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Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 2 March 2017 at 4.30 pm in Committee Room 1 - City Hall, Bradford

Members of the Committee – Councillors

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT
Carmody Gibbons	Greenwood A Ahmed Duffy Mullaney Sharp	N Pollard

Alternates:

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT
Barker Poulsen	Berry S Hussain T Hussain H Khan	Griffiths

NON VOTING CO-OPTED MEMBERS

Susan Crowe	Strategic Disability Partnership
Trevor Ramsay	Strategic Disability Partnership
G Sam Samociuk	Former Mental Health Nursing Lecturer
Jenny Scott	Older People's Partnership

Notes:

- This agenda can be made available in Braille, easy read, large print or tape format on request by contacting the Agenda contact shown below.
- The taking of photographs, filming and sound recording of the meeting is allowed except if Councillors vote to exclude the public to discuss confidential matters covered by Schedule 12A of the Local Government Act 1972. Recording activity should be respectful to the conduct of the meeting and behaviour that disrupts the meeting (such as oral commentary) will not be permitted. Anyone attending the meeting who wishes to record or film the meeting's proceedings is advised to liaise with the Agenda Contact who will provide guidance and ensure that any necessary arrangements are in place. Those present who are invited to make spoken contributions to the meeting should be aware that they may be filmed or sound recorded.
- If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.

From:

Parveen Akhtar
City Solicitor
Agenda Contact: Palbinder Sandhu
Phone: 01274 432269
E-Mail: palbinder.sandhu@bradford.gov.uk

To:

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

The City Solicitor will report the names of alternate Members who are attending the meeting in place of appointed Members.

2. DISCLOSURES OF INTEREST

(Members Code of Conduct - Part 4A of the Constitution)

To receive disclosures of interests from members and co-opted members on matters to be considered at the meeting. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

Notes:

(1) Members may remain in the meeting and take part fully in discussion and voting unless the interest is a disclosable pecuniary interest or an interest which the Member feels would call into question their compliance with the wider principles set out in the Code of Conduct. Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(2) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

(3) Members are also welcome to disclose interests which are not disclosable pecuniary interests but which they consider should be made in the interest of clarity.

(4) Officers must disclose interests in accordance with Council Standing Order 44.

3. MINUTES

Recommended –

That the minutes of the meeting held on 26 January 2017 be signed as a correct record (previously circulated).

(Palbinder Sandhu – 01274 432269)

4. INSPECTION OF REPORTS AND BACKGROUND PAPERS

(Access to Information Procedure Rules – Part 3B of the Constitution)

Reports and background papers for agenda items may be inspected by contacting the person shown after each agenda item. Certain reports and background papers may be restricted.

Any request to remove the restriction on a report or background paper should be made to the relevant Strategic Director or Assistant Director whose name is shown on the front page of the report.

If that request is refused, there is a right of appeal to this meeting.

Please contact the officer shown below in advance of the meeting if you wish to appeal.

(Palbinder Sandhu - 01274 432269)

5. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

Any referrals that have been made to this Committee up to and including the date of publication of this agenda will be reported at the meeting.

B. OVERVIEW AND SCRUTINY ACTIVITIES

6. IMPLEMENTATION PLAN FOR THE MENTAL WELLBEING IN BRADFORD DISTRICT AND CRAVEN: A STRATEGY 2016 - 2021

1 - 14

The Mental Wellbeing in Bradford District and Craven: A Strategy 2016 – 2021 was agreed by the Health and Wellbeing Board at its meeting of 29th November 2016 and was formally launched at an event on 19th January 2017.

The Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups and the Strategic Director of Health and Wellbeing will submit **Document "AD"** which provides an update on the planning and implementation process to deliver the strategy.

Recommended –

That activity undertaken on the development and delivery of an implementation plan for the Mental Wellbeing Strategy for Bradford District and Craven be noted and that the Committee provide any feedback and/or comments.

(Mick James – 01274 237686)

7. COMMUNITY MENTAL HEALTH SERVICES 15 - 24

The Bradford District Care NHS Foundation Trust and the Strategic Director, Health and Wellbeing will submit **Document "AE"** which provides an update on Adult Community Mental Health Services and current developments.

Recommended –

That the reported position for Community Mental Health Services including the developments outlined in Document "AE" be noted.

(Mark Trewin /Simon Long – 01274 431526/228300)

8. HOME FIRST - VISION FOR WELLBEING 25 - 46

The Strategic Director of Health and Wellbeing will submit **Document "AF"** which sets out the rationale, key aims and ambitions for the new vision (Home First) for wellbeing in Bradford and the new operating model for the department of Health and Wellbeing. The report also provides an update on the development process and outlines key next steps for the consultation and approval of the final documents.

Recommended –

(1) That the progress made towards the development of the new Home First Vision and the new operating model for the Department of Health and Wellbeing be noted.

(2) That the Committee provides comment and feedback on the vision (Home First) and the new 'To be' operating model.

(Imran Rathore – 01274 431730)

9. THE ACCESSIBLE INFORMATION STANDARD

From 1st August 2016 all organisations that provide NHS Care or Adult Social Care (this includes commissioned services) are legally required to follow the Accessible Information Standard.

The Accessible Information standard requires that all health, adult social care and any services they commission:

1. Identify people's accessible information or communication support needs
2. Record these
3. Flag records clearly
4. Meet people's accessible information and communication needs
5. Share their knowledge with other providers.

The Standard is concerned with meeting accessible information and communication needs related to disability. It is not about other language needs.

Bradford Council Adult Services has an Accessible Information Standard Implementation Plan and the Council has adopted accessible information as one of its equality objectives.

NHS England are also currently doing a review to find out how the Standard is working and the difficulties people have had or are still experiencing.

The District Manager, Department of Health and Wellbeing, will give a verbal report on the progress of the implementation plan and joint working with the major NHS bodies in the District.

(Alec Porter - 01274 430204)

10. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2016/17 47 - 50

The City Solicitor will submit **Document "AG"** which presents the work programme 2016/17.

Recommended –

That the information in Appendix A and B of Document "AG" be noted.

(Caroline Coombes – 01274 432313)

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Report of Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups and the Strategic Director of Health and Wellbeing to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 2 March 2016

AD

Subject: Implementation Plan for the Mental Wellbeing in Bradford District and Craven: A Strategy 2016 – 2021

Summary statement: The Mental Wellbeing in Bradford District and Craven: A Strategy 2016 – 2021 was agreed by the Health and Wellbeing Board at its meeting of the 29th November 2016 and was formally launched at an event on the 19th January 2017. This paper provides an update on the planning and implementation process to deliver the strategy

Portfolio:

Health & Wellbeing

Report Contact: Mick James
Phone: (01274) 237686
E-mail: mick.james@bradford.nhs.uk

1. Summary

The Mental Wellbeing in Bradford District and Craven: A Strategy 2016 – 2021 was agreed by the Health and Wellbeing Board at its meeting of the 29th November 2016 and was formally launched at an event on the 19th January 2017. This paper provides an update on the planning and implementation process to deliver the strategy

2. Background

2.1 In autumn 2015 there was an external review of joint mental health commissioning in Bradford district and Craven. One of that report's recommendations was the design and delivery of a new five year strategy for the district.

Public health colleagues updated the Joint Mental Health Needs Assessment to support this and from April to October 2016 an extensive engagement and development programme took place.

This also coincided with the publication of national policies setting out the expectations and drivers for mental health transformation under the Five Year Forward View for mental health.

Despite being acknowledged as an exemplar health and care economy for a range of innovations, at that time there were a number of negative perceptions about mental health services in Bradford district and Craven. It is clear that there are many areas that need improvement and local stakeholders expressed a desire to develop a truly aspirational and ambitious all age strategy.

2.2 Mental Wellbeing in Bradford District and Craven: A Strategy 2016 – 2021 was developed through close partnership working between CBMDC, NHS and VCS providers, service users and carers. It provides a strategic direction for people of all ages and emphasizes the importance of wellbeing and support for both mental and physical health. The strategy launch on the 19th January 2017 was a huge success and has created a great sense of energy and enthusiasm in support of the implementation. We are keen to maintain this momentum. The process of implementation has begun and this paper provides an update on the progress with establishing programme structures and planning the implementation.

3. Report issues

3.1 The strategy: During the engagement to develop the strategy, people emphasised the importance of:

- the impact on our mental wellbeing of 'life events' as triggers
- keeping healthy at the times of our life when there is added risk; and

- that people wanted to see actions to strengthen mental health awareness and resilience at population level
- recognising the importance of the impact of housing, employment, education, our environment and the economy on our wellbeing

As well as housing, environment and employment, things like drug and alcohol misuse, dementia, learning disabilities, physical health and autistic spectrum conditions also play a significant part in determining people's mental wellbeing. These are mentioned in the strategy, but we have not gone into detail. This is because there are separate strategies, either already agreed or in development, that tackle these issues and we are establishing links with these programmes to ensure a seamless approach to delivery.

The overarching vision of the strategy is based on *Hope, Empowerment* and *Support*. The key strategic commitments to deliver this are grouped under three pillars:

Our Wellbeing

We will build resilience, promote mental wellbeing and deliver early intervention to enable our population to increase control over their mental health and wellbeing and improve their quality of life and mental health outcomes.

Our mental and physical health

Mental health and wellbeing is of equal importance to physical health. We will develop and deliver care that meets these needs through the integration of mental and physical health and care.

Care when we need it

When people experience mental ill-health we will ensure they can access high quality, evidence-based care that meets their needs in a timely manner, provides seamless transitions and care navigation.

Across the three pillars there are 48 'we will' commitment statements supported by a further 12 enabling commitments. These form the basis for the implementation plan.

3.2 The implementation plan: Initially it was proposed that implementation would be structured through three work streams: Our Wellbeing, Our Mental and Physical Health, and Care When We Need It.

Our Wellbeing

Currently there is no sub-group of the Mental Health Partnership Board to drive this but an initial meeting between the CCG and Public Health leads has agreed the leadership of this programme and has set out some initial plans as well as overall timescales and priorities.

Our Mental and Physical Health

An initial meeting of relevant stakeholders to start this programme was held on the 24th January 2017. The meeting generated a great deal of ideas about how the work can be progressed and planning has begun and milestones for 2017/18 are listed in the implementation plan. The principal risk to the delivery of this programme is that we fail to address adequately the underpinning principle that the programme should release resources from acute hospital care to reinvest in meeting the psychological needs of patients in physical health pathways.

