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Democratic and Members Support
Chief Executive's Department

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HEALTH AND WELLBEING BOARD

Thursday 26 March 2015
10.00 am
Warspite Room, Council House

Members:
Councillor Sue McDonald (Chair)
Counicllors Ian Tuffin and Dr John Mahony.

Statutory Co-opted Members: Strategic Director for People, NEW Devon Clinical Commissioning Group representatives, Director for Public Health, Healthwatch representative, NHS England Devon Cornwall and the Isles of Scilly representative.

Non-Statutory Co-opted Members: Representatives of Plymouth Community Homes, Plymouth Community Healthcare, Plymouth NHS Hospitals Trust, Devon Local Pharmaceutical Committee, University of Plymouth, Devon and Cornwall Police, Devon and Cornwall Police and Crime Commissioner and the Voluntary and Community Sector.

Members are invited to attend the above meeting to consider the items of business overleaf.

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Tracey Lee
Chief Executive

HEALTH AND WELLBEING BOARD

PART I (PUBLIC COMMITTEE)

1. APOLOGIES

To receive apologies for non-attendance by Health and Wellbeing Board Members.

2. DECLARATIONS OF INTEREST

The Board will be asked to make any declarations of interest in respect of items on this agenda.

3. CHAIR'S URGENT BUSINESS

To receive reports on business, which, in the opinion of the Chair, should be brought forward for urgent consideration.

4. MINUTES (Pages 1 - 6)

To confirm the minutes of the meeting held on the 5 February 2015.

5. FEEDBACK FROM THE MENTAL HEALTH SOLUTION WORKSHOP (Pages 7 - 12)

The Board to receive an update from the Mental Health Solution Workshop.

6. PHARMACEUTICAL NEEDS ASSESSMENT - TO FOLLOW

The Board to sign off the Pharmaceutical Needs Assessment.

7. INTEGRATED HEALTH AND WELLBEING (Pages 13 - 34)

The Board to receive a presentation on Integrated Health and Wellbeing.

8. CARE ACT (Pages 35 - 66)

The Board to receive a presentation on the Care Act.

9. FAIRNESS COMMISSION UPDATE (Pages 67 - 70)

The Board to receive an update on the Fairness Commission.

10. EXEMPT BUSINESS

To consider passing a resolution under Section 100A(4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business on the grounds that it (they) involve the likely disclosure of exempt information as defined in paragraph(s) of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.

PART II (PRIVATE COMMITTEE)

AGENDA

MEMBERS OF THE PUBLIC TO NOTE

that under the law, the Panel is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

Nil.

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Health and Wellbeing Board

Thursday 5 February 2015

PRESENT:

Councillor McDonald, in the Chair.
Dr Richard Stephenson, Vice Chair.

Ian Ansell – Office of the Police and Crime Commissioner, Veryan Barneby - Community and Voluntary Sector, David Bearman - Devon Local Pharmaceutical Committee, Carole Burgoyne - Strategic Director for People, Peter Edwards - Healthwatch, Tony Fuqua - Community and Voluntary Sector, Dr Paul Hardy - NEW Devon CCG, Ann James - NHS Plymouth Hospitals Trust, Councillor Dr. Mahony, Kelechi Nnoaham - Director of Public Health, Councillor Tuffin and Clive Turner – Plymouth Community Housing.

Apologies for absence: C/Sup Andy Boulting - Devon and Cornwall Police, Lesley Gross - Community and Voluntary Sector and Steve Waite – Plymouth Community Healthcare.

Also in attendance: Richard Grant - Local Planning Manager, Caroline Marr – Policy and Planning Business Officer, Nicola Jones – Commissioning Lead, Rob Nelder – Public Health Consultant, Chris Slocombe and Chris Bowden – Marketing Means, Ross Jago – Lead Officer and Amelia Boulter – Democratic Support Officer.

The meeting started at 10.00 am and finished at 12.25 pm.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

35. DECLARATIONS OF INTEREST

There were no declarations of interest made.

36. CHAIR'S URGENT BUSINESS

The Chair reported that Amanda Fisk who represented NHS England has stepped down from the Health and Wellbeing Board. This Board is required by regulation to keep the seat open for NHS England to attend. A request would be sent to Anthony Farnsworth for a nominee.

The Chair also proposed that the Board meeting scheduled for 23 April 2015 would be replaced with a development session. At this development session would be an opportunity to review the work of the Board over the last year and to consider how the Board would work in the future.

Agreed that all Board Members attend the development session on 23 April 2015.

37. **MINUTES**

Agreed that the minutes of 20 November 2014 were confirmed.

38. **PLYMOUTH PLAN**

Richard Grant, Local Planning Manager and Caroline Marr, Policy and Business Planning Officer presented the Plymouth Plan to the Board. It was reported that -

a) the Plymouth Plan (Part One) – consultation draft plan went to Cabinet on 9 December. The consultation on Part 1 of the plan, the strategic framework commences on 21 January until 4 March. This was an attempt to bring together all the strategies into one strategic framework to shape Plymouth for the future and includes the Health and Wellbeing Strategy;

b) the purpose of bringing the plan today was to ask partners for support to ensure the right messages were contained within the plan for the city. The Plymouth Plan would go to Full Council in June 2015 and work was underway on Part 2 of the plan, the more technical planning document;

c) this was ground breaking work bringing together all the different agendas that would drive the city forward;

d) the children's agenda does need to be strengthened and have met with the Children and Young People's Partnership to discuss this.

In response to comments and questions raised, it was reported that -

e) they fully recognise the delivery of the plan and getting the plan right would require the input from a wide range of organisations. They have used community groups to consult with to develop policies and would continue to do this;

f) one of the principles is a clear strategic framework and they wouldn't get involved in the delivery of some of the principles. They weren't the experts and have devolved the delivery to partner organisations that were;

g) this was an ambitious plan but the plan doesn't quite capture what the voluntary and community sector was doing and its commitment. This was the feedback that was needed and welcomed and need to work out the correct way into the voluntary and community service and to recognise the importance of building this into the plan;

Agreed that –

1. The Health and Wellbeing Board is happy with the direction of travel for the Plymouth Plan (Part One) – consultation draft plan.

2. The Health and Wellbeing Board to review the Plymouth Plan in the municipal year.

3. Each organisation to take part and provide feedback on the Plymouth Plan.

39. **CHILDREN AND YOUNG PEOPLE'S PLAN**

Judith Harwood, Assistant Director for Learning and Communities provided the Board with an overview of the Children and Young People's Plan. It was reported that –

a) the plan had been revised and gathered under 4 objectives -
   - Raise Aspirations
   - Deliver Prevention and Early Help
   - Deliver an Integrated Education, Health and Care Offer
   - Keep our Children and Young People Safe

b) the Children and Young People's Partnership was not a commissioning partnership and seeks to complement the commissioning strategies;

c) representation from most statutory partners on the partnership to ensure children and young people's needs were met as well as providing support and challenge to the plan;

d) as part of the accountability for the partnership, the partnership was expected to report to this board on progress and expect challenge from this board and vice versa.

Please click on link below to access terms of reference for Children and Young People's Partnership.

ToR subcommittee HWB.docx

40. **PHARMACEUTICAL NEEDS ASSESSMENT**

David Bearman provided an update on the Pharmaceutical Needs Assessment. It was reported that consultation had taken place which ran from 17 November 2014 to 16 January 2015. The Health and Wellbeing Boards of Devon, Cornwall and Torbay worked together to produce a single approach to the document and would like to thank Sarah Ogilvie for her co-ordination of this approach.

The consultation was hosted by Plymouth City Council and 5 individuals completed the on-line consultation and feedback received was around ease of use. The Steering Group met last week to discuss how to take points on board and amendments would be made. The Pharmaceutical Needs Assessment would come back to the Health and Wellbeing Board on 26 March 2015 for ratification.

Agreed that the Pharmaceutical Needs Assessment to come back to the Health and Wellbeing Board on 26 March 2015 for ratification.

