emergency admissions for this age group. Our priority areas for use of this funding include continuation of our successful nursing home enhanced service, engagement with the community cluster model, and the use of Special Patient Notes.

Quality Premium – the value of quality premium relating to 2013/14 which we will receive during 2014/15 is as yet unconfirmed, so we have excluded both funding and expenditure from our financial plans at present. We intend to apply the full value available to engaging non-GP primary care contractors and third sector organisations in our work to support frail elderly people.

Readmissions – we have committed to reinvest funding withheld from providers in respect of avoidable readmissions in services which are linked to improvement in this area. Our current areas of focus are the Acute Care of the Elderly Unit at RUH and community-based reablement services.

Non-elective threshold – we have committed to reinvest funding withheld at 70% of the full cost of non-elective activity above a set threshold, to support providers in schemes linked to effective management of emergency activity.

8.4 Resource Releasing (QIPP) Plans

Our resource releasing (commissioner QIPP) schemes for 2014/15 and 2015/16 are summarised at Appendix 6, along with the investments required to deliver them, giving the net contribution made by each scheme. Schemes have been identified to the required level of £3.967m in 2014/15 and £4.179m in 2015/16. Resources released through QIPP are reinvested to fund areas of improvement, development or growing demand.

Provider efficiency targets are set at £6.192m for 2014/15 and £6.109m for 2015/16, giving a total efficiency gap for the health community of just over £10.000m each year.

8.5 Better Care Fund

Our plans include the CCG's contribution to creating the Better Care Fund for BaNES to a value of £12.049m in 2015/16. We have built on our existing financial commitments to the delivery of integrated care locally, and have jointly agreed plans which complement both CCG and Council financial plans through alignment with established and emerging QIPP, savings and investment projects.

8.6 Running Costs

We plan to manage our delivery capability within our allocated funding envelope for running costs. This will decrease by 10% in 2015/16 and we have developed proposals for reducing our costs to within the revised allocation, through reduction of spend with our commissioning support provider, review of our staffing structures and the balance of our capacity, and efficiency savings on non-pay items. The impact of these is included within our total QIPP plan for 2015/16.

8.7 Capital Expenditure

Having reviewed our priority programmes of work in consultation with NHS Property Services, we do not anticipate any significant changes to existing estate as a result of our plans and have not included any capital expenditure in our financial plan. Our focus in 2014/15 is to work with NHSPS to ensure excess or underutilised space is either disposed of or tenanted, removing costs of vacant space chargeable to the CCG. This forms part of our resource releasing plans.

8.8 Cash and Balance Sheet

We have prepared initial cash flow and balance sheet forecasts for 2014/15 and 2015/16, and do not anticipate any difficulties with either cash flow or working capital during the planning period.

8.9 Financial Risk and Mitigation

We have reviewed the financial plan for 2014/15 and 2015/16 in detail to assess and quantify the level of risk to delivery. Five areas of potentially significant risk have been identified:

- increased demand in non-elective activity above that anticipated in the plan, and including acuity as well as volume factors
- under-delivery of QIPP schemes
- tariff not delivering the expected level of deflation when applied to local activity
- service-specific risks including the Urgent Care Centre new service model and the complexity surrounding services provided by the RNHRD
- under-delivery of our running cost savings target

Financial mitigation of the consequences, should any of these risks materialise, will be achieved through:

- use of general and specific contingency reserves
- diversion of uncommitted investment funds
- review of planned investments for potential delay or reduction in costs
- over-delivery or bringing forward of alternative QIPP schemes
- risk-sharing arrangements with partner organisations

9. Improving Care in Year's 1 and 2 of the Plan

Our 5 year strategy represents a "build-on" to the work we have previously undertaken on urgent care, long term condition management and the development of community services but also signals a new and greater focus on how the CCG supports and influence the role of Prevention and Self care

across the system and focus on some of the “enablers” and changes that are required across the system to improve performance and secure sustainable local services.

The CCG has developed a one page summary of our 2 Year Operational Plan on a Page, which details the key initiatives in 2014-16 based on areas of care. This can be viewed at Appendix 1. The plans include a mix of initiatives, those which build on the work already started in the current year and those which start to implement the 6 priority work streams within our 5 Year Strategic Plan.

The diagram at Appendix 2shows the progress we expect to make during the period of the operational plan to implement our strategic priorities.
Something here re measuring success

10. Risk Management

Risk and Mitigation

In relation to the delivery of CCG's 2 year Operational Plan there are a number of key risks which have been identified as follows:

Risk	**Mitigation**
Urgent care system performance – sustaining delivery of the 4 hour target and system resilience with a particular risk associated with the patient flow changes associated with the Southmead move.	Oversight and leadership of the Urgent Care Working Group. Agreement on on-going funding to support winter pressure initiatives that have proved to be effective.in 2013/14. A continued focus on demand and escalation planning.
GP engagement - reduced GP engagement into the commissioning process against a backdrop of increasing GP workloads and competing pressures	CCG to review its engagement process with practices and GP Clusters.
RNHRD – the future of services provided by the RNHRD remains subject to the RUH's Foundation Trust application and confirmation of Monitor's view on the range of options to ensure continuity of service provision. there are on-going uncertainty about timing h this process	CCG to continue to work closely with the RNHRD and, Monitor. The CCG will align commissioning objectives for Rheumatology and other services with the potential sequencing of changes to local provision.
Capacity and Capability to deliver the CCG's 2 year operational plan priorities.- The CCG has an ambitious programme of work and may not have sufficient capacity and skills to deliver the operational plan.	Internal review of CCG capacity and structure in April 2014. Impact assessment of plans to be carried out jointly with Central Southern Commissioning Support Unit.

11. Assurance and Approvals

Everyone Counts: Planning for Patients 2014/15 to 2018/19 sets out the arrangements for the assurance of plans should contribute to the development of plans and who is responsible for ensuring their work triangulates with these plans. The

National Condition	**Produced By**	**Formal Assurance**	**Evidence of how our plans meet the condition**
Plans to be jointly agreed - Providers and Local Authority to contribute to development	Operational Plan – produced by CCG	NHS England to provide formal assurance. Triangulation by : • Providers • HWB • Local Authority and Unit of Planning	CCG Board sign-off on 27/03/2014 and Health & Wellbeing Board sign-off 26/03/2014 of 5 Year Strategy, Better Care Fund and Operational Plan. Full Council (18/02/2014) delegated sign-off of the Better Care Plan to the Health & Wellbeing Board in consultation with the Council's Chief Executive, Leader and Cabinet Member for Resources