Care When We Need It

Members of the existing Crisis Care Concordat have considered whether they would be well placed to lead this work stream, but agreed that the group's scope is too focused for effective leadership of all elements. Therefore, the Crisis Care Concordat will retain leadership for aspects of the work stream connected with the acute mental health care pathway while two new groups will be formed to progress work relating to (a) community mental health care and (b) talking therapies.

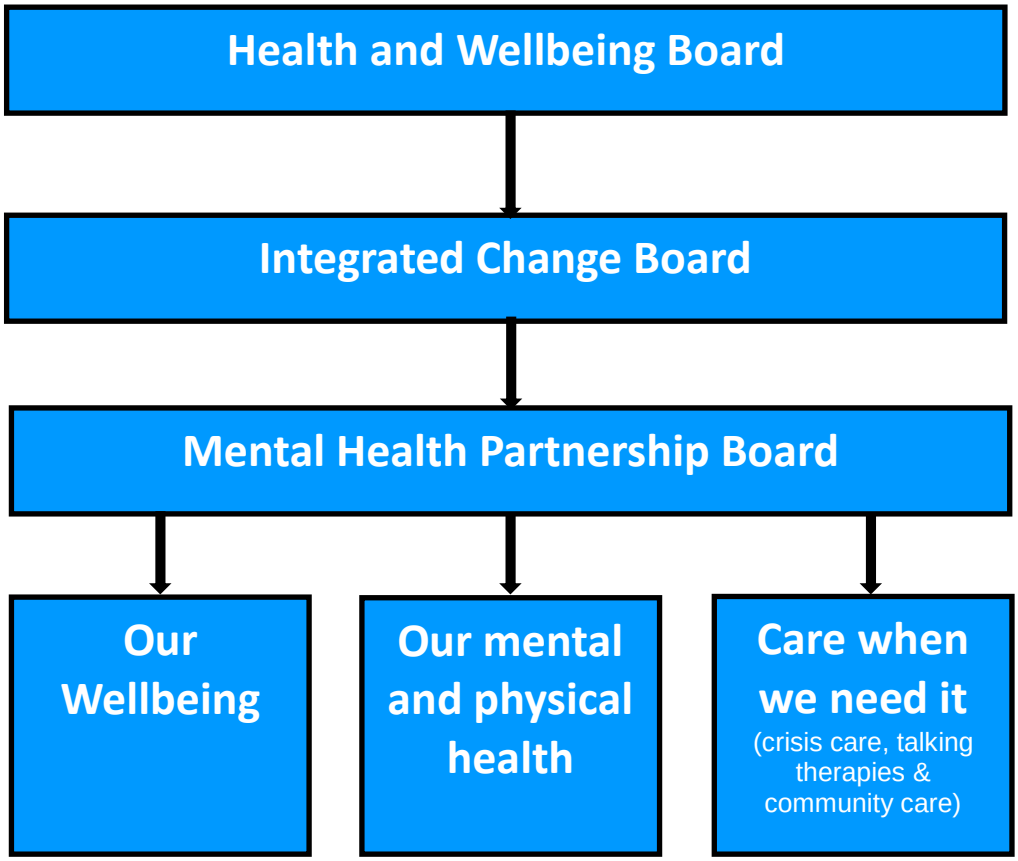
It is thus vital that the additional groups required are formed as soon as possible and commence their formal reporting to the Mental Health Partnership Board. The other area that will require picking up as a matter of priority are the cross cutting themes, but these can realistically only start to be addressed once the other work streams are delivering clear, detailed plans.

At the current time, the Implementation Plan is being populated in more detail on an ongoing basis as projects within the programme start to emerge. It is developing at a rapid pace with updated versions being produced on a very regular basis to accommodate this. In addition it should be noted that some of the actions are already complete or nearing completion

The resource commitments for 2017/18 and 2018/19 are noted in the outline Implementation Plan presented with this paper.

3.3 Governance

The following governance structure has been agreed for the Mental Health programme.



3.4 Ongoing engagement

The Mental Health Programme is committed to ensuring that the planning and implementation of the strategy will continue to build on the very effective and comprehensive engagement with a broad range of stakeholders.

3.5 Outcome framework

The agreed outcome framework is presented as Appendix B.

The commissioning support unit has commenced work on establishing a dashboard based on these agreed outcome measures, though there is not at this stage clarity about how quickly that work will be completed.

3.6 Current delivery

Work on implementation is underway and a number of individual projects have already been delivered.

- *Our Wellbeing* **-** For children and young people, commissioning of a 'buddy system' with the VCS to work with specialist providers of CAMHS to address emotional and psychological distress

- *Our mental and physical health* **-** Further development of the primary care wellbeing service that provides psychological support to people with medically unexplained symptoms

- *Care when we need it* **-** Re-procurement of the wellbeing navigation service which provides services to adults with a serious and enduring mental health problem. Successful bids for expanding perinatal services and development of IAPT. Extended access to crisis care through the First Response Service (FRS) by appointing CYPMH specialists within the team. Developed a dedicated looked after and adopted children therapy team to deliver support, consultations and supervision to those teams working with these vulnerable groups.

- *Overarching* - The Joint Mental Health Commissioning Board has become the programme board for the implementation of the strategy, informing the future integration of services.

4. Contribution to corporate priorities

The Implementation Plan reflects the ambition of the agreed *Mental Wellbeing in Bradford District and Craven: A Strategy 2016 – 2021* as well as the district plan for 'all of our population to be healthy, well and able to live independently for a long as possible' (District plan: Better health, better lives).

5. Recommendations

That activity undertaken on the development and delivery of an implementation plan for the Mental Wellbeing Strategy for Bradford district and Craven be noted and that the Committee provide any feedback and/or comments.

6. Background documents

Link to *Mental Wellbeing in Bradford District and Craven: A Strategy 2016 – 2021 (*http://www.bradfordcityccg.nhs.uk/be-informed/our-publications/our-strategies/)

7. Not for publication documents

None

8. Appendices

Appendix A: Implementation Plan for the Mental Wellbeing in Bradford District and Craven: A Strategy 2016 – 2021

Appendix B: Outcome Framework for the Mental Wellbeing in Bradford District and Craven: A Strategy 2016 – 2021

Mental Wellbeing Strategy 5-Year Implementation Plan and Priorities									
The delivery of the Mental Wellbeing Strategy will be through three principal programmes:									
Our wellbeing: Building resilience, promoting mental wellbeing and delivering early interventior									
Mental Wellbeing Strategy Implementation Plan and Priorities									
Project	Strategic Commitment	Lead	2017/18	2018/19	2019/20	2020/21	Standards	Finance	Update January 2017
Our Wellbeing		Dr Sarah Muckle				Our Wellbeing			
Milestones to be drafted after initial planning meeting 1 February 2017									
Self Care Strategy	W1 We will design and deliver a comprehensive Mental Health Improvement Programme which will target increased awareness, capacity for self-management and the need for early intervention and self care.	Ali Jan Haider	Over the life of the strategy we will train 10% of health and social care front line staff in Motivational Interviewing and promoting behavioural change.						Ensure that this work is embedded in the work to deliver the Self-Care strategy
	W2 We will ensure that Mental Health Improvement is a central outcome of all community investment and regeneration.	Sarah Muckle	Develop a framework to guide decision making. Currently in planning stage						
	W3 We will develop and deliver evidence based stigma and discrimination reduction programmes that focus on sustained behavioural change.								Need to explore options for action in the context of existing work being led by Judith Kirk (CSC)
	W4 We will promote mutual support opportunities and encourage the spread of mental health Champions in organisations and business.	Sarah Muckle	We will explore options for developing a network of Mental Health First Aiders as mental health champions across the economy, with support from existing MH focussed employment support pathways who have established links with the employer market in the district.						
	W7 We will ensure local housing and regeneration policy and planning creates public and private housing which provides a safe, stable environment that promotes community cohesion and mental wellbeing.								
	W9 As the largest local employers, we will lead the way in establishing a district wide network of organisations that are passionate about and committed to mentally healthy workplaces with all health and local authority services achieving a mental health charter mark. We will proactively share best practice and facilitate small to medium enterprises to engage through accessible training and tools.	Sarah Muckle	Develop proposals for the local NHS and LA bodies to become Mindful Employers. BDCFT already signed up to the Charter.						
Employment support	W10 We will support people to develop the skills and confidence needed to be work ready, engage with employers to enhance accessible job opportunities, and provide support to both individuals and employers to help more people with mental health problems to retain their employment.	Mick James.	With LA use EU funding to support partnership bid from BDCFT and Cellar Trust to provide additional MH employment support. Develop outcomes and thresholds.			Double access to IPS from 2016/17 baseline	**2017 – 2019 planning guidance:** Increase access to IPS for SMI in secondary services by 25% by April 2019 from 17/18 baseline	£78,000 IPS employment support workers (60K 5YFV + 18K demographic monies)	STP areas selected for targeted funding of IPS Supported previously non-recurrently funded IPS scheme provided by BDCFT with VCS Cellar Trust
Self Care Strategy	W20 We will tackle loneliness, fear and isolation through supporting the further development of schemes that improve mental health in later life through supporting emotional and social connections.	Ali Jan Haider	Self Care strategy currently undertaking asset mapping. Work within self-care strategy to promote social prescribing which will deliver required outcomes.						Need to check work currently underway within Community Development (Steve Hartley)
	H3 We will develop the role of VCS and Community groups to provide access to early intervention support which improves personal resilience.								
	C16 We will develop housing, education, employment and social care and support systems for people leaving prison, forensic care or other forms of custody								
Suicide Prevention Strategy and Action Plan		Peter Roderick	Draft plan for review and approval by Mental Health Partnership Board February 2017				2017 – 2019 planning guidance: Reduce suicide rates by 10% against the 2016/17 baseline		Draft Suicide Prevention Plan circulated for review

