Appendix 2

Bath & North East Somerset

Better Care Plan

2014/15 – 2018/19

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Chapter 1 Our Inspiration

"It's much easier of course to think that there is a pill that will cure, rather than to decide to go and put on your coat and hat and walk down the street and find something, that's much more challenging, that's why you need help to do it. But in the long run much more rewarding because you will make friends from doing that" (Older Person feedback in relation to services that help to address social isolation)

"It's a lot better than being in hospital. It's just like home from home. You can't beat it. It has helped me come back to the reality of life with the support I have had." (Stroke Survivor, talking about Step Down from Hospital Service)

Chapter 2 Our Vision

Our vision is to provide care and support to the people of Bath & North East Somerset (B&NES), in their homes and in their communities, with services that support people to take control of their lives and reach their potential and are characterised by:

- 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.

Chapter 3 Delivering Our Vision

The starting point for our vision of the future is predicated on existing levels of integration within B&NES. Commissioning of adult and children's health and social care has been integrated since 2009. 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. Our commitment to 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.

Since 2009, provision of community health and social care services for adults has been led through a single management structure. From October 2011 the community services formerly provided by the PCT and Council have operated as an independent Community Interest Company (Sirona Care & Health CIC). Integrated health and social care services to people with mental health problems are provided by multi-disciplinary teams that are co-located through partnership arrangements between the Council, CCG and Avon & Wiltshire Mental Health Partnership NHS Trust (AWP). For B&NES the Better Care Fund acts as a further enabler and structure to build on and expand existing joint commissioning and provision.

We see daily the benefit of close working between health, social care and third sector partners and we know from our experience the energy required to maintain an integrated approach to care. Our focus for the future is on further alignment of resources that influence the wider determinants of health and wellbeing. To this end, we will maintain a focus on developing patterns of behaviour in our communities that promote active aging, positive reablement and strong, empowered citizens.

In the current climate we believe that harnessing the good will, commitment and energy of our partners and our communities to co-produce solutions will deliver the best outcomes for local people.

Our plan for whole system integration is ambitious and ground-breaking, reflecting and building on the established integration of commissioning and provision. Our plans encompass not only mental health, physical health, social care, public health and housing but also further alignment of the resources, services and partners that influence the wider determinants of health and wellbeing. We have looked far beyond service and organisational boundaries to ensure community connectivity, mutual learning and support.

Our Transformation

In order to create a community where individuals have the power to choose and control their own integrated solutions, we are embarking on a radical and exciting transformation of the way we all work together. Key elements of this transformation are:

- Putting power in the hands of the individual – power to decide, power to ask, power to share information.

- Systems, processes, pathways and solutions that are: flexible; coordinated; communicating; connecting; offering choice; simple and easy to access; efficient; and focused on wellbeing and maximising independence.
- Hearing the voice of the individual – "*nothing about me without me*", self-directed, engaging the ideas and stories of older people today and tomorrow.

Our vision and plan for whole system integration has been developed and endorsed by a broad range of partners, including: The Care Forum, host of Healthwatch B&NES; the Royal United Hospital Bath; Dorothy House Hospice; Sirona Care & Health CIC; Curo Housing Group; Age UK B&NES; Avon & Wiltshire Mental Health Partnership NHS Trust; B&NES Council and BaNES Clinical Commissioning Group. B&NES Health & Wellbeing Board is the Sponsor of our 5-year programme, the implementation of which will be overseen by a Programme Board, with members reflecting the breadth of our partnership and which will report to the H&W Board.

Our Compact

We will articulate and underpin our commitment to whole system integration by developing a local integration compact, which sets out how we all work together to improve outcomes for local people. Our initial exploration of what we understand by *"whole system integration"* gives us a platform on which to base our compact. Large or small; public, private or third-sector; commissioner, provider, service user or carer; our individual perspectives are diverse but our understanding of whole system integration has a high level of resonance.

Our compact, seeks to align the "I" statements in *Making It Real: Marking progress towards personalised, community based support* with "We" statements that set out our commitment to the people and communities we serve and to the way in which we will work together.