41. **URGENT AND NECESSARY MEASURES**

Nicola Jones, Commissioning Lead provided the Board with an update on Urgent and Measures now being referred to as Potential Interim Disinvestments. It was reported that the CCG had responded to the worsening financial circumstances by introducing a list of urgent and necessary measures. Following feedback and engagement from the public, stakeholders, clinicians and a range of organisations, the CCG's approach has altered and some of the services under review are believed to be more suitable as referral guidance to clinicians.

In response to questions raised, it was reported that -

a) with regard to emotional impact on people, have taken that point back to the officers working directly on those measures and was a constant balance in getting the services right across the board;

b) they were looking to help people with lifestyle changes and were not saying that you can't have the operation;

c) communication around urgent and necessary measures was not handled as well as could be and the CCG were asked to make decisions quickly to try and resolve the financial situation;

d) the CCG undertook some considerable consultation and took on board the emotional content and the CCG now have the opportunity to reflect and the measures would go through a finer sieve to ensure people get the best for their health spend.

The following comments were made –

e) we do not have limitless resources and at the same time do not want to worsen health inequalities for the local population. In Plymouth still grappling with the missing millions and dealing with some decisions if they were implemented would be a 'risk' to certain populations but difficult choices do have to be made;

f) this was a very complex set of issues in the short term and strategically and there was a need to be clear on what the drivers are, are they financial or clinical evidence based. If the clinical evidence base they should be part of an on-going programme. This was the tip of the ice berg and what were the other things that needed to be addressed and much bigger in terms of costs. This Board to look at the bigger issues and focus on the Western Locality;

g) the CCG made some proposals and the combination of the media knocked this proposal off track. There would be bigger decisions to face down the line and this Board to support the CCG when they make these tough decisions;

h) this Board signs off the commissioning principles and when we disinvest do not want to destabilise the system when the board makes tough decisions.

The Health and Wellbeing Board agreed New Devon CCG's current position in relation to disinvestments and further discussion would take place at the Development Day on 23 April 2015.

42. **WELLBEING SURVEY**

Rob Nelder, Public Health Consultant reported that they undertook to carry out the Wellbeing Survey because they weren't good at measuring wellbeing and to generate baseline information for Plymouth. It would enable them to focus on wellbeing over time. Colin Slocombe and Chris Bowden from Marketing Means provided the Board with a presentation on the Wellbeing Survey. Please click on link below to access the Wellbeing presentation.

PCC017 2409_Wellbeing_pres

In response to questions raised, it was reported that -

a) to get a representative sample, the data had been weighted and half of the sample received from 60 years plus. Then weighted by ward and was a representative as a sample of this size;

b) the break down was to a locality and ward level, they could come down to post code level but were looking at very low numbers in particular areas;

c) the data collected would start to inform the work around 4-4-54 (Thrive Plymouth). The Public Health team would be undertaking a series of deep dive events and would be inviting experts to discuss in more detail how to address the 4 behaviours in the city. ;

d) they were looking a repeating the Wellbeing Survey every 2 to 3 years to ensure that progress had been made.

Agreed that the Health and Wellbeing Board note the Wellbeing Survey.

43. **EXEMPT BUSINESS**

There were no items of exempt business.

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Health and Wellbeing Board Solution Shop

Report and findings from the

Mental Health workshop

Plymouth Mental Health Provider Network

Introduction

On Friday 7th November, Plymouth Mental Health Network hosted a solution shop for the Plymouth Health and Wellbeing Board Solution on mental health. Members of the Board, community and voluntary sector, service representatives, public health, commissioners, carers and people with lived experience of mental illness, met to discuss the mental health system and hopes for the future.

Feedback described the event as a success with many attending to share their expertise and aspirations with the health and wellbeing board, and raise key issues for Plymouth to support the Board in its role

- Promoting the health and wellbeing of people in Plymouth,
- Overseeing the Health and wellbeing Strategy and….
- Ensuring systems and processes make best use of resources and
- Supporting the prevention, health and wellbeing agenda

After a short presentation from network representatives highlighting the current systems, challenges and experiences of mental health services, those attending the workshop gathered on tables to discuss 'Bob'.

Bob represented someone in our lives who was experiencing varying levels of mental distress. Table groups discussed the challenges and needs for a mental health system that could offer Bob a service at various stages of a spectrum – maintaining his mental wellbeing, early intervention as he deals with life situations, crisis and suicidal behaviour, and long term mental health needs.

The groups were asked to focus on the following three questions rather than think about what we already have in place.

- What would help Bob?
- Who might be involved?
- How can the city deliver this for Bob?

Summary of Table Discussions

The results of the table discussions and flip charts have been compiled and the key themes raised are summarised below under each of the stages of Bob's journey as discussed.

Scenario 1 – Health Promotion and Mental Wellbeing

Bob is your average guy on the street. He has the usual ups and downs of life. He is aware of keep physically fit but does not think about his mental wellbeing. How do we address this?

A strong consensus across all tables that society needs to recognise mental health on a par with physical health and that we all need to be looking after both our mental and physical health together and that messages should go hand in hand, one should not be discussed without the other. It was also consistently raised across the groups that as a society, we need to work together proactively towards dispelling the myths and stigma around mental health.

It was accepted that work towards eliminating stigma was going to be a long term process not a quick fix solution. Such work was identified as requiring the following:

1. More joined up thinking amongst agencies and organisations.
2. That all agencies/organisations need to be sending the same consistent message, in particular that recovery is possible.
3. That work needs to link to existing frameworks and a concerted effort was needed to avoid developing further silos.

This raised the issue of how to connect and engage with individuals and communities, particularly as people find speaking about mental health issues difficult.

Practices perpetuating the existing stigma in society need to be addressed – this should begin with mental health and wellbeing promotion with children and young people within our schools. Initiatives such as Five Ways to wellbeing (CLANG – Connect, Learn, Activity, take Notice, Give) and Time to Talk are models which are clear, informative and easy to understand and as such could be considered as an appropriate message for younger people. Promotion amongst children and young people will assist in communicating the message wider within the home, i.e. to parents, sibling and family members.

Other social groups were also mentioned for the targeting of mental health promotion campaigns. For example, men and employers. There were suggestions that any mental health and wellbeing promotion should be packaged and used effectively, i.e. use of appropriate materials for the target group, focused distribution and targeted display areas.

Local, national and social media (particularly for young people) can also play a huge role in helping eliminate stigma around mental health – people should regularly read and hear positive messages about mental health and wellbeing rather than sensationalised stories about mental illness. Furthermore, it was recognised that access to up-to-date information for everyone was important to the process.

GPs are generally the first health professionals that people with an underlying mental health issue make contact with, yet there was a consensus that GPs needed to be better trained and educated in the subject of mental health. It was also felt that many patients themselves may find the current GP appointment systems (waiting times and 10 minute appointment times) as a barrier to opening up and discussing their mental health. Groups suggested that GP's with better mental health awareness could lead to patients being more appropriately diagnosed, treated or sign posted to other supporting agencies.

Scenario 2 – Early intervention

Bob split up with his long term partner 6 months ago. He is finding it difficult to cope financially. He is becoming isolated, not going out much and not maintaining his regular contact with you.

It was acknowledged that we all experience stressful, major life events. However, it was also acknowledged that the general population may not be aware of the triggers and stress-related behaviours associated with such events or how to stay well when they occur. It is believed that awareness and education focussed on mental wellbeing associated with life's pressure points could build resilience for such times. Tying mental health early intervention work to other services that deal with such life events (such as debt advice, family solicitor or redundancy advice services) would also help. Places where people might discuss life events (pubs, hairdressers etc.) could also have training and signposting creating mental health champions outside of the usual settings.

Stigma around mental health and employment is prevalent in actions and language within the workplace, and society in general – and it remains a significant issue and concern. It was emphasised that employers have a duty and responsibility to identify and discuss mental distress in their employees, yet it was accepted that the majority of employees would not choose to disclose a past or current personal mental health issue. It was suggested that workplace managers should be trained in identifying issues and equally be able to provide support. Despite mental health and wellbeing being on the equalities agenda there remained a great deal of work to be done in addressing mental health in the workplace.