Project	Strategic Commitment	Lead	2017/18	2018/19	2019/20	2020/21	Standards	Finance	Update January 2017
Our physical and mental health		Brendan Kennedy, Mick James							
Wellbeing Service	W6 We will adopt wellbeing models and pathways that integrate physical and mental health, in which social care is a core part of our strategy and we will support social function, spirituality, self-management and peer support through the Care Act 2014.	Mick James, Brendan Kennedy, Angela Moulson	Development of a cross agency task and finish group to agree short and long term plans for three identified themes: Informatics, Integration & Coordination of pathways, agree outcomes					Current plans to look at using existing resources to facilitate	Group established and membership agreed. Commence more detailed work at February Task and Finish meeting
	W12 We will provide support to people with mental health problems and complex physical needs to navigate services to maximise wellbeing and independence.	Angela Moulson, Kate Dale	Development of a cross agency task and finish group to agree short and long term plans for three identified themes: Informatics, Integration & Coordination of pathways, agree outcomes					Current plans to look at using existing resources to facilitate	Group established and membership agreed. Commence more detailed work at February Task and Finish meeting
	H2 We will develop a model of integrated physical and mental health services whereby people can have their care needs met at the same location as part of an agreed pathway of care.	Mick James, Brendan Kennedy, Angela Moulson	Development of a cross agency task and finish group to agree short and long term plans for three identified themes: Informatics, Integration & Coordination of pathways, agree outcomes.					Current plans to look at using existing resources to facilitate	Group established and membership agreed. Commence more detailed work at February Task and Finish meeting
	H4 We will develop an integrated approach to the identification of mental ill health in secondary care pathways, to improve the outcomes of physical health treatment.	Mick James, Brendan Kennedy, Angela Moulson	Development of a cross agency task and finish group to agree short and long term plans for three identified themes: Informatics, Integration & Coordination of pathways, agree outcomes					Current plans to look at using existing resources to facilitate	Group established and membership agreed. Commence more detailed work at February Task and Finish meeting
	H5 We will further develop the targeted approach to patients with medically unexplained symptoms (MUS) in Primary Care to improve patient outcomes and efficiency.	Mick James, Brendan Kennedy, Angela Moulson	Develop new model of care to expand services to create larger footprint and expand population served by Feb 2017, implementation from April 2017.					2017/18 £151,000 GP enhanced service	Agreed commissioning priority
	H8 We will reduce premature mortality associated with physical ill health in people with severe mental illness to below the Yorkshire and Humber average by 2020.	Angela Moulson, Kate Dale	30% SMI on register receive screen	60% SMI on register receive screen		Reduction in premature mortality (nat target not set Local target in strategy)	5YFV		
Care When We Need It						Care When We Need It			
	W13 We will extend the Recovery College Service model through a multi-provider network to offer online evening and weekend psychological interventions.		Finalise subcontracts: end August 2017						Moved to lead provider contract and branded the new IAPT network as MyWellbeing College Developing standard contract for subcontracting IAPT Development complete subject to finalisation of IAPT subcontracts. Existing grant arrangements to VCS organisations remain unchanged.
	W14 By 2020/21, 90% of people who access Psychological Therapies will engage through direct self-referral.		Establish baseline for percentage of self-referrals	Use baseline to increase percentage of self-referrals		90%			
	W15 We will ensure that local services/pathways are skilled to recognise and meet the longer term needs of people who experience sexual assault or domestic violence.			Review existing pathways, services, access, referral routes Increase staff awareness in all services Increase access to trauma pathway including communications with health and social care professionals					Awareness training on domestic violence and sexual assault is available for all IAPT staff and safeguarding procedures to support CAMHS PMHW Capacity utilised within CSE Hub commenced September 2016 Specialist care provided by VCS organisations in Bradford and Keighley EMDR provided by BDCFT Workstream will also involve primary care and hospitals
	W19 We will provide improved detection and access to evidence based treatment of depression for older people			Commence programme of work Consider potential positive impact of IAPT services for people with Long Term Conditions					Introducing Stress Buster via locally community groups for older people and our older people's mental health service

Project	Strategic Commitment	Lead	2017/18	2018/19	2019/20	2020/21	Standards	Finance	Update January 2017
Improving Access to Psychological Therapies	H6 We will increase access to IAPT from 15% - 25% prevalence providing an additional 7,500 treatments per year, 5,000 of whom will have Long Term Conditions		12-month pilot Confirm intentions for potential resource shift to services providing both physical and mental healthcare and pscyhological therapy groups	Access is 19% of estimated prevalence		Access is 25% of estimated	**2017 – 2019 planning guidance>** Additional Psychological Therapy so 19% access treatment integrated in Primary Care	2017/18 Bid submitted to NHS England to fund 12-month pilot (£240,000 approx). 2018/19 £123,000 CCG funding committed to support IAPT targets. Intention to supplement this with savings from LTC care demonstrable from 2017/18 pilot	Introduction of Stress Buster sessions across the district. Direct access (no referral required) and provide referral pathway into wider IAPT service. These will be offered in a range of settings, including education providers, employers and retailers. Sessions can accommodate up to 100 people.
	H7 We will ensure that services provide a balanced range of effective therapies as well as pharmacological interventions that are culturally appropriate and effective							Implemented MyWellbeing College website with online and telephone self-referral Implemented Self-Referral Hub, to take telephone self-referrals and provide immediate suitability assessment	Monitoring/reporting of IAPT interventions is in place
	P4 We will use the "Pathways and Packages" approach to commission evidence based care to meet people's needs		Develop pathways	Implement currency					IAPT is system ready for clustering Clustering of patients to commence in April 2017 at point of suitability assessment
Future in Mind	W16 We will develop a network to deliver mental health and emotional support in each school to promote mental wellbeing amongst young people							2017/18 £91,000 Mental Health Champions in Schools	Future in Mind funding has secured Primary Mental Health Worker provision recurrently (April 2016) Appointees to vacant posts all now in place PMHW capacity mapped to new 0-19 pathway cluster model *PMHW lead is part of the Public Health-led Future in Mind workstream for school engagement including MH Champions in School, workforce development, network of schools based support for emotional health and wellbeing.
	W17 We will improve the awareness and understanding of mental health for all people working with children and young people.	Sue Sykes							Workforce development is cross cutting workstream. Workforce and Training post in place at BDCFT. Existing workforce training plan in place. Being revisited and planned in context of schools engagement work.
	C1 We will establish mental health expertise within the entry point to children's services to enable access to early help/mental health services.						2017 – 2019 planning guidance> More MH services for C&YP with 32% access to evidence based services April 2019 and all areas part of CYP IAPT by 2018	Buddy Scheme (Barnardo's) £232,000 (NHSE non-recurrent)	Primary Mental Health Workers aligned with Early Help points of access to children's social care
	C2 We will develop a community based service for young people with eating disorders to support care delivery at home in order to reduce Hospital admissions.	Mark Vaughan	Implement service action plan	95% target for access within 1 week (urgent), 4 weeks (routine)		Services to be compliant with Better Access Waiting time standard by April 2020.	**2017 – 2019 planning guidance>** Commission community eating disorder teams so 95% of C&YP receive treatment within 4 weeks for routine and 1 week for urgent referral	2018/19 £324,000 NHSE funding for Future in Mind	Workforce plan in place and being recruited to for completion by Jan 2017 QNCC ED self assessment tool to be utilised to create service action plan 17/18
	C4 We will develop a dedicated Looked After and Adopted Children therapy team to deliver support, consultations and supervision to those teams working with these vulnerable groups.	Complete							Business case and funding agreed in June 2016. This included some new investment and also LA CAMHS social worker capacity being ringfenced. CAMHS health have recruited to posts and will all be in post by Jan 2017. Already offering extended consultation into Childrens' Homes.
Perinatal Mental Health	C5 We will work with partners to develop a West Yorkshire specialist perinatal mental health team which interfaces with local evidence based pathways.	WY Perinatal Mental Health Steering Group	Complete recruitment to service Implement service			Increased access to specialist PNMH support	5YFV 2020/21 increased access to specialist PNMH support		December 2016 successful bid to NHSE for local service BDCFT to develop service CCG to confirm funding arrangements
	W8 We will develop a range of social and supported housing options for people with mental health care needs		LA and NHS commissioners work with providers of residential and nursing care to improve quality of care and meet contractual quality standards Joint scoping of requirements for jointly commissioned services LA and NHS jointly retender accommodation services for people with mental health care needs (September 2017)						Supported living and personalised support frameworks already developed. Either can be used to provide specialist support at home for existing and changing client needs. LA has commissioned housing providers for people leaving forensic care / criminal justice system or who have a challenging history of living in the community to meet needs and reduce delayed transfers of care.

Project	Strategic Commitment	Lead	2017/18	2018/19	2019/20	2020/21	Standards	Finance	Update January 2017
	C7 We will complete a review of the current model of CMHT and redesign services to meet future needs, ensuring that the needs of people with Personality Disorder and dual diagnosis, or within criminal justice services are incorporated into future pathways			Develop and implement pathways linked to clustering pathways				2017/18 £160,000 CMHT Advanced Nurse Practitioners (demographic monies)	
	C8 We will design and implement a clear pathway of care to meet the needs of people with a personality disorder in the community.			Develop and implement pathways linked to clustering pathways					Pathway for people with borderline personality disorder already exists in BDCFT Psychological Therapies service
	C9 We will design and implement a clear pathway of care to meet the needs of adults with eating disorders.		Review demand and capacity of children and young people's Eating Disorders service		Commence development of adult service				Low intensity intervention and online package available but low uptake
	C12 We will ensure improved access for older people to addiction services.								
	C14 We will recommission the local diagnostic pathway for Autism for adults to improve access, quality and outcomes								Agreed commissioning priority for 2017/18
	C17 We commit to the identification and prioritisation of access to services by armed forces veterans in line with the Bradford Community Covenant Pledge.								Gate keeping assessment completed by FRS identifies whether the referral is a current/ex armed force member and prioritises access to services
	C18 We will ensure the needs of people with dual diagnosis are embedded within agreed multi agency pathways of care.								
Crisis Care	C3 We will extend access to crisis care through the First Response Service (FRS) by appointing CYPMH specialists within the team.		Complete					2017/18 Vanguard funding for Safer Spaces £228,000	Complete: FRS already offering service to CYP. Specialist CAMHS offering weekly consultation, case discussion and training. Recruitment ongoing. Case tracking of under 18 activity within FRS to support learning and pathway development.
	C10 We will use stakeholder feedback to deliver continuous improvement in the operation of First Response.	Simon Long					2017 – 2019 planning guidance> Eliminate out of area placements for non-specialist acute care by 2020/2021		FRS independent service user evaluation report published 2016 Feedback from Safer Spaces: Haven, Sanctuary, Towerhurst (annual or as required) through life of strategy. Compliments and generic feedback (FFT, service user and carer forum, individual feedback) Safer Spaces Steering Group governance to be provided through BDCFT Quality and Safety Committee and Crisis Care Concordat
	C11 We will ensure our local acute providers have all-age Mental Health Liaison teams in place and by 2020/21 will meet the "Core 24" standards.	Mark Vaughan, se	Work with Physical-Mental Health steering group and Crisis Care Concordat to identify impact of enhanced service to plan allocation of resource from 2020/21 onwards. Stakeholder engagement: identify acute trust leads				2017 – 2019 planning guidance> Delivery of MH access and Quality Standards inc 24/7 access to CRHT and MH Liaison	National funding for Liaison services and A&E Liaison plus 2017/18 £70,000 Care Home Liaison expansion	Awaiting outcome of bid submitted for £409,000 funding in 2018/19.
Early Intervention in Psychosis	W18 We will develop an evidence based pathway for people at risk of psychosis to reduce the risk of transition to psychosis.			Expand EIP capacity so 53% experiencing first episode start NICE treatment within 2 weeks		Expand EIP capacity so 60% experiencing first episode start NICE treatment within 2 weeks	2017 – 2019 planning guidance> Expand EIP capacity so 53% experiencing first episode start NICE treatment within 2 weeks	No additional investment required	EIP have implemented an At Risk Mental State service
	C6 We will improve access for people experiencing a first episode of psychosis to a NICE approved care package within 2 weeks of referral from 50% to 60% by 2020/21.							No additional investment required	Currently exceeding target of 50% patients accessing treatment within 2 weeks. Routine monitoring and reporting in place.
	W5 We will continue to support a strong social care and social work role within mental health services, integrated with health and VCS service provision		Alignment of CPA and Care Act care planning Review options for integration of LA and NHS 24-hour crisis services for children						LA adult social worker budget secure for 2017/18. MH specialist social workers embedded with all BDCFT teams and Safe Spaces commissioned from VCS LA has participated in Social Work for Better Mental Health project to redesign social worker roles in integrated services; this will enable a strategic approach to deployment of social workers with BDCFT teams
	W21 We will ensure that carers are identified, their needs are assessed and a plan agreed to support their personal wellbeing and role as a carer.								EIP: meeting carers assessment standards via the national audit
	H9 We will empower older people and their carers by improved involvement in personalised care planning to reduce admissions and ensure improved partnership between intermediate care and mental health.								