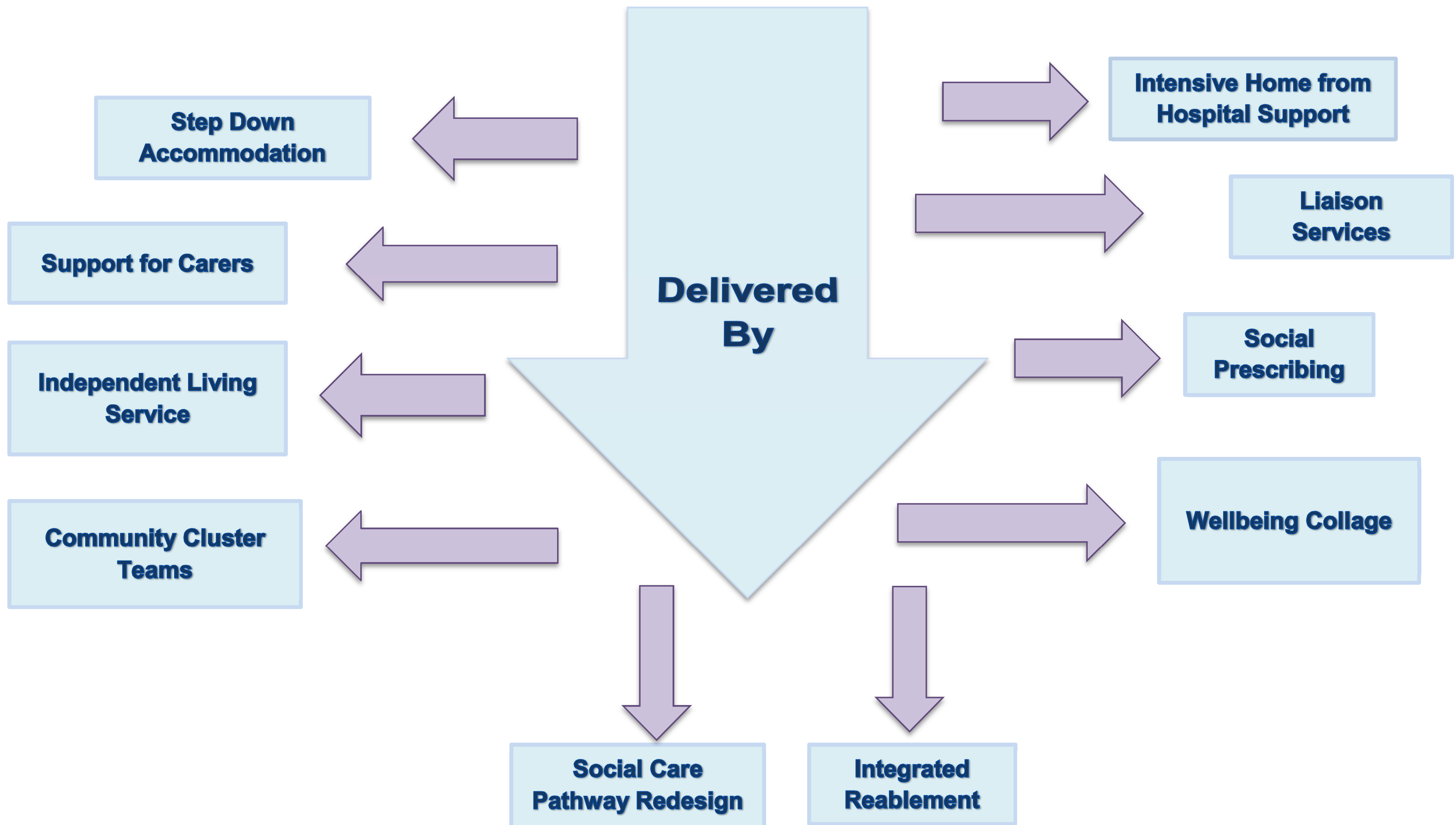
Our compact is likely to include:

- We will share our power and believe the most important person to share power with us is the individual.
- We will integrate pathways and services around individuals.
- We will support individuals to identify their Personal Guide who might be a family member, friend, neighbour, voluntary sector or 'professional' person who would agree to adopt this role. We will train Personal Guides and support them to help individuals to develop their personal Life Map, which clearly articulates their wishes and identifies their likely support needs and how they would like these to be met.
- We will respect the role and position of the Personal Guide as advocate for the individual and they will be treated as an equal partner within the integrated system.
- We will formally recognise the role of Personal Guide and will, to some degree, be willing and able to forego our own individual agency need to further assess and evaluate once there is an agreed personal Life Map protocol in place.
- We will take into account a person's whole life, including physical, mental, emotional and spiritual needs.
- We recognise that there is really important cultural change associated with whole system integration and will use a variety of means to support that cultural change.
- We will further develop *Living Life to the Full: A Joint Older People's Strategy for B&NES* as a fully integrated strategy for people aged 65+ and align our individual plans with the principles set out in this integrated strategy.

- Whilst our initial emphasis may be on those older people with the highest risk profile, we will not lose sight of the value of focusing energy and attention on prevention, early intervention, reablement and self-care. This will include provision of integrated support to carers so that they feel they are not struggling to cope alone and can take a break from their caring responsibilities.
- We will actively seek to harness the wider community offer, extending integration beyond organisational or service boundaries, focusing on people within their natural communities, including promoting positive opportunities for interaction between young people and older people.
- There is life beyond our 5-year programme - we will engage with people aged 50+ to understand what we should be designing for the future. We will engage and involve young people. We will, harness their skills and creativity as well as influencing and being influence by the culture of future generations.

Your House of Care

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. Key components of our integrated system are described in the diagram below along with the overall aims and objectives we are seeking to achieve. 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 7-day or 24/7 basis.



Integrated Care and Support
Delivered By
Step Down Accommodation
Support for Carers
Independent Living Service
Community Cluster Teams
Intensive Home from Hospital Support
Liaison Services
Social Prescribing
Wellbeing Collage
Social Care Pathway Redesign
Integrated Reablement

Community Cluster Team Model

The overarching aim is to deliver an integrated approach from virtual teams which are aligned with the five practice clusters in B&NES in order to respond in a sustainable way to the increasing volume, complexity and acuity of older people and those with long term conditions.

The key objectives are to:

- Provide better coordinated services giving GPs and community staff more time to provide face to face care for those with greater need
- Increase focus on early intervention to prevent people's health and social circumstances deteriorating
- Utilize the risk stratification tool proactively to identify people who are at most risk of loss of independence or hospital admission
- Develop a sustainable model of care that responds to the growing pressure of more and sicker people being cared for in the community
- Prevent hospital admission and admission to long term institutional care as well as facilitating timely and safe discharges from acute and community hospitals
- Support patients with long term conditions to self-care and feel self-empowered in the management of their condition

There is a high degree of inter-operability between the community cluster model and social care pathway redesign, which includes increased Social Work capacity funded from the Better Care Fund ensuring input into integrated, personal care plans and multi-disciplinary planning.

Social Care Pathway Redesign

The overarching aim is to deliver an integrated service that will support and safeguard older and vulnerable people to remain independent through timely interventions that contain, stabilise, decrease and/or de-escalate emerging risks, care and support needs. This will involve a shift in focus and of resources to the 'front end' of the social care pathway to place greater emphasis on prevention and early intervention.

For those who appear to be in need of social care services, within the current eligibility framework, a short-term, intensive period of integrated reablement to reduce or delay the need for a long term package of care and support will be offered. This significant expansion of the reablement service is being funded from the Better Care Fund pooled budget, with early implementation, anticipated to be from July 2014, to be funded from Council reserve.

For those with the most complex needs the model will focus on in depth assessment, support planning and regular review to avoid the need for hospital/residential admission or escalation of need.