People need to dispel the myths and help fight the stigma to work towards Plymouth becoming a truly inclusive city. One of the most useful and encouraging ways to achieve this is by reminding people that it is okay to talk about their mental health challenges, whether they talk to family and friends, as long as they start to talk. Indeed, these wider support systems play a very important role in early intervention.

Although family members and friends were considered an important part of early intervention, society now sees people living long distances from their family which limits the opportunity for them to identify and act on it. When visiting the GP, sometimes people find that they speak to GPs only about specific issues, which may not be focussed on their mental health. As mentioned previously, if GPs received appropriate mental health awareness training, their role in early intervention would be more complete.

Other suggested methods for early intervention from the group discussions were quite broad:

- Training all front line services to be more aware of indicators
- All public services to have mental health champions
- Seeing the implementation of social prescribing initiatives
- Support workers being based in GP surgeries
- Knowledge of services from across the sectors, including debt advice and counselling, of where to signpost people

Scenario 3 – Crisis Support

Police have brought Bob into A&E. he has increased his level of drinking and today he felt that he couldn't see a way out. He has now lost his job so his financial issues have got worse and he is still suffering following the breakup of his relationship.

Mental health is everybody's business, including all the public services. Acknowledging the work of the street triage initiative, it was believed that there was opportunity for A&E, other hospital department staff and emergency services to be more versed in mental health and more involved in recognising and signposting to appropriate services.

It was hoped that eventually there would be recognition in A&E departments that someone presenting with a drink problem, for example, will be treated as someone in crisis who would receive a holistic assessment including mental health screening with key questions to look for stress factors, thereby helping to address the drinking and the emotional state. This is recognised to be a more effective way of treating the person and achieving greater longer lasting results. In addition to this, it was stressed, that there should be follow up carried out, post crisis.

Discussion around the role of mental health professionals featured greatly (GPs, CHMT) but particularly in terms of the lack of continuity for individuals accessing mental health services. Current strains on the system mean that workers can change regularly.

It was also suggested that individuals would benefit from the better joining up in service provision (dual diagnosis) and, with reference to mental health assessments, it was strongly suggested that any such assessments should be performed by appropriately qualified practitioners.

The role of the community was also discussed and it was believed that some people in communities may be able to pick up and signpost someone in crisis, supporting the call for mental health champions. Depending upon the remit of the mental health champions it could be that they would be able to assist individuals to reconnect with their communities.

The role of peer support was also highlighted as important to recovery. Connecting to someone who has been through your journey can challenge the sense of isolation. It was also thought that within services, having one professional / link person accompanying the individual throughout their journey would be beneficial, developing a consistent, enduring relationship. This is good practise internationally.

Scenario 4 – Long term Mental Health issue

Bob has now been known to the secondary mental health services for a number of years. He has a chaotic lifestyle and finds it difficult to cope with everyday life. He has episodes when he is unwell and needs increased support, however there are also times in his life when he is relatively well and is able to look at positive actions to try to resolve some of his difficulties.

Groups discussed how individual mental health experiences can be, everyone's journey is different. It is important for all services to treat the individual and their lifestyle needs as unique and personal to them- not as part of generic 'one size fits all' response to need.

There needs to be an understanding of what helps keeps the individual well and what are the triggers for problems, this includes being aware that the individual would benefit from medical and social support groups as and when they desired. Choice and control over the service, frequency, duration and worker is instrumental in recovery.

Consequently access to varying levels of support that meet the individuals varying need must be considered. Current systems do not have an open door approach and it is difficult to re-engage at times when it's needed, people have to start again in the system. There was a call for better, smarter use of existing and future resources, with a reference to making them more easily available in the local community. Community support provides a more accessible, cost effective solution to acute settings and Specialists.

Individuals should experience a better consistency of care which could be in the form of having one professional attached to their care, and it was suggested that it should be each person's choice of worker.

There was a great deal of emphasis on empowerment of the individual – not just enabling them to be better informed of their rights but enabling them to make informed decisions and taking responsibility for such decisions. Indeed, advocacy and self-advocacy was deemed a very important issue. Furthermore, the promotion and implementation of documents such as the Advanced Statement of Wishes were considered key empowering experiences, supporting people to identify their own care needs that services can work to deliver when they are unwell.

The Equality Act requires employers to make reasonable adjustments for employees with a disability in order for them to continue with their work – and this includes those with a mental health condition. Groups suggested that employers should be more versed with such reasonable adjustments and encouraged to see that reasonable adjustments can make good business sense too. Also, there was a call for more opportunities for meaningful and supported occupation, enabling an individual to fulfil a goal that is personally and/or culturally meaningful, getting relevant vocational experience and improved pathways back to work.

Key points for the Health and Wellbeing Board

Considering the consensus of opinion about how a mental health system should work for Plymouth and for Bob, the mental health network would like the Health and wellbeing Board to consider the following points in delivering its workplan –

- How we can encourage and embed mental health and wellbeing promotion across the city – whether that be through existing initiatives and strategies (4-4-54) or through service expectations and contractual structures?
- How we can deliver mental health support in the widest community settings, and work with other service areas to take responsibility for championing mental health and wellbeing and identifying and engaging people?
- How can we support primary care to improve its offer to enable people experiencing mental distress to get the most appropriate response?
- How can we ensure mental health and wellbeing promotion starts as early as possible with children and young people?
- How we can support the development of a system which provides more choice and consistency for people in distress?
- How we can design services that can be more flexible to meet differing needs while providing an open door for people experiencing crises again in the future?
- How we can make mental health everyone's business so that contact with professionals and services include holistic assessments and mental health screening and response?

PLYMOUTH CITY COUNCIL

NHS
Northern, Eastern and Western Devon Clinical Commissioning Group

Integrated Health and Wellbeing

Delivering “One System, One Budget”

Why are we doing this?

- Significant health inequalities
- Requirement to focus on providing Best Start to Life
- People experiencing fragmented services
- Greater complexity of needs & rising demand
- Financial challenges
- Political consensus
- Do nothing option - rationing and reduction
- Or Transformation to improve public services

People have told us

“I want services that support me to manage my situation in life not just my condition”

“I want the information I need to make healthy choices and stay healthy, and to have systems in place that can help me at an early stage to avoid a crisis”

“I want the ability to talk to a health or social care professional when I need to and to tell my story once - share my information with colleagues”

“I want to be able to have services provided in lots of different places, at a time that suits, me having choice and control over the care I need”

“I want access to a range of services that support me and the people who care for me to lead a full and healthy life”

HWB Board Vision of Integration

Integrated Commissioning	• Building on co-location and existing joint commissioning arrangements the focus will be to establish a single commissioning function , the development of integrated commissioning strategies and pooling of budgets.
Integrated Health and Care Services	• Focus on developing an integrated provider function stretching across health and social care providing the right care at the right time in the right place. • An emphasis on those who would benefit most from person centred care such as intensive users of services and those who cross organisational boundaries
Integrated system of health and well being	• A focus on developing joined up population based, public health, preventative and early intervention strategies. • Based on an asset based approach focusing on increasing the capacity and assets of people and place

Our Response to the Integration Challenge

- **Creating One System**
  - Integrated Governance Arrangements
  - Integrated Commissioning Strategies covering Cradle to Grave
  - Commissioning of Integrated Health and Social Care Provider
- **Creating One Budget**
  - Section 75 between PCC & NEW Devon CCG
  - Pooling Funds of £460 million
  - Underpinned by Risk Share and Financial Framework

Section 75 - Overview

- Section 75 of the National Health Service Act (2006) (formerly Section 31 of the 1999 NHS Act) provides the framework for health bodies and local authorities to pool money, delegate functions and integrate resources and management structures. The framework allows for the commissioning of existing or new services and provide for arrangements for working together.
- Section 75 has been drafted by Plymouth City Council Legal Team based on Bevan Brittan model