Project	Strategic Commitment	Lead	2017/18	2018/19	2019/20	2020/21	Standards	Finance	Update January 2017
	P3 We will significantly expand the use of personal budgets to enable people to achieve greater choice and control over their own care and support.	Mark Trewin	All newly assessed people to have personal budgets. Management of budgets will be offered by LA.						Care Act fully implemented: LA staff trained in use of SystmOne. Increase in number of people with Individual Care Budgets
	P4 We will use the "Pathways and Packages" approach to commission evidence based care to meet people's needs						**5YFV/2017 – 2019 planning guidance>**		Clustering implemented within EIP NICE approved packages of care available for all EIP patients, linked to cluster
Workforce									
	H1 We will improve the knowledge and awareness of mental health within the Primary Care workforce to enable a more holistic approach to patient management.								
	P5 We will develop a mental health workforce plan to deliver the outcomes set out in this strategy.								
ASC									
	C15 We will contribute to the development and implementation of Autism strategies for both children and adults in Bradford district and Craven.								
Engagement									
	P1 We will seek the views of people with a lived experience, families and carers and professionals to design and deliver services to support this strategy.								
	C13 In view of the critical role of carers, we will actively seek their feedback and contribution to the future design of services.								
Evidence base									
	P2 We will base our commissioning decisions, service design and delivery models on the best evidence available and build on our partnerships with academic institutions to evaluate innovations delivered locally.								
Capacity building									
	P6 We will work with the VCS sector to help build their capacity to respond to the priorities set out in this strategy								
Governance									
	P8 The Joint Mental Health Commissioning Board will become the Programme Board for the implementation of this strategy, informing the future integration of services.	Complete							
Finance									
	P9 We will commit to protecting the current level of investment in real terms in MH services, recognising the importance of effective MH and wellbeing interventions in reducing the overall health and care bill.							2017 – 2019 planning guidance> Increase baseline spend to meet MHIS	2017/18 investment standard met. 2018/19 current plans if delivered meet investment standard.
	P10 We will rigorously review the use of those protected resources to ensure their effective use.								
	P11 We will articulate the case for additional investment through the appropriate QIPP and business planning processes.								
Information									
	P12 We will support the development of integrated records, which will facilitate the delivery of this strategy.								
	P13 We will support the use of collaboration tools which will improve the quality and efficiency of the management of crisis.							2017/18 £122,000 Acute Care Pathway: IHTT community infrastructure (demographic monies)	
	P14 We will support the implementation of digital applications to facilitate self care and therapeutic interventions.								

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Appendix B: Outcome Framework for the Mental Wellbeing in Bradford District and Craven: A Strategy 2016 – 2021

1. The people of Bradford district and Craven will be supported to recognise and value the importance of their mental wellbeing and take early action to maintain their mental health through improved prevention, awareness and understanding
1.a Self-reported wellbeing
1.b Suicide rate **(NHSOF 1.5iii)
2. Enjoy environments at work, home and in other settings which promote good mental health and improved wellbeing
2.a Social isolation † (ASCOF 1.18)
2.a.i Percentage of adult social care users who have as much social contact as they would like
2.a.ii Percentage of adult carers who have as much social contact as they would like
2.b Employment
2.b.i Employment rates for district
2.b.ii Employment of people with long-term conditions (ASCOF)
2.b.iii Employment of people with mental illness (ASCOF 1F** & PHOF 1.8**)
2.c Housing
2.c.i Proportion of adults in contact with secondary mental health services living independently with or without support
2.c.ii Households in temporary accommodation (ASCOF 1.15ii)
2.c.iii Fuel poverty (ASCOF 1.17)
2.d Index of multiple deprivation: proportion of lower layer super output areas (LSOAs) in most deprived 10% nationally
3. Experience seamless care and have their physical and mental health needs met through services that are integrated and easily accessible
3.a People with long-term condition (LTC) feeling supported to manage their condition(s) (IAF) (CCGOF)
3.b Improving outcomes from planned treatments: Total health gain as assessed by patients for elective procedures (i Physical health-related procedures; ii Psychological therapies; iii Recovery in quality of life for patients with mental illness)
3.c Enhancing quality of life for people with mental illness: Health-related quality of life for people with mental illness (ASCOF 1A** & PHOF 1.6**)
3.di People with SMI receiving a full annual health check
3.dii Excess under 75 mortality rate in adults with serious mental illness (PHOF)
4. Reach their maximum potential through services which are recovery focussed, high quality and personalised and which promote independence
4.a Proportion of people who use services who have control over their daily lives (ASCOF)
4.b Improving Access to Psychological therapies (IAPT) - recovery rate
4.c People with first episode of psychosis starting treatment with a NICE-recommended package of care within 2 weeks of referral

4.d Percentage of CYP with a diagnosable mental health condition receive treatment from an NHS funded community mental health service
4.e Percentage of people with common mental health problems accessing psychological therapies
4.f Enhancing quality of life for carers: Health-related quality of life for carers (ASCOF 1D**)
4.g Proportion of community mental health service users feeling that overall they had a good experience (NHS Community Mental Health Survey)
5. Expect support to be commissioned and delivered in a way that leads to increases in efficiency and enables transformation of care through reinvestment.
5.a Spend and outcome tool (SPOT) (www.yhpho.org.uk/default.aspx?RID=49488)

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Report of the Bradford District Care NHS Foundation Trust and the Strategic Director, Health and Wellbeing Department to the meeting of the Health Social Care Overview & Scrutiny Committee to be held on 2 March 2017

AE

Subject:

Community Mental Health Services

Summary statement:

The Health and Social Care Overview and Scrutiny Committee requested an update report on the Community Mental Health Services delivered by Bradford Council Mental Health Services and Bradford District Care Foundation Trust. The report consists of a summary update of Adult Community Mental Health Services and current developments.
The report has been written by Bradford District Care NHS Foundation Trust and Bradford Council Mental Health services and will be presented by them jointly.

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Bradford District Care NHS FT

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Portfolio:

Health and Wellbeing

1. SUMMARY

The Health and Social Care Overview and Scrutiny Committee requested an update report on the Community Mental Health Services delivered by Bradford Council Mental Health Services and Bradford District Care Foundation Trust. The report consists of a summary update of Adult Community Mental Health Services and current developments.
The report has been written by Bradford District Care NHS Foundation Trust and Bradford Council Mental Health services and will be presented by them jointly.

2. BACKGROUND

Bradford District Care Trust has been serving people with mental health problems and adults with learning disabilities across urban and rural Bradford, Airedale, Wharfedale and Craven since April 2002. On 1 April 2011, the majority of Bradford and Airedale's Community health services transferred to the Trust as part of the national Transforming Community Services initiative. The Trust provide a range of urgent and non-urgent inpatient and community services from over 50 sites. The Trust has an overall rating of 'good' from the Care Quality Commission. The Trust operates community mental health services in partnership with Bradford Council and the services are integrated together using a joint operating model.

Bradford Council is both a commissioner and provider of Mental Health services for Bradford, Airedale and Wharfedale (North Yorkshire Council serves the Craven area). The Council's Health and Wellbeing Department provides Community and Acute Mental Health Services in partnership with the Care Trust and also commissions a range of Adult Social Care and Public Health services via commissioned frameworks.

3. REPORT ISSUES

Community Mental Health Services in Bradford, Airedale, Wharfedale and Craven

There are four community mental health teams (CMHT) in which the Bradford District Care Foundation Trust (BDCFT) and Council work together to provide community mental health services for working age adults. These are all aligned with the Clinical Commissioning Groups (CCG) and Council Constituencies.

These four teams are:

North Bradford CMHT at Somerset House, Shipley.
City CMHT at Horton Park Centre, Little Horton.
South and West CMHT at the Field Head Centre.
Aire wharfe CMHT at Meridian House, Keighley.

The **Craven CMHT** in Skipton is operated by BDCFT in a partnership with North Yorkshire Council.

The **Community Drug and Alcohol teams** both work with people who have a dual diagnosis of mental health and substance misuse.

The CMHTs are multi-disciplinary and jointly staffed and managed by BDCFT and Bradford Council. They include Community Psychiatric Nurses, Advanced Nurse Practitioners, Mental Health Social Workers, Consultant Psychiatrists, Mental Health Therapists, Occupational Therapists, Employment Specialists, Clinical Psychologists, Support Workers and Service User Development Workers. Approved Mental Health Professionals provide a specialist service under the Mental Health Act 2007 and Best Interest Assessors under the Mental Capacity Act 2005.

The teams are based in BDCFT buildings and we have a shared database, RIO is used as the person's record for both organisations. This is in line with recommended good practice for integrated services. In addition, all LA staff have access to Systm One, the adult social care record, which allows us to record and workflow packages of care within adult social care.