In facilitating these fundamental changes in the adult social care pathway, the key objectives are to:

- Enhance opportunities for co-producing solutions with potential service users and carers
- Be explicit about the intended outcomes of interventions, placing a stronger emphasis on the achievement of independence

- Prioritise the development of enabling approaches, in the broadest sense, as well as specific service interventions to support recovery
- Challenge the assumption that services will always continue at the same level for relatively long periods of time
- Promote a culture within adult social care that engenders independence and community inclusion
- Empower people to remain in control of their own lives by extending self-directed support and direct payments

Hospital discharge initiatives

The following initiatives were tested as extended research pilots and, following evaluation, which included service user engagement, joint-funding will continue as part of our Better Care Fund plan.

- Step Down Accommodation, Care & Support – delivered through a partnership between Sirona CIC and Curo Housing Group; and
- Intensive Home from Hospital Support – delivered through a partnership between Age UK and Care & Repair HIA.

Both these initiatives, delivered through partnerships of local Voluntary, Community & Social Enterprise (VCSE) organisations, have been evidenced to reduce length of stay in hospital and delayed transfers.

Liaison Services

We are already investing in a range of innovative liaison services as follows:

- Mental Health Primary Care Liaison;
- Alcohol liaison provided by the Specialist Drug & Alcohol Services based at the Royal United Hospital (RUH);
- Primary Care provided Care Home Liaison;
- Psychiatric liaison service provided by AWP based at the RUH.

These services play a key role in securing a model of integrated care that is not limited to community health and social care services but extends across the system to embrace acute, primary, secondary, and specialist services ensuring that individuals' experience is one of seamless service delivery with the organisations delivering those services taking a holistic and co-ordinated approach. We will keep capacity within liaison services under review, utilising additional Better Care Fund monies as and when appropriate.

Wellbeing College Pilot

The Wellbeing College Pilot is the first step in a system wide transformation project and, depending on the results of the pilot, may lead to a full open tender being released in 2016. As well as being a vehicle for increasing the levels of early intervention to address health and social care needs and increasing the capacity of the local community in self- management of long term conditions, the Wellbeing College Pilot is intended, if the model is successful following this proactive market testing and development phase, to be an essential element of the transformation of all local health, public health and social care services.

The overarching aim of the Wellbeing College Pilot is to contribute to our ability in B&NES to actively facilitate 'whole life' recovery and wellbeing based support and resilience within the community to enable people to stay out of hospital, in their own homes and communities, and near to their social networks wherever possible.

Mental Health Reablement

B&NES has one of only two adult of working age Mental Health reablement services in the country. This, along with community support services and the addition of three pre-crisis/respite beds in a community setting will enhance the ability of community services to intervene early without escalation into secondary mental health services. It is proposed to pilot this model over two years as an addition to existing services to ensure consistency and enhance value for money.

The current draft *Crisis Concordat 2013* written by a range of national organisations and led by clinicians emphasised the need to have step-up and step-down facilities and teams to help avoid admission to hospital and to prevent crises from occurring.

The DoH's early policy implementation guide (PIG) for Early Intervention Services (EIS) advises that avoidance of lengthy hospitalisation can be facilitated through the provision of community respite units. These facilities provide a local, low stigma setting where crises or impending crises, not requiring formal admission, can be effectively contained and which can also promote expedient discharge from hospital.

Social Prescribing

Social Prescribing can be defined as providing *"a pathway to refer clients to non-clinical services, linking clients to support from within the community to promote their wellbeing, to encourage social inclusion, to promote self-care where appropriate and to build resilience within the community and for the individual"* (Developing a Social Prescribing approach for Bristol, Dr Richard H Kimberlee, University of the West of England, October 2013).

A social prescribing initiative has been operating in Keynsham since 2009. The service has demonstrated an improvement for people in mental wellbeing and general wellbeing; and a trend was identified towards a reduction in the use of NHS resources after 12 months of clients' engagement with the SP scheme.