Overview of integrated fund by partner contributions

Net Integrated Fund £462m	
PCC Net Contribution £131m	**CCG Net Contribution** £331m

Net Pooled Fund £241m		Net Aligned Fund £221m	
PCC Contribution £123m	CCG Contribution £118m	PCC Contribution £8m	CCG Contribution £213m

Notes

PCC contribution is based on full 14/15 gross People Directorate and ODPH commissioned contracts budgets
Gross PCC contribution based on 14/15 budget is £308m
CCG contribution is based on 14/15 budget
Changes will be made to these figures as budgets are finalised for 15/16 and services included in the integrated fund become further defined

Integrated Fund by Strategic Area

Pooled

Children and Young People £43m	Wellbeing £17m
Community Based Care £149m	Complex Care £32m

Aligned

Children and Young People £8m	Wellbeing £0m
Community Based Care £3m	Complex Care £210m

Further identified contributions and income to pooled funds are:

Central/back office running costs of CCG	£7m
Staffing related costs within Adult Social Care	£14m
Grant and service user income	£22m

Integrated Commissioning Board

- The Board will:
  - Act as the **single health and wellbeing commissioning body** for the City of Plymouth for people of all ages and will commission in line with the priorities identified in the Joint Health and Wellbeing Strategy
  - Provide **focus and direction** for the integrated commissioning function to ensure that it achieves the strategic objectives of the partners of the fund
  - Encourage **collaborative planning** and ensure that integrated commissioning is working well
  - **Monitor** the performance of the integrated commissioning function and ensure that it delivers the statutory and regulatory obligations of the partners of the fund
  - Provide **assurance** to the governing bodies of the partners of the integrated commissioning fund on the progress and outcomes of the work of the integrated commissioning function

ICB Key Functions

- **Commissioning Leadership for Health and Wellbeing**
  - The **Health and Wellbeing Board** will continue to act **as system leaders** for Health and Wellbeing in Plymouth and will set the **strategic direction** in the Health and Wellbeing Strategy, informed by the Joint Strategic Needs Assessment
  - The Integrated Commissioning Board will commission in line with the Joint Health and Wellbeing Strategy through the development of four **integrated commissioning strategies** to ensure **integrated service delivery, improved outcomes** and a focus on **reducing inequalities**.
  - Produce **reports for the Health and Wellbeing Board**, to report on the progress of integrated commissioning
  - The Health and Wellbeing Board will hold the Integrated Commissioning Board to account for the promotion and delivery of integrated commissioning

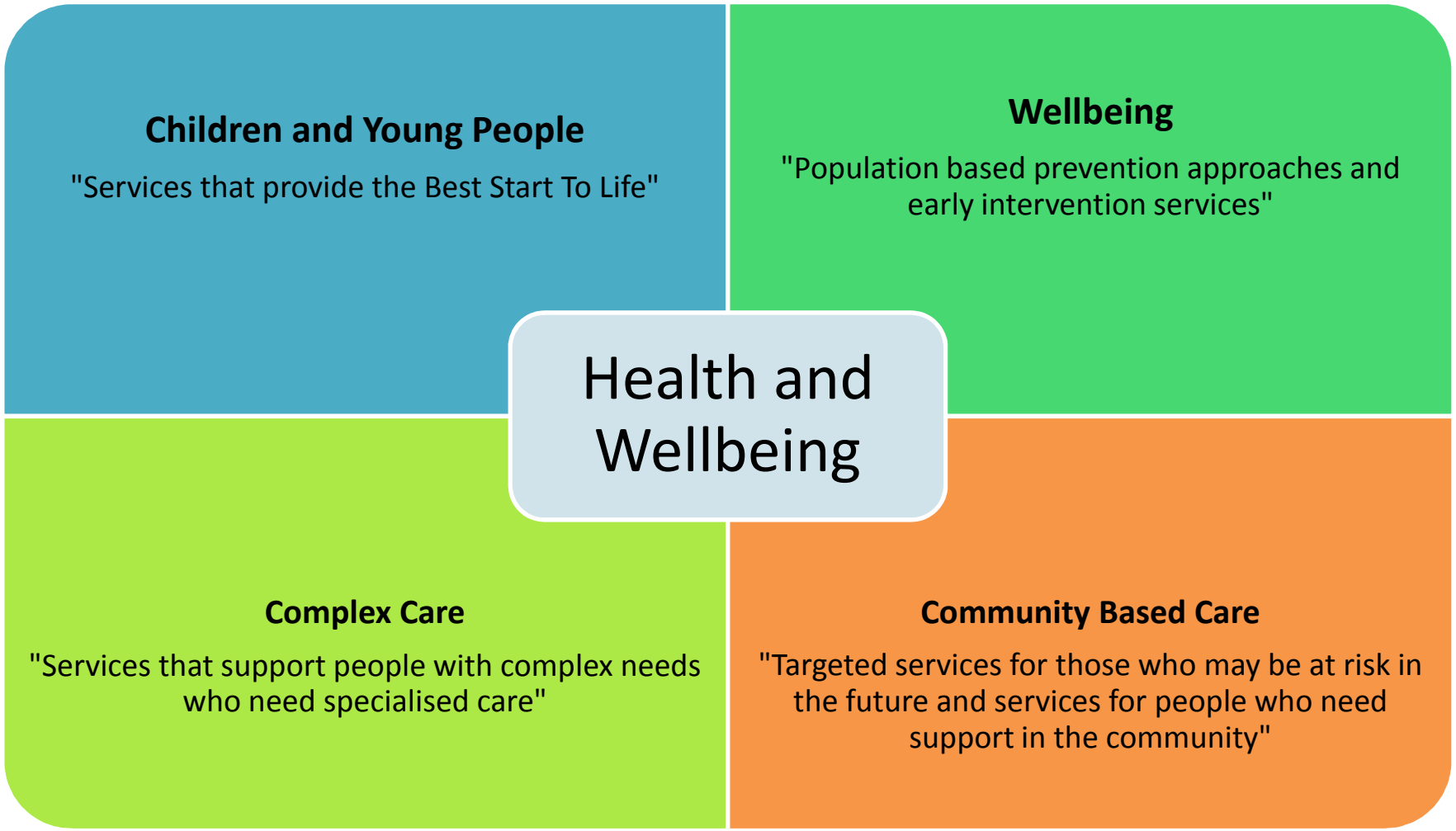
ICB Key Functions

- **Promoting and ensuring integrated commissioning**
  - Approve proposals for the priorities of the integrated commissioning approach to address the issues highlighted through the joint strategic needs assessment and by the Health and Wellbeing Strategy (with decision making within existing CCG and PCC governance structures)
  - Approve the four Integrated Commissioning Strategies (Children and Young People/Wellbeing/Community Based Care/Complex Care) and associated Annual plans
  - Designated ICB Officers to act as Senior Responsible Officers for each of the Strategies
  - Ensure that commissioning activity is aligned to and delivered through the Annual plans
  - Approve any in year commissioning decisions not referenced in the Annual Plans

Overview of Commissioning Strategies

- Cover the wellbeing, health and social care system for people of all ages in Plymouth
- Drive the commissioning activity across Plymouth City Council and the Clinical Commissioning Group
- Interdependencies – the solution to an issue raised in one strategy may lie in another
- Common themes thread throughout each one – prevention, transitions, medicines management

Integrated Strategies



Scope of Strategies

Children's Commissioning Strategy	Wellbeing Commissioning Strategy	Community Based Commissioning Strategy			Complex Care Commissioning Strategy
	Low level preventative services	**Multiple Needs**	**Urgent Care**	**Long Term Support**	
Early Help	Health Promotion & Healthy Lifestyle choices	Mental Health	Rapid Response	Supported Living	Residential Care
Family Support	Strong safe communities and social capital	Substance Misuse	Dom Care	Direct Payments	Respite
Early Childhood Development	Carers	Offending Behaviour	CHSC (Rapid)	Day Opportunities	Individual Patient Placements
SEND	Domestic Violence	Homelessness	CES	Telecare/ Telehealth	Nursing Care
Children in and on the edge of care	Information, Advice & Advocacy & Housing Options		Hospital Discharge	CHSC (Localities)	Acute Activity
Vulnerable Children & YP	Emotional wellbeing and mental health		Single Front Door		

Structure of Strategies

WHAT THE PLYMOUTH HEALTH AND SOCIAL CARE SYSTEM NEEDS TO RESPOND TO…..