Each CMHT has a Social Care team manager and one or two NHS team managers, depending on team size. In addition there is both an NHS and LA service manager overseeing the teams.

Access to the health and social care services, including the Care Act function of the teams is via the BDCFT single point of access or First Response team. Requests for a Care Act Assessment can also be taken through any of the Adult Services access point.

The teams work in line with the Care Programme Approach and Care Act guidance on assessment, reviewing and care or support planning.

Mental Health Social Work within community mental health services is currently subject to the national 'Social Work for Better Mental Health' programme that is led by the British Association of Social Workers and is designed to support the development of professional social work practice within integrated teams. This will be completed in March and lead to the development of a mental health social work strategy.

CMHTs work to a recovery and prevention model and they also work very closely with the First Response Crisis Service, the Intensive Home Treatment team and the Acute Care services. Through the CPA process, each individual receives the appropriate treatment to support them to recovery. The Community mental health services provide a range of models of evidenced based care and work in partnership with other statutory and non-statutory organisations. Within CMHTs there are a number of individual services that are provided. These include:-

The Early Intervention Team

The Early Intervention Teams (EIP) are based in the Hub at the YMCA Culture Fusion building and in each of the CMHTs. EIP teams work to a specific remit and is specifically designed to support people with first episode psychosis. The service offers up to a 3 year pathway with a strong psycho-educational - social approach following a recovery model and provides a multi-disciplinary service consisting of NHS and social work care coordinators, support worker, psychologists and consultant psychiatrists. LA funding for this team comes from our public health department.

The Early Intervention Service was originally created to provide a service for young people to the age of 35. However, the better access to mental health standard for Early Intervention in Psychosis during 2015/16, stated that 50% of all those experiencing a first episode of psychosis are to be treated with a NICE approved care package within 2 weeks of referral to mental health services – this included increasing the access age for those experiencing first episode psychosis to 65. The access standard came into effect from April 2016. NHS England made funds available for this expansion and the CCGs provided recurrent funding to expand the EIP teams during 2016/17. This service is currently being recruited to and they are achieving the access targets, now providing dedicated services for all those experiencing a first episode of psychosis within the community.

The Assertive Outreach Team
The Assertive Outreach Team (AOT) is based in North CMHT and South and West CMHT. The AOT model is designed to support people who are hard to engage and may not have family or other local networks. Engagement can be 'assertive' in that professionals work hard to keep in contact with service users and minimise any risk of deterioration in their mental health.

Physical Health Monitoring
The Physical Health monitoring in secondary care in Bradford consists of five Physical Health / Wellbeing Clinics within Community Mental Health Teams (CMHTs). All patients initiated on antipsychotics are referred for appropriate baseline physical health checks and ongoing monitoring until stable enough to return to the care of their GP. Band 4 Associate Practitioners (APs) carry out the baseline tests and are trained to perform phlebotomy, electrocardiogram (ECGs) and give lifestyle advice including appropriate referral. The APs are supported by a Band 7 Mental Health Nurse specialising in Physical Health to ensure appropriate training and development is supported across inpatient and community services.

The Mental Health Physical Review Template has now been adapted for primary and secondary care and for community and inpatient settings. It can be replicated onto other IT systems and the SystmOne and EMIS version of the templates are available for use nationally. The RIO version can also be replicated easily with the appropriate support and meets the required CQUIN targets. All the templates are aligned to the nationally recognised Lester Tool to ensure the appropriate interventions are carried out. The template guides clinicians through the completion of an appropriate comprehensive check with the physical health information stored centrally in a locatable place in SystmOne EMIS and RIO.

Alongside the template Bradford & Airedale published 'Antipsychotic Shared Care and Physical Health Monitoring' recommendations which highlights the specific responsibilities of both primary and secondary care staff when carrying out physical health checks. The success of the Physical Health Review template and the Shared Care Recommendations in preventing ill health in this high risk group and in promoting 'parity of esteem' has resulted in national interest, the project has received national recognition for the 'Bradford Model' of physical health care;

The Reviewing Team
The local authority Reviewing Team operates across all of these teams and reviews high

cost placements and all packages of care placed by the Local Authority. This team works according to a strength based, 'Home First', recovery and enablement model based on the principles of the Care Act 2014.

Benefits advice and Support
Both the NHS and CBMDC commission benefits advice into the wards and community teams. Austerity and changes to benefits have had an affect on our service users and CMHTs increasingly have a role in supporting our service users with this issue. We have recently developed links with the 'money and mental health' project and have champions and expertise in each team.

VCS Partners
BDCFT and the Local Authority have a very positive partnership with a number of community VCS services that are funded by the LA and/or CCG. There are many services that we use who do not have mental health as part of their funding arrangements. The mental health specific services are:

- **The Cellar Trust** operates employment and vocational support services and also the Haven, a specialist service to support people in crisis and at risk of mental health deterioration in the community or Accident and Emergency department and the BDCFT Wellbeing Recovery College (previously Improving Access to Psychological Therapies).

- **Making Space** operates the Mental Health Wellbeing service and also support for carers within the Community Teams. The wellbeing service provides specialist time limited support to enable recovery and meaningful activity for people with mental health problems on CPA**.**

- **Carers Resource** operates support for carers within the Care Act for adult social care.

- **MIND** Operates a range of services including a drop in, The Sanctuary out of hours Crisis Support service, the Maastricht Interview Centre (offering a social model of support for voice hearers), Guideline telephone support service and a health and well being service.

- **Sharing Voices** is commissioned to provide mental health support to all of our diverse communities in the Bradford area.

- **Naye Subah –** Providing Support to women from a South Asian background.

- **Roshni Ghar** – Providing support to women from a South Asian background

- **ISIS –** Providing mental health support for women

- **The Hale Project** – Based in Shipley, The Hale project provides a range of services to improve health and wellbeing, including mental health.

- **Bradford and Airedale MH Advocacy service:** provides advocacy support for people detained under the Mental Health Act and within the Care Act.

In addition to services funded or operated directly by Bradford Council with BDCFT, Bradford Council commissions a range of mental health services in the community via a number of care and support provides.

These include:

- **The Support Living Framework:** This Framework provides for a range of supported accommodation at medium, high and specialist levels of mental health support. This is a key service for supporting people in the community and enabling people to stay well and prevent admissions to hospital.

- **The Personalised Support Framework:** This Framework provides for support in peoples homes and communities, delivering personal care or support. People with eligible needs are able to have a direct payment and choose their own care and support.

- **The Residential and Nursing care Framework:** This Framework provides for clear standards for people living in care homes and specifically to ensure that care homes are focussed on what the person can do and that people are supported to recover – a 'strength based' approach.

- **Advocacy Framework:** To provide advocacy services under the Care Act and Mental Health and Mental Capacity Acts.

Perinatal Mental Health

BDCFT commissioned provision for perinatal mental health has been limited to a Perinatal Mental Health Lead/Parent-infant therapist (0.8wte). This role has assisted Bradford and Airedale to develop:

- An integrated perinatal referral pathway,
- Fast-track within IAPT plus IAPT perinatal groups

During 2016, NHS England released funding for the development of perinatal mental health services and both the CCGs and BDCFT were successful in receiving funding to develop this service for Bradford and Airedale. The funding, supported recurrently by the CCGs will allow the creation of a unique district wide team that will offer a direct service to:

- Women with a first onset of mental illness that is moderate-severe within the perinatal period
- Women with a history of or current mental illness which has resulted in community mental health involvement

The service will embrace a family-centred approach and carers and family members will be offered support and information. Needs and risk assessments of women will result in

the development of personalised programmes of care. The parent-infant relationship will be understood by all the team and interventions will be mindful of this.

The service will provide additional assessment , monitoring, care planning, and interventions; and consist of a Consultant Psychiatry, Psychology, Care coordination and nursery nurses and support workers. Currently the clinical lead and service manager are establishing the operational and service development processes and initiating recruitment. It is expected that this service will be fully functional during 2017.

The Haven

The haven service is a new service developed in partnership with the Cellar Trust providing a 365 day service – 10am-6pm and has a specific aim to provide an alternative to Accident and Emergency for those requiring mental health support. The Haven, based at the Cellar Trust in Shipley provides a therapeutic environment where people can attend at times of distress after contacting the First Response Service or via Community mental health services. The emphasis is on peer support from people with lived expertise and aims to support people in distress and work with them to develop plans to stay well and improve coping strategies. The Intensive Home Treatment team also provide NHS and Social Care duty workers based at the Haven whom can offer support and signposting to further acute and community services.

In addition there is a new 'safe space' for children and young people and the 'Sanctuary' at MIND fulfils this role out of hours.

Improving Access to Psychological Therapies – My wellbeing college

The Bradford Improving Access to Psychological Therapies (IAPT) Service is delivered across the district operating a 'stepped care model', covering 'low intensity therapy', appropriate for people with mild anxiety and depression; 'high intensity therapy', appropriate for people with moderate anxiety and depression. Over the previous year BDCFT took on the lead provider role for psychological therapies working in partnership with the VCS and have developed a recovery model approach for IAPT. The vision, and that of our commissioners and service users, was to develop the Wellbeing College; an integrated psychological therapy provision across Bradford District; incorporating BDCFT IAPT services and VCS providers. Recovery Colleges are co-produced in local partnerships; providing a range of different courses, seminars and workshops that allow them to cater for people with diverse needs and preferences. This flexibility lends itself as an ideal service model for the proposed psychological lead provider arrangements and IAPT.

The My Wellbeing College provides a self referral and single point of access to a range of IAPT based approaches using an educational model where people can receive low or high intensity therapy, enrol on a number of courses such as mood matters, which helps overcome low mood, stresspac, which aims to manage stress and anxiety effectively and mindfulness which demonstrates how to "just be" in the present moment. As well as telephone access, the service offers a web based enrolment process which also provides a wealth of self help material and information and access to phone advice or one-to-one courses at a range of locations as well as access to computerised cognitive behaviour therapy courses.

The single point of access for my wellbeing college is co-located with the First Response service and provides clinical triage, sign posting and direct referral to urgent services if required. The website is www.bmywellbeingcollege.nhs.uk

Review of Community Mental Health Services

Community Mental Health Services are currently subject to a joint review in line with the recommendations of the Bradford, Airedale, Wharfedale and Craven Mental Wellbeing Strategy and the NHS England review of Community Mental Health services to support the Five Year Forward View.