The intention is to review learning from both the local service and from other models in order to extend the evidenced benefits of a holistic social prescribing service across Bath and North East Somerset with a particular focus on our local pockets of social deprivation.

Emotional Health & Wellbeing for young people

The School Health Unit Survey (SHUE) and the Primary and Youth Parliaments in 2013 have highlighted increased concerns among children and young people around self-esteem and emotional wellbeing and resilience. We wish to test the provision of an open access on-line counselling service that young people can access from 10am to midnight daily, which would supplement the current Primary Child and Adolescent Mental Health (PCAMHS) and CAMHS services.

The pilot will be provided by Mindfull, a national programme helping young people to improve and sustain positive mental health, emotional resilience and wellbeing.

Support for Carers

The B&NES Joint Adult Carers Commissioning Strategy, agreed by the Health & Wellbeing Partnership Board (the precursor to the Health & Wellbeing Board), is underpinned by a pooled carers budget, which has been in place since April 2012.

The overarching aim of both the national and local Carers Strategy is: *Carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals needs enabling carers to maintain a balance between their caring responsibilities and a life outside of caring, whilst enabling the person they support to be a full and equal citizen.*

Key objectives set out in the Strategy, which are in line with the high level outcomes to be achieved for carers set out in *"Recognised, Valued and Supported: next steps for the carers strategy"* (Department of Health, 25 November 2010) are to:

- Support those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages;
- Enable those with caring responsibilities to fulfil their educational and employment potential;
- Provide personalised support both for carers and those they support, enabling them to have both a family and community life;
- Support carers to remain mentally and physically well.

The provision of integrated care and support to carers provides a very strong foundation for delivering both our overall vision for Bath and North East Somerset but also key requirements of the Care Bill 2013-14 when it comes into law.

Chapter 4 Engagement

Our vision and plan for whole system integration was developed and endorsed by a broad range of partners, including: The Care Forum, host of Healthwatch B&NES; the Royal United Hospital Bath; Dorothy House Hospice; Sirona Care & Health CIC; Curo Housing Group; Age UK B&NES; Avon & Wiltshire Mental Health Partnership NHS Trust; B&NES Council and BaNES Clinical Commissioning Group. B&NES Health & Wellbeing Board is the Sponsor of our 5-year programme.

The Joint Health and Wellbeing Strategy, which was agreed in September 2013, was informed and shaped by a formal consultation period, which launched on 30 April and ran until 7 June 2013. Consultation responses were received from a range of stakeholders including health and social care providers and VCSE sector organisations, members of the public and service users.

Engagement on the Better Care Fund plan has being aligned with consultation on the CCGs operational and strategic plans. Specific engagement took place with the Health & Wellbeing Board Strategic Advisory Group which comprises representatives of the large local health and social care providers, and is chaired by the Chair of the H&W Board. The role of the Better Care Fund as part of the CCG's 5-year Strategic Plan was included within the second stakeholder workshop on 27th February, which focused on agreement and content of priority workstreams, and the third stakeholder workshop on 13th March, which reviewed proposed governance arrangements.

Chapter 5 Governance

The governance structure underpinning the implementation of ***'Seizing Opportunities',*** the CCG's 5-Year Strategy will include the implementation of our Better Care Plan. These arrangements reflect the views expressed during the stakeholder consultation, that transformational change can be delivered more successfully, maximising benefits for all the participating organisations if the change programme is managed on a system wide basis. The proposed programme management arrangements are based on sound change management principles, the philosophy of Managing Successful Programmes (MSP).

A Transformational Leadership Board ("the Board") will oversee implementation and be accountable to the participating organisations governing bodies. The Board is accountable to the participating organisations governing bodies and will report to the Health & Wellbeing Board. The governance structure is illustrated in diagrammatic form in Annex 4.

These specific governance arrangements sit within the context of a Joint Working Agreement between the Council and CCG. A Joint Commissioning Leadership Team meets monthly, providing assurance to the Council Cabinet, CCG and Health & Wellbeing Board that commissioning intentions and plans are aligned and will deliver agreed priorities and strategic objectives. The partners have also recently established a Joint Committee for the Oversight of Joint Working, which monitors and reviews the effectiveness of the partnership arrangements and the outcomes delivered.