National and Local Strategic Drivers - focus on **Prevention** and **Integration** and **Person centred care**

Demographic changes – increased demand and complexity of need, high levels of deprivation

Local consultation – people want choice and control and to have more care delivered at home and in their communities

HOW ARE WE DOING AT THE MOMENT…

Limited coherent approach towards commissioning for whole systems

High spend on specialist care

Limited focus on prevention

Outcomes – what the future system needs to achieve / how will we know if it is working…..

Increased healthy life expectancy (quality of life as well as length of life)

Reduce health inequality

Delaying and reducing the need for care and support – less need for residential care and hospital

Preventing people from dying prematurely – reduce levels of preventable disease

People are cared for and recover well - better quality care with people more able to return home more quickly

People have a positive experience of care and support

Safeguarding and Safe Practice

Children well-prepared for adulthood – health, education and aspiration

WHAT ARE WE PLANNING ON DOING ACROSS THE SYSTEM TO MEET NEED AND IMPROVE OUTCOMES….

All strategies meet the above challenges in different ways:

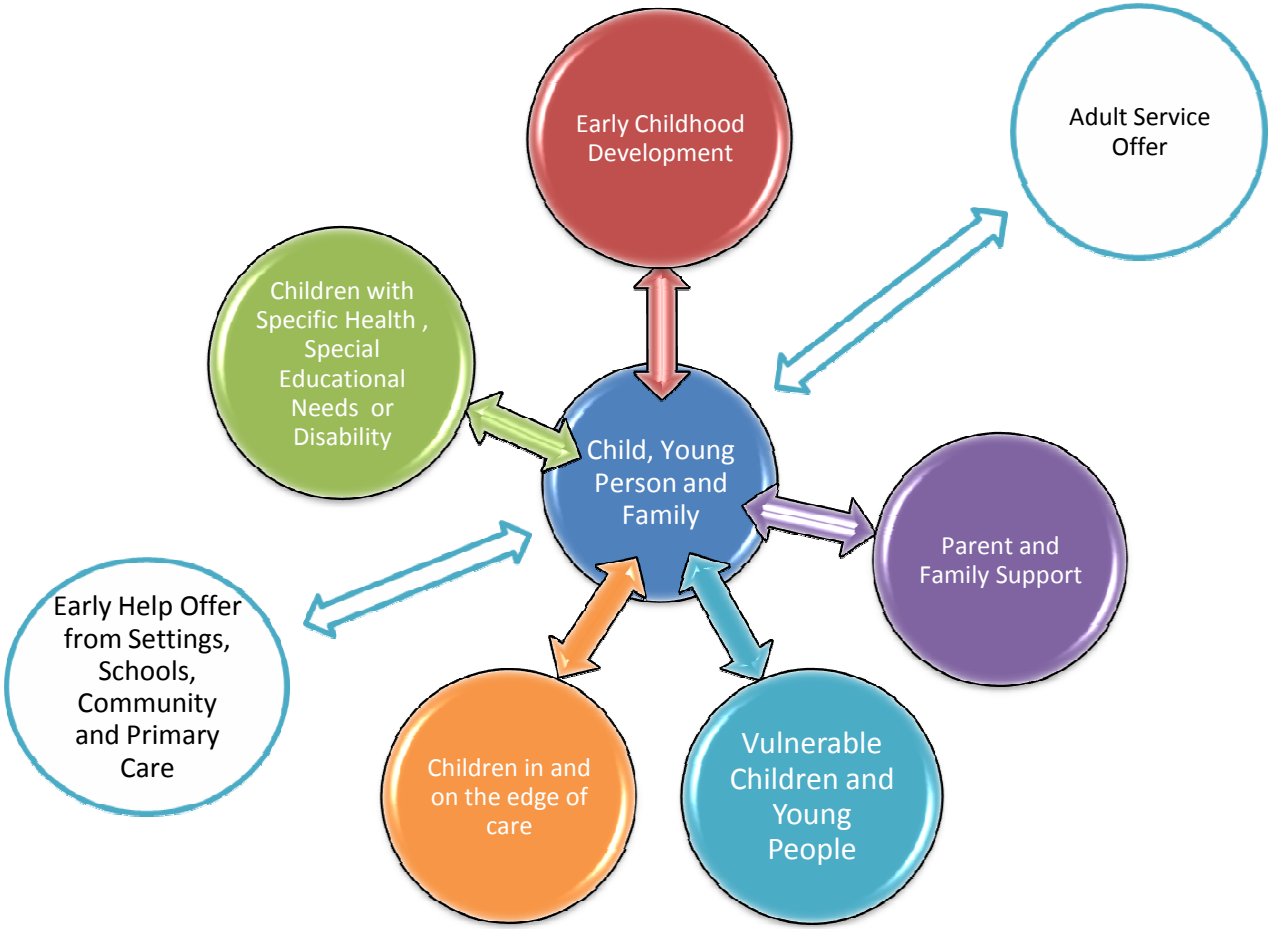
Wellbeing – promoting health lifestyle choice and reducing preventable diseases

Community – integrated care maximising independence for longer

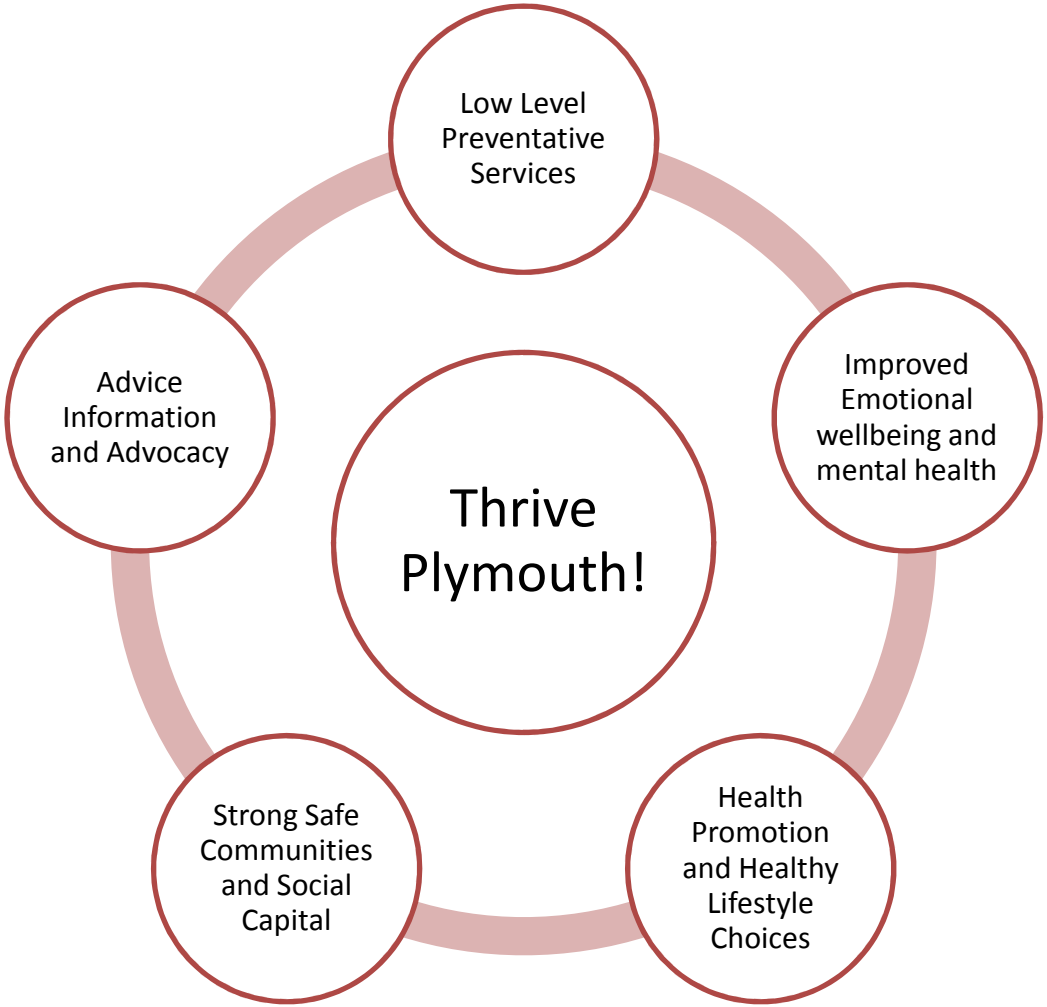
Complex - ensuring consistent high quality placements only when necessary