BDCFT and the Council have initiated a review of adult community mental health services in order to explore demand and capacity, improved clinical pathways and services under the Care Act. This review is due to be completed in quarter 4 2016/17. A recent program has been initiated to review the whole pathway across adult acute and community mental health services with a view to explore a wellbeing and recovery model, including the principles of the Care Act. Building on the success of the acute care pathway and work overseen by the crisis care concordat, this program is now exploring changes required across both acute and community mental health pathways to reduce difficulties in service transition, silo working and improve a wellbeing approach to mental health problems.

The program includes representation from the Trust, service users, Local Authority and our voluntary service partners and alongside the review of CMHTs, will look to design an enhanced recovery model that will provide increased and improved care closer to home for service users as well as focus on recovery and improvement.

BDCFT and CBMDC are both members of the national Positive Practice in Mental Health collaborative, designed to share and develop good practice in mental health provision. Bradford has the leads for transformation, social care and parity with physical health.

Bradford is a member of the West Yorkshire Mental Health Vanguard and BDCFT leads on the development of liaison services.

4. OPTIONS

None

5. CONTRIBUTION TO CORPORATE PRIORITIES

This is included in the Better Health Better Lives Council delivery plan.

6. RECOMMENDATIONS

That the Health and Social Care Overview and Scrutiny Committee notes the reported position for Community Mental Health Services including the developments noted above.

7. APPENDICES

None

8. BACKGROUND DOCUMENTS

Mental Health Wellbeing Strategy

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Report of the Strategic Director, Health and Wellbeing to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on 2nd March 2017.

AF

Subject:

Home First – a new vision for wellbeing in the Bradford District and a new operating model for the Department of Health & Wellbeing to deliver the aims set out in the new vision.

Summary statement:

This report sets out the rationale, key aims and ambitions for the new vision (Home First) for wellbeing in Bradford and the new operating model for the department of Health and Wellbeing. The report also provides an update on the development process and outlines key next steps for the consultation and approval of the final documents.

Bev Maybury

Strategic Director: Health and Wellbeing

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Portfolio:

Deputy Leader and Health & Wellbeing

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

1.1 This report sets out the rationale, key aims and ambitions for the new vision (Home First) for wellbeing in the Bradford District and the new operating model for the Department of Health and Wellbeing.

1.2 The report also provides an update on the development process for the new vision and operating model and outlines key next steps for the consultation and approval of the final documents.

1.3 The draft vision (Home First) is centred around the belief that where possible, people in the Bradford District who are in receipt of health and social care services should be supported to stay in their own home, so that they can continue to enjoy relationships with their family, friends and be active members of their local community while being able to participate in activities in the wider District.

1.4 The associated draft operating model sets out the organisational policy, governance, decision making and commissioning arrangements that will support the delivery of our vision, through enabling people to have control over how they manage their Health and Social care needs with a greater focus on the use of personal and community assets and working in partnership with key partner agencies within the public, private and voluntary sector.

2. BACKGROUND

2.1 The context within which the Department of Health & Wellbeing delivers services is constantly evolving. There are significant changes in: demographics; customer needs and expectations; legislation; and financial pressures. These include:

- *The Care Act (2014) sets out a new framework of local authority duties in relation to the arrangement and funding of social care, along with a number of changes to the regulation of social care providers. The Act also demands that local authorities must promote greater integration with the NHS,*
- *The government's Spending Review and Autumn Statement (2015) sets out that every part of the country must have a plan for integrated Health and Social Care in 2017, to be implemented by 2020.*
- *The money from central government to the Council has greatly reduced and continues to do so over the life of this parliament, which is putting pressure on service delivery.*
- *The Health and Wellbeing service which is now made up of Adult and Community Services, Public Health and Environmental Health has a total proposed savings target of £20.9m in 2017/18 and £11m in 2018/19*
- *The number of people who use Adult and Social care is expected to rise from 8,500 now to 8,843 in 2 years' time, which is a 2% increase on an annual basis. We expect that the demand will continue to keep rising by 2% each year until 2030. (Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI)).*
- *ADASS annual budget survey (2016) suggests that adult social care accounts for 35% of total council spending, while the Local Government Association (LGA) analysis shows that the proportion could rise to 40% by 2020.*

2.2 The nature of the issues outlined above requires an approach that ensures sustainability of support to people, which maintains their independence, living within their own communities and improves their quality of life and general wellbeing. National best practice research also shows that a strength and community based approach can improve the quality of life for people who have health and social care needs, whilst reducing costs.

3. RATIONALE, PURPOSE AND APPROACH

3.1 Over the last few months, the Department of Health & Wellbeing has been reviewing how it provides support services to people in the Bradford District. One of the outcomes of this review has been the development of a new vision and operating model for Health and Wellbeing, which will guide and shape how we will work with our partners to deliver the high level outcomes set out in the Council's Corporate Plan 2016-20, for everyone in the district to have a long healthy and full life.

3.2 The development process for both the draft vision and operating model has included working with partner organisations in NHS, community and voluntary sector (VCS), service user groups, partnerships, networks and elected members. The draft vision and operating model incorporates feedback from these groups and are attached to this report as appendix 1 and 2.

3.2 VISION – HOME FIRST

3.2.1 The issues outlined above are reflected in our aim and ambitions for the wellbeing of Bradford District, and are set out in our Home First Vision document, which is currently being developed. Our vision is centred on the belief that:

> "*where possible, people in the Bradford District who are in receipt of health and social care services should be supported to stay in their own home, so that they can continue to enjoy relationships with their family, friends and be active members of their local community while being able to participate in activities in the wider District".*

3.2.3 The delivery of our vision will rely heavily on a whole system approach that enables people to intervene early, and delay or prevent the need for long term care, while supporting them to maintain their independence as long as possible. As such, the vision will guide the way we work with our partners across the Health and Adult Social Care spectrum to develop, shape and commission services.

3.2.4 As a result of our approach, it is likely that, in the future there will be fewer people receiving on going, longer term social care support – however this is in the context of the drive to support people to live independently.

3.3 "TO BE" OPERATING MODEL

3.3.1 To support the delivery of our vision we are also reviewing our operating model to ensure that it enables us to work creatively and collaboratively with our partners within the public, private and voluntary sector.

3.3.2 The new (To Be) operating model builds on our local experience and national good practice, and is based on a vision of shared responsibility between Council (including public sector), the community and the person. It recognises that the role of the Department of Health & Wellbeing is to work collaboratively with our partners to align our resources to support people's independence and ability to be part of their communities for as long as possible.

3.3.3 By helping people to stay healthy and well, supporting them to regain their independence after illness or injury, and encouraging them to make greater use of their own and community resources, the new operating model also aims to reduce demand for public sector resourced care and support.

3.3.4 The model proposes changes to how we do things e.g. processes, team and organisational culture and working practices, for example:

- *A greater focus on resources on front line support and time limited interventions to help people get back on their feet and in their own homes.*
- *Investing in good quality information and advice which will enable people to intervene early and delay or prevent the need for long term care.*
- *Strengthening our self-care and self-directed support offer in local communities through the development of multi-agency community hubs,*
- *Delivering a workforce development programme across all agencies to ensure they are fully equipped with the right skill set to support the delivery of our shared approach.*
- *Developing an integrated strategic commissioning approach that aligns resources and supports flexible delivery solutions.*
- *Improving the use of digital information platforms to develop and deploy support services that meet the needs of people and communities.*
- *Enhancing the use of assistive technologies that enables people to maintain their independence and enhances their quality of life.*

3.3.5 Appendix two provides further detail on the "To Be" operating model and includes a visual description of the key components.

4. DEVELOPMENT, CONSULTATION AND APPROVAL

4.1 We are committed to taking an inclusive approach to the development of the new vision, operating model and associated delivery plans. The approach and principles behind the vision has been discussed with a range of stakeholder groups in draft form to help support its development and seek input on the overall approach and direction. Presentations have been given to the following groups, and feedback has been received:

- *Department of Health & Wellbeing staff roadshows – Nov to Dec 2016*
- *Strategic Disability Partnership, Older People's Partnership, Learning Disability Joint Budget Consultation Workshop – 23.01.17*

- *Health & Social Care Overview and Scrutiny Committee – 26.01.2017*
- *Bradford Talking Media User Group – Jan to Feb 2017*
- *Integrated Change Board (ICB) – 17.02.17*

4.2 Further presentations and consultations are also planned with:

- *Health & Social Care Overview and Scrutiny Committee – 2nd March 2017*
- *Health & Wellbeing Board – 28th March 2017*
- *Older People's Partnership Board - 9th March 2017*
- *Strategic Disability Partnership Board - 6th April 2017*

4.3 Feedback from these groups will be used to refine the vision, the operating model, related success measures and delivery activity. However, in general the feedback received to date has been positive and supportive of the overall approach e.g. the vision and operating model was presented to ICB who endorsed the approach set out in the documents and were keen to support the implementation plans.

4.4 The final draft of the Home First Vision and operating Model for the Department of Health & Wellbeing will be presented to the Council's Executive on 4th April 2017 for their approval.

5. IMPLEMENTATION TIMESCALE

5.1 Subject to Executive's approval in April we are expecting work to begin on the implementation of the Vision through the roll out of the new operating model. We envisage that it is likely to take 6 to 12 months to fully implement the core components. Appendix two includes detail of key delivery milestones.

6. FINANCIAL & RESOURCE APPRAISAL

6.1 Moving to a model based approach on early intervention and prevention through a greater focus on self-care, personal and community resources will play an essential role in the departments plans to reduce demand and costs. As such, the new operating model will contribute to achieving the pre-agreed savings allocated to the department by full Council for 2017/18, alongside the savings to be agreed by full Council in Feb for 2017/18 and 2018/19.

7. RISK MANAGEMENT AND GOVERNANCE ISSUES

7.1 The proposals are key to the Department of Health and Wellbeing in delivery of its responsibilities under the Care Act 2014 and to ensuring this is done within the allocated budget.

7.2 These proposals mitigate against potential budgetary and performance risk for the department.

7.3 Equality assessments have been carried out on the vision and operating model, and will continue to be updated to enable mitigation against any risks.

8. LEGAL APPRAISAL

8.1 When making decisions around service delivery, the Council must consider its specific duties under the Care Act 2014 and the Public Sector Equality Duties and consultation requirements.

9. OTHER IMPLICATIONS

9.1 EQUALITY & DIVERSITY

9.1.1 The implementation of the new vision and operating model will place the individual at the centre of services and enable wider access to services that the person can direct according to their preferences. This will promote fairness and equality by ensuring that service access requirements for people with equality protected characteristics (e.g. age, disability, ethnicity etc.) are met according to their personal choice.