Lead commissioners have signed individual agreements giving them formal accountabilities to act across and on behalf of both partner organisations. Embedded processes for integrated performance management and risk-assessment and mitigation will provide a sound platform on which to build in order to support oversight by the Health & Wellbeing Board and assurance to all partners.

Chapter 6 The financial implications

In developing our plans for jointly funded services from 2014/15 onwards, our starting point has been the scale and scope of our existing transfers from health to the Council and the integrated services that they support. We have reviewed the existing plans for application of that funding and have concluded that the schemes which it supports are aligned with the aims of the Better Care Fund and are demonstrating a level of success which justifies their continuation.

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. A summary of schemes to be funded from the Better Care Fund is included at Annex 5.

We have assessed the impact of our Better Care Fund plans on local health services, in particular the acute sector, to ensure our success is not delivered at the cost of destabilising the important services provided by our partners in this sector. The system benefits from our well-established foundation for the creation of the Better Care Fund, in that we have for some years now used existing flexibilities to progress the development of integrated care initiatives and support for social care services, most notably s75 and s10 pooled budgets and s256 transfers in excess of nationally mandated levels. This has demonstrated that the introduction of schemes supported by all parties, at a well-managed pace which recognises realistic timing differences between the introduction of new approaches and the realisation of benefits, is achievable without destabilising otherwise sustainable providers whose income may reduce as a result.

We have quantified the impact as requiring the CCG to deliver QIPP (resource releasing) schemes in 2015/16 at a level which is approximately 25% higher than in the previous year or in subsequent years, at 1.8% of total income compared to 1.4% in other years. There is also an increase in the value of schemes impacting directly on acute health care services, attributable to a range of factors including the creation of the Better Care Fund. The impact is manageable to this level through the existence of two factors:

- Transfers in excess of the nationally mandated minimums are already in place locally, with the funding relating to these released from other services at a managed pace in prior years
- The CCG has elected to use monies released from the reduced requirement to hold headroom for non-recurrent schemes from 2015/16 to fund part of the increased Better Care Fund contribution. Whilst this mitigates the direct impact on acute providers, we recognise that there is an indirect impact in that this reduces the monies available to support the development of transformative ideas within the health system

We believe this level of impact on acute providers can be managed without destabilising otherwise sustainable organisations, if mitigated by careful sequencing of financial flows. We will use the capability offered by the Better Care Fund and by remaining CCG headroom investment to support providers to respond to change in a phased manner which sustains safe and stable services through periods of transition. This will include supporting providers to reduce or reshape their cost base in response to reductions in income, and supporting reasonable periods of double running whilst change initiatives take effect.

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.

We intend to continue with our existing pooled budget arrangements but do not envisage incorporating them fully into the Better Care Fund in its first full year of operation. We will keep this under review during 2014/15 and if we believe a consolidation is deliverable in a sustainable way, we will progress this.

Managing financial risk

We recognise the risk that not all initiatives included in the Better Care Fund plan may deliver the quantitative improvements envisaged, or may deliver to a lesser scale or at a slower pace than planned. A specific risk attaches to the Better Care Fund in that 25% of the value is attached to demonstrably improved outcomes, and funding may be diverted to alleviate pressure on other services if outcomes are not delivered. Both the Council and the CCG have robust processes for managing financial risk, which will be applied, should the need arise, to ensure that successful schemes are able to continue alongside the diversion of any funding.

To mitigate financial risk this we will have the following arrangements in place:

- Regular monitoring of financial and performance metrics through both the Council's and CCG's internal reporting mechanisms, alongside the wider project governance arrangements described above
- A clear understanding that schemes not demonstrating delivery of either qualitative or quantitative objectives will be subject to review and may be terminated
- Use of non-recurrent funding sources to manage reasonable timing differences and double running costs
- Use of contingency reserves to support recurrent gaps