CYP – ensuring children are well prepared for adulthood

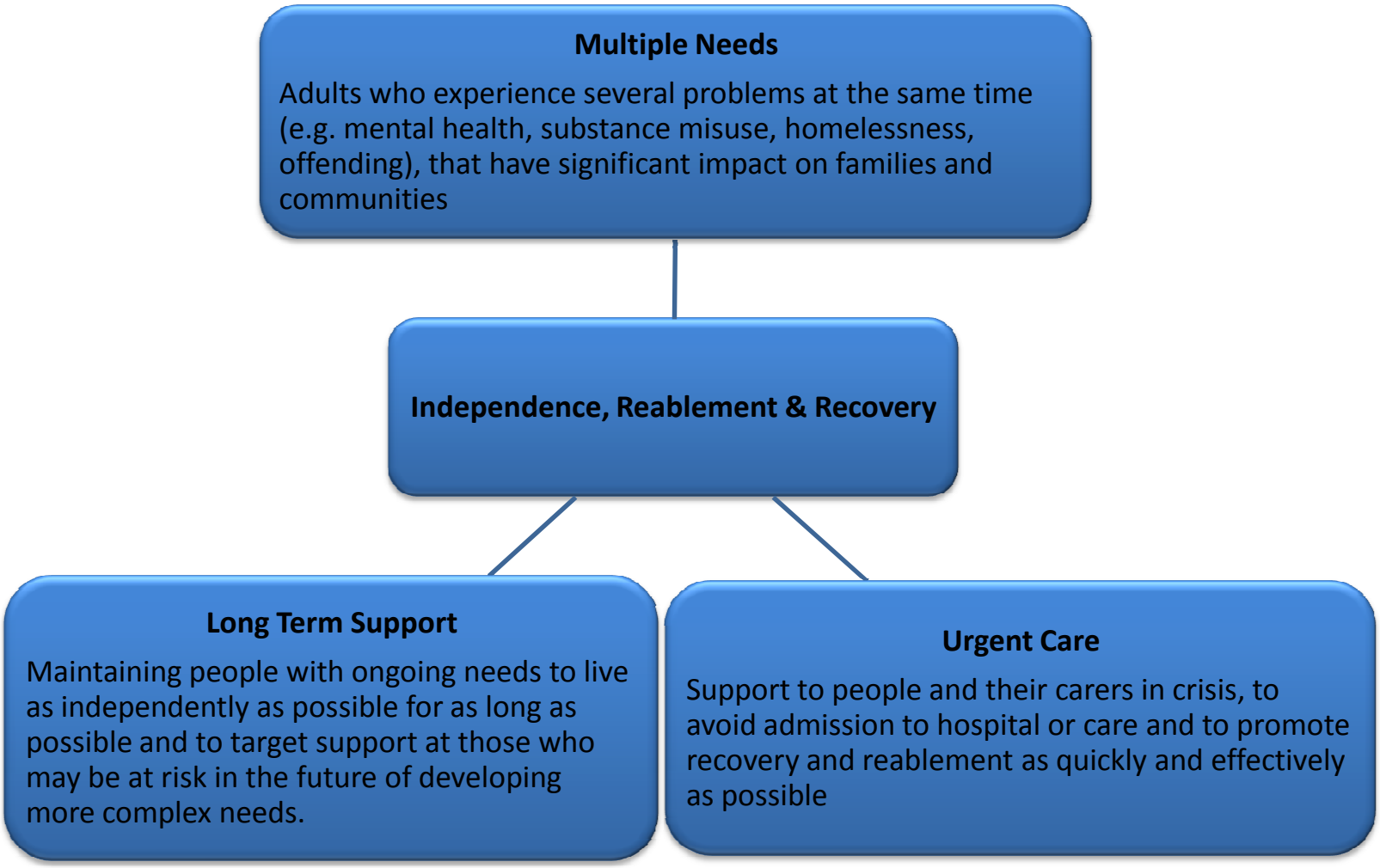
Children and Young People System Overview



Wellbeing System Overview



Community System Overview



Complex Care System Overview

Complex Care - System Overview			
"Quality specialist health and care delivered close to home that promotes choice, independence, dignity and respect"			
Individual Placements "Care provided at home or as close to home as possible in the least restrictive environment"	**Residential and Nursing Care** "Meeting the needs of people with dementia or multiple long term needs and avoiding unnecessary hospital admissions"		**End of Life** "People supported to die with dignity in the settings they chose"
System Enablers			
Prevention and Wellbeing	Pro-active Primary Care	Seamless Integrated Care Pathways	Skilled professionals, supported by Clinical Effectiveness and Medicines Optimisation
System Outcome			
Reducing Reliance on Acute Provision and Acute Episodes of Care			

Integrated delivery of care

- **Integration of delivery of community health and adult social care** for the Plymouth population commencing **1st April 2015**
- 170 **staff** transferring from PCC to Plymouth Community Healthcare CIC on 1st April 2015
- **Redesign** of delivery model to bring together the delivery of health and adult social care services (e.g. single 'front door', integrated therapies)
- **Assurances** to service users regarding continuity of care

Why are we doing this? Improving Outcomes

- Provide and enable brilliant services that strive to exceed customer expectations
- People will receive the right care, at the right time in the right place.
- Help people take control of their lives and communities.
- Children, young people and adults are safe and confident in their communities.
- People are treated with dignity and respect.
- Prioritise prevention
- A Sustainable Health and Wellbeing System
- Improved system performance

Next Steps

- Go live 1st April 2015
- Consultation on integrated strategies
- Developing integrated commissioning
- Delivering and transforming integrated delivery
- Delivery of commissioning intentions

CARE ACT 2014

Kate Jones
Project Manager

Health and Wellbeing Board 26 March 2015

The Legislation

- The Care Act is an historic and significant piece of legislation that modernises the framework of care and support law, bringing in:
  - New duties for local authorities
  - New rights for service users and carers
- The Act places more emphasis than ever before on prevention – shifting from a system which manages crises to one which focuses on people's strengths and capabilities and supports them to live independently for as long as possible
- It aims to make care and support clearer and fairer and to put people's wellbeing at the centre of decisions, and embed and extend personalisation
- Local authorities have new responsibilities towards all local people, including self funders
- There are significant changes to the way that people will access the care and support system
- The Care Act 2014 introduces a range of duties for local authorities, as well as implementing the funding reforms laid out in the Dilnot report

Underpinning Principles (Section 1)

- Care Act places a Duty to promote the Well-being of individuals (Adults and Carers)

- The Duty applies to Local authorities and their staff / members when exercising ‘any function under part 1 of the Act The(i.e. Sections 1-80)

- When discharging an obligation under the Act the LA must have regard to:

  - the individuals views, wishes, feelings and beliefs
  - the need to prevent / delay the development of need for Care and Support
  - the need to make decisions that are not based on stereotyping individuals;
  - the importance of individuals participating as fully as possible in relevant decisions
  - the importance of balancing between the individual’s wellbeing and that of friend or relatives involved as Carers
  - the need to protect people from abuse and neglect
  - the need to ensure that restrictions on individual rights / freedoms be kept to the minimum necessary

Prevention (Section 2)

Local Authorities will under a general Duty to provide a range of preventative services that they ‘consider’ will:

(a) Contribute towards preventing or delaying the development of by adults in its area of needs for care and support

(b) Contribute towards preventing or delaying the development by Carers in it’s area of needs for support

(c) Reduce the need for Care and Support of adults in it’s area

(d) Reduce the need for Care and Support in its area

Integration with the NHS (Section 3)

Section 3 places a duty on local authorities to promote Integration with the health provision where it would:

(a) Promote the well-being of adults with needs & Carers in it's area; or

(b) Contribute to the prevention of the development of needs in adults/ carers;

or

(c) Improve the quality of care for adults / Carers, provided

A component of this duty includes the establishment of the Better Care Fund, to facilitate hospital discharge, prevent unnecessary admissions and promote Integrated packages of care.