9.1.2 An initial equality impact assessment has been completed for the new vision and operating model, this will be further refined and updated as we firm up the detail implementation plan and updates and as a result of feedback from the implementation process.

9.2 SUSTAINABILITY IMPLICATIONS

9.2.1 The long term sustainability of the Council's ability to continue to provide support to people is under considerable pressure due to the increasing demand and the reduction in funding. This issue is not isolated to Bradford and is currently being discussed nationally by the Government and other influential bodies.

9.3.1 GREENHOUSE GAS EMISSIONS IMPACTS

9.3.1 None

9.4 COMMUNITY SAFETY IMPLICATIONS

9.4.1 None.

9.5 HUMAN RIGHTS ACT & TRADE UNION

9.5.1 Staff have been involved in the development of both the vision and operating model from the outset of the process to help shape the approach and thinking. We will continue to involve them as we move into the implementation process. If any HR implications are identified as part of the implementation plans, then these will be managed in a formal manner in accordance to the agreed Council policy and employment legislation.

10. NOT FOR PUBLICATION DOCUMENTS

10.1 None.

11. RECOMMENDATIONS

11.1 That the Committee notes progress made towards the development of the new Home First Vision and the new operating model for the Department of Health & Wellbeing.

11.2 That the Committee provides comment and feedback on the vision (Home First) and the new 'To be' operating model.

12. APPENDICES

Appendix one: Draft Home First Vision

Appendix two: "To be" operating model

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APPENDIX 1

Home First

Our vision for wellbeing

January 2017

DRAFT

City of Bradford MDC
www.bradford.gov.uk

Foreword

Councillor Val Slater

Deputy Leader and Health and Wellbeing Portfolio Holder

As Deputy Leader & Health and Wellbeing Portfolio holder in Bradford Metropolitan District Council I am pleased to introduce "Home First – our vision for wellbeing" for Bradford District.

This document sets out our vision and ambitions for wellbeing in Bradford District, which are structured around the themes of Home, Health and Happiness. I firmly believe that by focussing our activity around these key themes we will be able to improve and enhance the support and care we provide to people and to deliver the commitments we set out in the District Plan 2016 -2020

We have called the vision – "Home First" because we believe that where possible people in the Bradford District who are in receipt of Adult & Social care support should be supported to stay in their own home, so that they can continue to enjoy relationships with their family, friends and be active members of their local community while being able to participate in activities across the wider District.

As such, the vision will guide the way we work with our partners in the public sector (including Health), the Voluntary and the Community Sector and Private sector to deliver a range of services that will support individuals to live as independently as possible, and recognise their rights and choices about what is right for them, and to ensure they are protected when necessary.

The delivery of our vision will require a collective effort from all stakeholders in the district and therefore I look forward to working with you all to positively reshape the way we support people in the District and make this vision into reality.

Councillor Val Slater

Bev Maybury

Strategic Director Health and Wellbeing

I would like to welcome you all to 'Home First' which describes our vision for wellbeing in Bradford District. My team and I intend to use this document to share our thinking, consult and open up the discussion with people who use services, their families and carers and our wider partners about how we make the vision real. We know that there are things we can do better and I would welcome feedback on how we can work together to make positive changes.

Through investing in good quality information and advice which enables people to intervene early and delay or prevent the need for long term care alongside investment to strengthen our self-care and self-directed support offer in localities we believe that we can better support people to feel in control and make choices about how they want their support arranged around them to meet their outcomes. Having more choice and control is empowering. We should all be equal partners in making decisions that affect us. This leads to more of us being confident and independent and achieving our aspirations for a happier, healthier and more fulfilled life. Support and care have a vital role to play in ensuring everyone can enjoy the same human rights - dignity, equality of opportunity and access. When people feel happier, in control and safe they experience improved wellbeing and health outcomes.

I hope that you find the vision document accessible, clear and interesting. Please contact 01274 435400 or tweet us at [insert] to let us know what you think.

Bev Maybury

Our Dept of Health and Wellbeing

HOME FIRST - This aims to help people to be independent and have a better quality of life by meeting their care and support needs within their own home, keeping them near their friends and family for as long as possible.

The department's main purpose is to strengthen the connections between health and social care, with the aim to enhance the wellbeing of our residents and ensure greater independence and choice for individuals.

The department also has a leadership role in driving integration and transformation both within the Council and across the local healthcare system.

The department is made up of three service areas, which includes Public Health, Environmental Health and Adult Social Care.

- **Public Health:** The service focuses on what can make a difference to an individual's health, and then takes actions to promote healthy lifestyles, prevent disease, protect and improve general health, and improve healthcare services.

- **Environmental Health:** The service tackles and addresses many issues which are fundamental to good health and wellbeing. These include food safety, air quality, noise and other nuisances, contaminated land, drainage and drinking water supplies. In addition they have a key role in communicable diseases control. Outcomes are achieved through preventative work, eg with planning and other partners, inspection, advice and enforcement and in response to customer complaint.

- **Adult Social Care:** The service helps adults with eligible social care needs find care and support so they can live as independently as possible in their own homes

Our ambition for Bradford: Home, health, happiness

Our ambition is for Bradford to be a place where:

- People are understanding that contributing to Bradford and District is being recognised and valued.
- People are supported to live healthy, happy lives, where they are in control and able to make the best lifestyle choices for themselves and their families.
- We recognise and support the different and diverse communities that make up Bradford and District and offer support appropriately.
- Communities and places across Bradford District help people to live the healthiest and sustainable lives they can with access to clean air and a good range of housing options.
- We ensure access to information, advice and support in such a way that it enables people to help themselves.
- We empower people who choose to access support from services and empower staff involved in providing services to uphold people's rights to be in control and have their wishes, feelings and beliefs upheld.

CASE STUDY

Betty's story

Betty's has been living on her own since her husband died. Her 2 sons live close by and both pop in once a week to check that she is OK. Betty's sons have been worried about her as her home care workers have reported to them that she is losing weight. Betty had a bad infection, which made her confused and led to a bad fall during the night. The home care workers found her 6 hours later and rang for an ambulance. When she was taken to hospital they found that she had broken her hip. Betty's sons really want her to move into a care home as they were really worried about the fall but Betty really wants to go home. Through discharge to an intermediate care bed Betty's social worker has had the time and opportunity to build up a relationship with Betty and better understand Betty's strength and that she is making an informed choice to go home. The social worker arranged for a risk enablement meeting with Betty, her sons, the Occupational Therapist and other professionals to help Betty explain that she wishes to return home but needs some support around the risks. The social worker recommended that Betty has access to telecare equipment so that if she becomes confused and falls again her sons would be immediately notified and a mobile response worker would go out to help support Betty. Betty is supported by the Occupational Therapist to do a home from hospital visit. The Occupational Therapist also recommends that Betty has some equipment fitted in her bathroom. Betty's social worker arranges for a local community group worker to meet Betty from the taxi taking her home. The worker makes sure that she is settled, the heating is switched on and that she has a cup of tea. They arrange to come back each day that week and take her out every Monday and Wednesday to the local café to meet with a group of other ladies who are the same age as Betty.

CASE STUDY

Tariq's story

Tariq was born with a learning disability. He really likes his mum's cooking, but has over the years gained weight. The learning disability nurses have told his mum that he has diabetes. Tariq has just turned 18. He loves his mum but he wants to get out more, like other young people his age and make friends. Tariq's social worker from the Transitions Team spends time with him to find out what things are important to him in his life. The social worker finds out that Tariq likes the actors in films and TV drama. He has a top 20 of favourite actors and can tell his social worker all their best lines! Tariq's social worker makes contact with a voluntary organisation who have a regular social group which meets at a café in a local film Museum. The group have just started working with a production company that supports adults with a learning disability to produce plays and musicals. They help Tariq to learn how to become an actor and his mum is really proud to attend his first play. His mum tells you that he has started to lose weight. Tariq tells his social worker that he is planning to be a supporting actor in a television drama set in Bradford.

Our responsibility: A General Duty of Wellbeing (Section 1 of the Care Act)

The Care Act 2014 sets out a number of new rights for adults who choose to access support from services, their carers and families the centre of adult social care and new duties for City of Bradford Metropolitan District Council. These rights are underpinned by a general duty on the Council to promote the wellbeing of all our citizens.

Please note:
Public Health Case Study to be added

Wellbeing is not just the absence of disease or illness. It is a combination of physical, mental, emotional and social health factors. Wellbeing is linked to happiness and life satisfaction. In short, wellbeing could be described as how you feel about yourself and your life, being comfortable, healthy or happy.

Our approach in delivering our duty will be centred around a rational and compassionate approach.

What will this mean?