Information (Section 4)

Local Authorities have an enhanced duty to provide adults in need / Carers with information about care and support arrangements, including;

- how care systems operate
- Care and support choices they have
- how to access support and
- how to raise safeguarding concerns

The duty includes how to access independent financial advice.

Duty to promote high quality providers (Section 5)

The provision Includes:

(a) ‘Market oversight’ arrangements that will involve the Care Quality Commission - amongst others (Sub sec 53-57 Care Act 2014)

(b) Temporary Intervention if a provider fails (sub sec 48-52)

(c) Duty to promote an effective and efficient local market ‘with a view to ensuring’ a variety of providers and high quality services to choose from

Cooperation (Sections 6-8)

- Section 6 -provides a general duty to cooperate.
- Section 7 enables Social Services to request assistance and this must be provided - unless it would be 'incompatible with its duties, or have an adverse effect on the exercise of its functions. (in such a case the body must provide reasons)
- Section 8 - contains an illustrative list of what may be provided to an adult in need of a Care - namely:

  (a) accommodation in a Care home or premises of some other type

  (b) Care and support at home or in the community

  (c) Counselling, advocacy and other types of Social Work

  (d) Goods and facilities

  (e) information and advice

Assessment of adults in need (Section 9)

- The duty within the Care Act 2014 to assess adults in need is closely aligned to the existing duty (sec 47 NHS and Community Care Act)

- The duty is triggered by the appearance of need.

- The assessment must have specific regard to the wellbeing criteria (ie s1(2) and must involve the adult and carer.

Carers Assessments (Section 10)

The new Duty is triggered by the appearance of need and is no longer dependent on upon the Carer providing or intending to provide regular or substantial care or on the Carer making a request.

The act also contains specific provision for Carers of disabled Children in transition and young Carers in transition into adulthood.

The assessments must ascertain:

- whether the Carer is able / willing to provide and continue to provide the care
- the impact on the Carers wellbeing
- the outcome the Carer wishes in the day to day life
- whether the Carer works or wish to work and or participate in education, training or recreation.

Eligibility Criteria (Section 13)

Where an assessment identifies that an individual has needs for care / support than the local authority must decide if these needs meet the eligibility criteria.

- Eligibility (for adults and Carers)now placed on a statutory footing

(1) The person is unable to carry out basic activity;

(2) The consequence is a significant risk to that persons wellbeing.

(The threshold is closer to the current Moderate than substantial banding)

The criteria for Carers measure (broadly) if the Carer is unable to undertake certain key tasks / roles, including employment, recreation, education and or, their health is at significant risk.

(The criteria is considered to be more generous than those previously in place)

Cap and Costs (Sections 15-16)

- The cap on Care costs has been set at 72k (Dilnot recommended 35k)

- 12k of care home fees will be deemed for ‘daily living costs’ (accommodation, food etc)

- 2016 change to the capital limits from 23,750k to 118,000k if a persons home is included in the calculation 27k if not

This means that someone with savings of 117,000k who seeks LA assistance will have to contribute 20,000k per annum from the capital at the same time lose their DLA / Attendance allowance care component.

Duty / Power to provide care and Support for adults / Carers (Sections 18-20)

- Where an Individual's needs(Adult / Carer) meet the eligibility criteria then there will be a duty to ensure their care and support needs are addressed.
- They must be an ordinary resident in the LA area.
- If their assets are above the financial limit, that they ask the LA to meet their needs.

The Governments impact assessment identified:

- 180,000-230,000 new care users
- Reviews to increase by between 440,000-530,000 in 2016-17 - increasing local authority costs by over £2bn per annum.

NHS Interface (Section 22)

The current boundary between Local authorities and the NHS (NHS continuing care boundary (defined by the *Couglan judgement) r*emain unchanged.

Care and Support plans (Section 26)

The duty to prepare care and support plans for those who have been assessed as meeting eligibility is sustained within the Care Act. It does however include the following:

- Adults must have personal budgets
- Preparation of a support plan must involve; the adult, any Carer the adult has, and any person that appears to the authority to have an interest in the adults welfare.
- For Carers; preparation must include the Carer, the adult needing care, if the Carer asks and any other person whom the Carer asks.

Direct Payments (Sections 31-33)

The most significant change is that Direct Payments are now available to people in residential care placements. This change will come into force in April 2016.

Continuity of Care
(Sections 37-38)

- Where a Local Authority (1st local authority) is providing care and support for an adult and another LA (2nd authority) is notified that the adult will be moving into their area (and is satisfied that the intent is genuine) than it must, among other things, undertake an assessment of the adults needs, and those of any Carers they may have.

- If the assessments have not been completed by the time the adult actually moves, than the second LA must meet the needs identified by the first local authority, until the assessment is complete.

Safeguarding
(Sections 42-45)

The Act places on a statutory footing some of the Safeguarding obligations that were present in the guidance (principally the ‘ No Secrets Guidance)

Sec 42 places a duty to make enquires if adults with care and support needs:

- is experiencing, or is at risk of abuse or neglect; and
- is unable to protect him or herself against abuse or neglect.

There are statutory obligations to have a Safeguarding Board and to undertake investigations and to require individuals to provide information etc.

Independent Advocacy

(Section 67)

There is a duty on the LA under Sec 67 to arrange independent advocacy if the authority considers the individual would experience ‘substantial difficulty’ in participating in amongst other things their assessment and or the preparation of their care and support plan.

Statutory appeals process (Section72)

Guidance is currently being drawn up regarding the appeals process, however the new process is anticipated to include:

- Be flexible, local, proportionate system avoiding unnecessary bureaucracy
- Include element of independence from the Local Authority
- Seek to avoid duplication with existing arrangements for complaints and redress.

Human Rights Protection
(Section 73)

The Care Act extends the current Human rights Act 1998. Sec 73 provides that where care is arranged by a LA or paid for, directly or indirectly in whole or in part and that the care is provided by a registered care provider to an adult or a Carer either in their own home; than the provider is deemed to be a public authority for the purposes of the 1998 Act.

s117 Mental Health Act 1983 (Section 74)

After Care services are not defined by the 1983 Act. The care act inserts a new subSection (5) into the 1983 Act to limit services to those:

(a) Arising from or related to the Mental disorder and

(b) Reducing the risk of deterioration of the persons mental condition(i.e that they may require re-admission)

The Care Act confirms that ordinary residence is determined by where the person was based immediately prior to being detained and gives powers to the secretary of state power to resolve ordinary residence disputes. It also inserts a new s117 that provides for regulations to introduce a limited 'choice of accommodation' for persons subject to s117.

Implementation of the Act in Plymouth

- We have project plans in place for:
  - Assessments
  - Person Centred Care and Care Plans
  - Transitions
  - Ordinary Residence & Continuity of Care
  - Communications
  - Finance
  - Commissioning:
    - Wellbeing & Prevention
    - Information and Advice
  - Workforce Development
  - Informatics

Care and Support Needs New Policy

- This policy sets out the offer to Plymouth Citizens for Care and Support Needs.

- It includes:

1. Wellbeing and Prevention	9. Reviews
2. Information and Advice	10. Transitions
3. Assessment	11. Portable Accounts
4. Eligibility	12. Continuing Healthcare
5. Delegating Statutory Responsibilities	13. Safeguarding
6. Financial Assessment and Charges	14. Confidentiality
7. Support Planning and Personal Budgets	15. Policy Review
8. Carers and Personal Budgets	

Financially Assessing Carers

- Cabinet approval on 10th February not to financially assess Carers with eligible needs who might have a Personal Budget
- Rationale:
  - It could impact negatively on the Council should carers decide to withdraw from their caring role
  - We believe that the personal budgets carers might required for their unmet needs will be relatively low one off costs
  - Back office processes would be resource hungry for potentially little return in terms of income
  - This will be reviewed during 15/16 when we have a clearer understanding of the numbers of Carers receiving a Personal Budget

Deferred Payments
New Policy

This policy includes the following:

- PCC's Deferred Payments Policy Statements
  - Eligibility Criteria
  - Administration Fees and Interest Charges
  - Independent Financial Advice
  - Financial Arrangements
  - Types of Security
  - Deferred Payments Agreements
  - Termination of Deferred Payment Agreement
  - Review and Appeals Procedure

Deferred Payments
Independent Financial Advice

- Advice Plymouth (consortia delivers a universal advice and information service in Plymouth. The service holds a nationally recognised quality standard (Advice Quality Standard – AQS).
- PCC Co-operative Commission has mapped providers offering information and advice, and identified a number of organisations which will be supported to ensure their service offer is clear on the Plymouth Online Directory.
- Work is on-going nationally to identify how quality standards can implemented for information and advice providers which do not have the AQS.
- Advice Plymouth offers financial advice.
- Co-operative Commissioning has mapped providers of financial information and advice, and will be supporting those not already registered with SOLLA (Society of Later Life Advisors – accreditation programme recommended by ADASS as a standard). Providers will be supported to register on the Plymouth Online Directory.
- In addition to encouraging providers to become SOLLA accredited, Co-operative Commissioning is looking at extending the quality standards by discussing additional requirements.
- **NB.** The public will be signposted to POD but individual providers of information and advice will not be recommended.

Deferred Payments Administration Charges

- The provision of deferred payments must be cost neutral
- Under the Act we can apply administration charges
- We are applying an admin fee of £500 for setting up a deferred payments, These have been modelled on a cost neutral basis taking into account the time and tasks required to set up an agreement. We are not outliers across the region with these costs
- We are applying a fee of £100 a year to maintain the deferred payment activity each year, this cost is a guide and will change for each person where they actual charges are more or less than this. Again this fee has been modelled on a cost neutral basis

Deferred Payments Interest Charges

- Plymouth will set its interest rate in line with the gilt rate - This currently sits at 2.65%
- Setting it at this level ensures that the Councils not making a profit, but it does allow for some costs of ruining the scheme to be covered and the cost of borrowing money, if required to fund the scheme
- A person will be advised to seek independent financial advice

Length of time for a Deferred Payments

- A deferral of payment can last until death
- people will choose to use a deferred payment agreement as a bridging loan to give them time and flexibility to sell their home when they choose to do so
- This is entirely up to the individual to decide

Deferred Payments
Valuation of Property

- Initially we will use Zoopla as a means to value property.
- Once take up trends of deferred payments is known then we will review how we undertake our valuations
- We will periodically revalue a person's home to ensure that the property is not dropping into negative equity
- If a person can provide their own valuation if they wish
- At the point a person has deferred 70% of the value their circumstances will be reviewed
- The Care Act guidance sets out the equity limit of a person's property which will be the maximum anyone is allowed to defer.
- Where a property is joined owned the council will not enter into a deferred payment agreement unless all owners give their consent to a charge being placed on the property

Care Act Part 2 Consultation

- This has now been issued
- Closing date is 28th March 2015
- We do not expect the final guidance and regulations until early summer
- By October 2015 we will be required to have our processes in place to assess any potential self-funders and for those with eligible needs set up their Care Account ready to start from 1st April 2016

FAIRNESS COMMISSION RECOMMENDATIONS

Health and Wellbeing Board

PURPOSE

This paper updates the Board on the Fairness Commission final recommendations relating to the Health and Wellbeing Board and seeks agreement that progress against them is reported to the Fairness Commission.

Fairness Commission Recommendations	Actions taken / planned
○ The Fairness Commission recommends that a comprehensive and holistic response to Plymouth's mental health needs, including those of children and young people, is developed and agreed by all agencies, and that resourced commissioning plans are published to show how services and support will be delivered	On Friday 7th November, Plymouth Mental Health Network hosted a solution shop for the Plymouth Health and Wellbeing Board Solution on mental health. Members of the Board, community and voluntary sector, service representatives, public health, commissioners, carers and people with lived experience of mental illness, met to discuss the mental health system and hopes for the future. This report forms a basis for discussion at the meeting of the 26th March 2015. In addition the Board will receive in June an annual update on the implementation plan it commissioned following the completion of the pledge 90 report which will address specific recommendations provided by the Fairness Commission.
○ We recommend that Plymouth's comprehensive response to mental health ensures a significant redirection of cross-sector resources for evidence-based early intervention, prevention and promotion programmes for mental health. This should specifically include children, young people and those with multiple and complex needs, with targets set for how redirected resources will be used. If insufficient expertise and/ or modelling tools exist locally to support this shift towards prevention then external support should be used.	
○ We recommend that a joint review be completed to agree what crisis response is appropriate for anyone presenting with a mental health need. This should include those who may require a place of safety while a mental health assessment is undertaken and, where appropriate, follow up or after care is provided.	
○ The Commission recommends that an evidence-based and coordinated	The "reduce the strength campaign" has been led by the Shekinah Mission and Harbour Drug and

approach to reducing the retailing of cheap vodka and 'super strength' beer and cider as stated in the Strategic Alcohol Plan for Plymouth 2013-18 and being implemented in Ipswich, is developed and resourced.	Alcohol Services working in partnership with the local authority. The Health and Wellbeing Board is fully supportive of the approach and will consider further progress in September when it considers its annual update on all elements of the Strategic Alcohol Plan.
o The Plymouth Fairness Commission seeks confirmation that arrangements to deliver the Commissioning Plan for the Plymouth Domestic Abuse Partnership 2012-2019 will be able to meet the scale of the problem in the city. As such we recommend an urgent review of the following: • Joint commissioning arrangements and resource allocation. • Agreement and ownership of shared outcomes. • Effectiveness of current partnership arrangements.	The commissioning plan for the domestic abuse is within the terms of reference for the Safer Plymouth Partnership (Crime and Safety Partnership). The Board will discuss on the 23rd April how greater links can be made across these partnerships.
o We recommend that steps are taken to ensure cross-sector funding for Domestic Abuse services continue to be protected and, where appropriate, increased to ensure sufficient services and support are in place to meet rising demand.	
o The Commission recommends that, using the learning from other areas who have implemented this such as Islington, all primary school children in the city are offered a daily free school meal. o We recommend that a pilot to provide a free daily meal to disadvantaged pupils outside of term-time is trialled to assess potential take-up, costs and benefits. o We also recommend that all schools providing meals in Plymouth must meet the National School Food Standards.	The City Council Education Catering Service has implemented this for key stage 1 pupils. Further evaluation will be undertaken before moving this into key stage 2. The Education Catering Service is exploring a number of options for using current assets to the benefit on the community when not in use providing school meals. Ed Catering has achieved and gone this recommendation by ending transported meals with all food cooked on site using seasonal fresh local produce. The Education Catering Service are actively involved in the national school food plan and are working for the on the way forward for all school catering services across the country.

○ Many organisations, such as Food Plymouth and Sustainable Food Cities are already leading promising food initiatives in the city. ○ However, the Commission believes the benefits of these different initiatives could be extended if they were better co-ordinated.	The Board will explore how to bring elements from across the system together in the new municipal year.

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