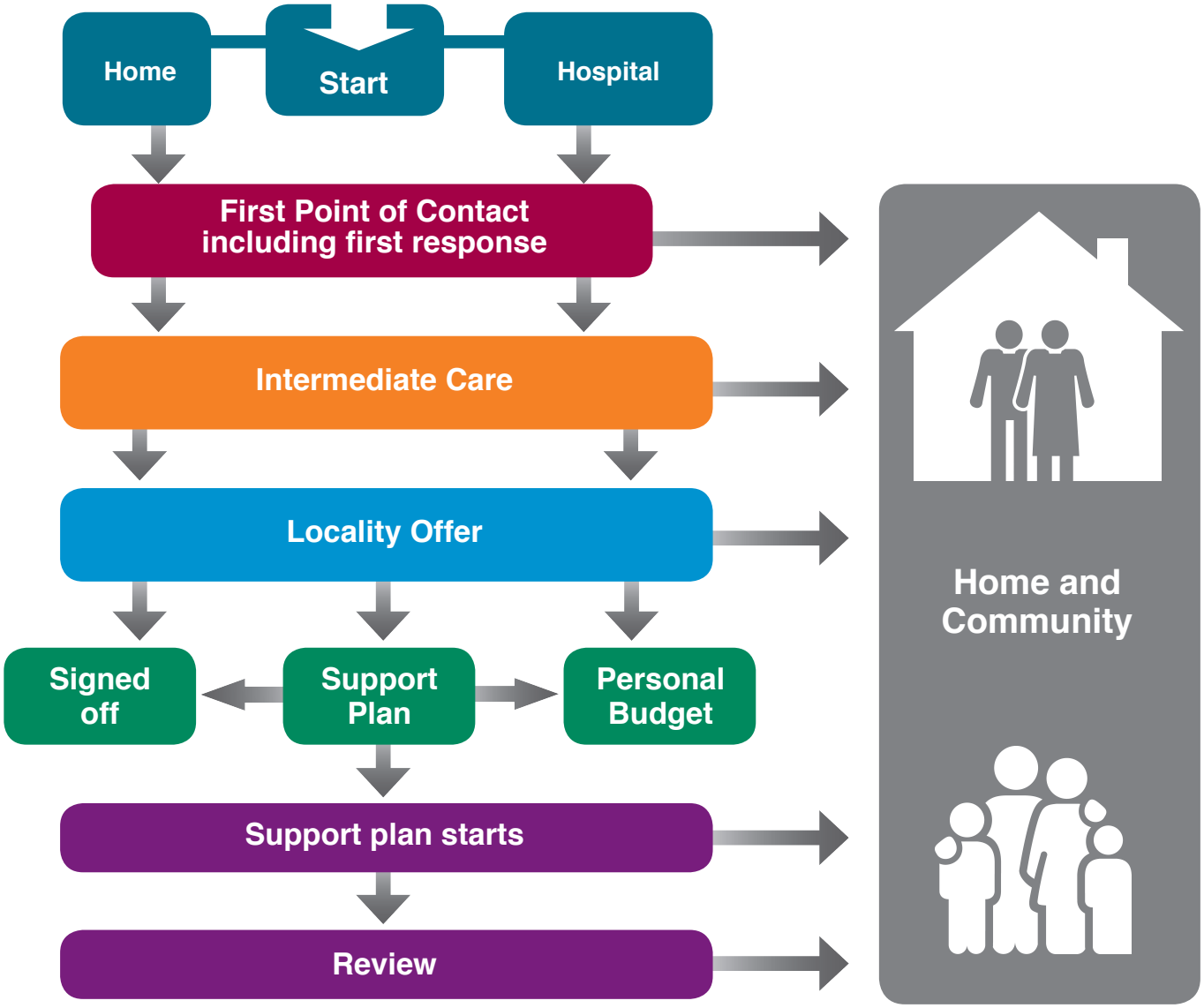
We will work with people who choose to access support from services, their carers and family members and our communities to develop new systems which build on their strengths. Strengths based approaches involve:

- Making information and advice easily accessible so that people can make informed decisions about their support needs
- Early intervention which builds on people's natural networks of support
- Ensuring that all practicable steps are taken to ensure the wishes, feelings and beliefs of people who have long term support needs from the services are communicated, understood and upheld.

We will do this by:

- Listening to people
- Improving the accessibility of our information about options
- Finding personalised solutions
- Being proactive to support for self-care which supports healthier lives
- Helping early to delay and prevent minor things developing into something major
- Strengthening and investing in our Social Workers and the culture of social work practice
- Transferring power away from traditional services to people, their families and communities
- Using technology
- Treating all people with dignity and respect
- When you are in hospital, we will strive to get you home as quickly as possible
- Establishing arrangements to uphold and enable people's right to take positive risks
- Ensuring that where a person is at risk of abuse that we put in place measures that ensure they remain in control
- Where a person requires the deprivation of liberty safeguards we take all practicable steps to ensure their rights are upheld.

The Social Care customer journey



CASE STUDY

Ian's story

Ian has lived in a care home in Wales since the age of 16. He has a physical disability and uses a wheelchair. Staff at the care home report that he has lost contact with his family in Bradford but appears bored in the home and that he is going out drinking in the town centre. They are worried that people are taking advantage of him and his money. Ian is known to enjoy buying and selling electronic goods. Ian doesn't want to speak to a social worker. He has had a yearly visit from a social worker to review his placement. He refuses to meet with the social worker when they visit. A new social worker spends time reading about Ian before making contact with him and notices that he likes electronics. The social worker asks the care home to give Ian the social media contact for the social work team. Over a period of 3 months Ian gets to know the social worker through using social media. Ian agrees that the social worker can ring him to discuss his care arrangements. The call goes well and Ian suggests that the social worker users facetime on their workphone to speak to him. He tells her that he is lonely and he misses his family. The social worker arranges for Ian to come to Bradford and spend a long weekend in a local care home with support from a Personal Assistant who supports him to visit his family and reconnect back to Bradford through visiting places he remembers from being a child. Ian decides he wants to stay in Bradford and would like to live independently using a Direct Payment to arrange support from a Personal Assistant.

Personal Budgets

In order to deliver our approach, we will use a personal budget process which will include the following steps:

1. **Resource Allocation System (RAS)**

   An indicative personal budget is calculated to reflect the level of support required to meet the assessed need.

2. **Support Plan**

   A plan that identifies how people will spend the money allocated to them to get the life they want.

3. **Approving the Support Plan**

   The Council will have to sign off the approved support plan before the personal budget is released.

4. **Personal Budget**

   People will have four options for using their personal budget:

   a) **Direct Payment (DP) –** Money paid by the Council to an eligible person (or someone acting on their behalf) so that they may arrange their own care and support instead of receiving arranged services. Records of how the money is spent are audited regularly.

   b) **Individual Service Fund (ISF) –** Money given to a third party (fund holding provider) to hold on behalf of the person and used to pay for care and support services in line with the support plan.

   c) **Managed Care –** Services that are arranged by the Council; people who use them have less choice and control over how they are delivered.

   d) **Combination of the above**

A DP may be used to manage some of the care and support services arranged to meet a person's needs with the rest arranged through a managed ISF arrangement.

CASE STUDY

John's story

John celebrated his 45th birthday recently. Birthdays have always been difficult for John. It is a time when he can feel really alone. This year however things were different. John's social worker in the Community Mental Health Trust had formed a strong relationship with him over the last 2 years and knew that he found this time of year difficult. John's social worker arranged to meet with John in the community café at the Cellar Trust a few months earlier. He had found out that John used to be a mechanic and he used to love working on cars. John went on the Stepping Stones course which helped him think about how to get back into work and stay well once he was in employment. He started a work placement with a local garage, working 2 days a week to begin in the week of his 45th birthday. When John's colleagues found out about his birthday, they arranged to get him a card which they had all signed. John is starting to feel that he can remain healthy and well in work and is beginning to regain his confidence that he is not alone.

Glossary

The Care Act 2014:

The Care Act is a law about care and support for adults in England. It gives clear and simple rules about what care and support people should be able to get as well as what councils have to do.

For further information on the Care Act please visit www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Customer journey:

The experience a service user goes through at each stage from start to finish from being at home or in hospital and assessing the needs required through to the putting a plan together allowing the service user to live independently and further reviewing the support plan.

Early Intervention:

Early intervention means taking action as soon as possible to tackle problems before they become more difficult. Its purpose is to improve the life chances of people and benefit their families and immediate communities, and at the same time reduce long term costs.

Home First Model:

This aims to help people to be independent and have a better quality of life by meeting their care and support needs within their own home, keeping them near their friends and family for as long as possible

Personalisation:

Personalisation is a way to give everyone more choice and control over the support they get. Personalisation means

- that services are tailored to the needs of every individual, rather than delivered in a one-size-fits-all fashion.
- that families get better information about care and support
- that we spend more money on keeping people well, so there is less need for care, especially residential care
- that we encourage people to stay independent.

Contacts and further information

For more information on our Home First Vision visit:
https:Homefirst.Bradford.gov.uk
Twitter:
Facebook:
Telephone: 01274 435400
Email: hwbvison@bradford.gov.uk

Alternatively you can write to:
Health & Wellbeing Department
5th Floor, Britannia House, Bradford, BD1 1HX

To protect the identities of service users and providers stock photographs have been used throughout this report.

The wording in this publication can be made available in other formats such as large print and Braille. Please call 01274 431989.

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"To Be" Operating model

Department of Health & Wellbeing

Bev Maybury

Strategic Director – Health & Wellbeing

Version 0.3 - 21st February 2017

1. Introduction

Our vision (Home First) for Wellbeing in Bradford is centred around the belief that where possible, people in the Bradford District who are in receipt of health and social care services should be supported to stay in their own home, so that they can continue to enjoy relationships with their family, friends and be active members of their local community while being able to participate in activities in the wider District.

To support the delivery of this vision we recognise that our policies, governance and decision making arrangements should be structured to enable us to work creatively and collaboratively with our partners within the public, private and voluntary sector.

The new "To Be" operating model has been designed to enable the department to deliver the aims and ambitions set out in our Home First Vision and is based on the principles of shared responsibility between Council (including public sector), the community and the person.

It recognises that the role of the Department of Health & Wellbeing is to work collaboratively with our partners to align our resources to support people's independence and ability to be part of their communities for as long as possible.

We believe that by helping people to stay healthy and well, supporting them to regain their independence after illness or injury, encouraging them to make greater use of their own and community resources, the new operating model will reduce demand for public sector resourced care and support.

2. Key components / principles

The "To Be" operating model builds on our local experience of delivering services and the good work undertaken within the department, while also incorporating national best practice. The key components of our operating model are visually described in the diagram overleaf, and are summarised below:

- A greater focus on early intervention and prevention by reshaping support to reach people earlier and being more accessible in local communities
- Strengthening our self-care and self-directed support offer in local communities through the development of multi-agency community hubs, which will enable us to better support people to feel in control and make choices about how they want their support arranged around them to meet their outcomes

- By building capacity within communities, people will be able to access support within their own communities, while also reducing isolation and loneliness.
- A greater focus of resources on front line support and time limited interventions, such as reablement services, to help people get back on their feet and in their own homes. This will also mean emphasising the importance of being highly responsive when people are in crisis and developing a plan that helps them to regain as much independence as possible
- Delivering a workforce development programme across all agencies to ensure they are fully equipped with the right skills set to support the delivery of our shared approach e.g. ensuring that our front line staff are able to identify support requirements at an early stage (e.g. safeguarding) and also help people develop and maintain skills that will maximise their independence
- Implementing an organisational change programme that is aligned to the workforce development programme and focuses on affecting culture change, enabling transformation and streamlining bureaucracy, with an emphasis on enabling a bottom up approach e.g. people centric dialogue to identify what people, their families and carers want to tell us and working with them rather than doing to them
- Making best use of digital platforms and assistive technologies to support employees to be more effective and help people to maintain their independence and enhances their quality of life
- Investing in good quality information and advice which will enable people to intervene early and delay or prevent the need for long term care. This will ensure that we have a universal approach across all our contact points that sign posts people to the right information or support service which meets their needs. For example Connect to support, website, social media and access team
- Developing an integrated strategic commissioning approach that aligns resources and supports flexible delivery solutions.

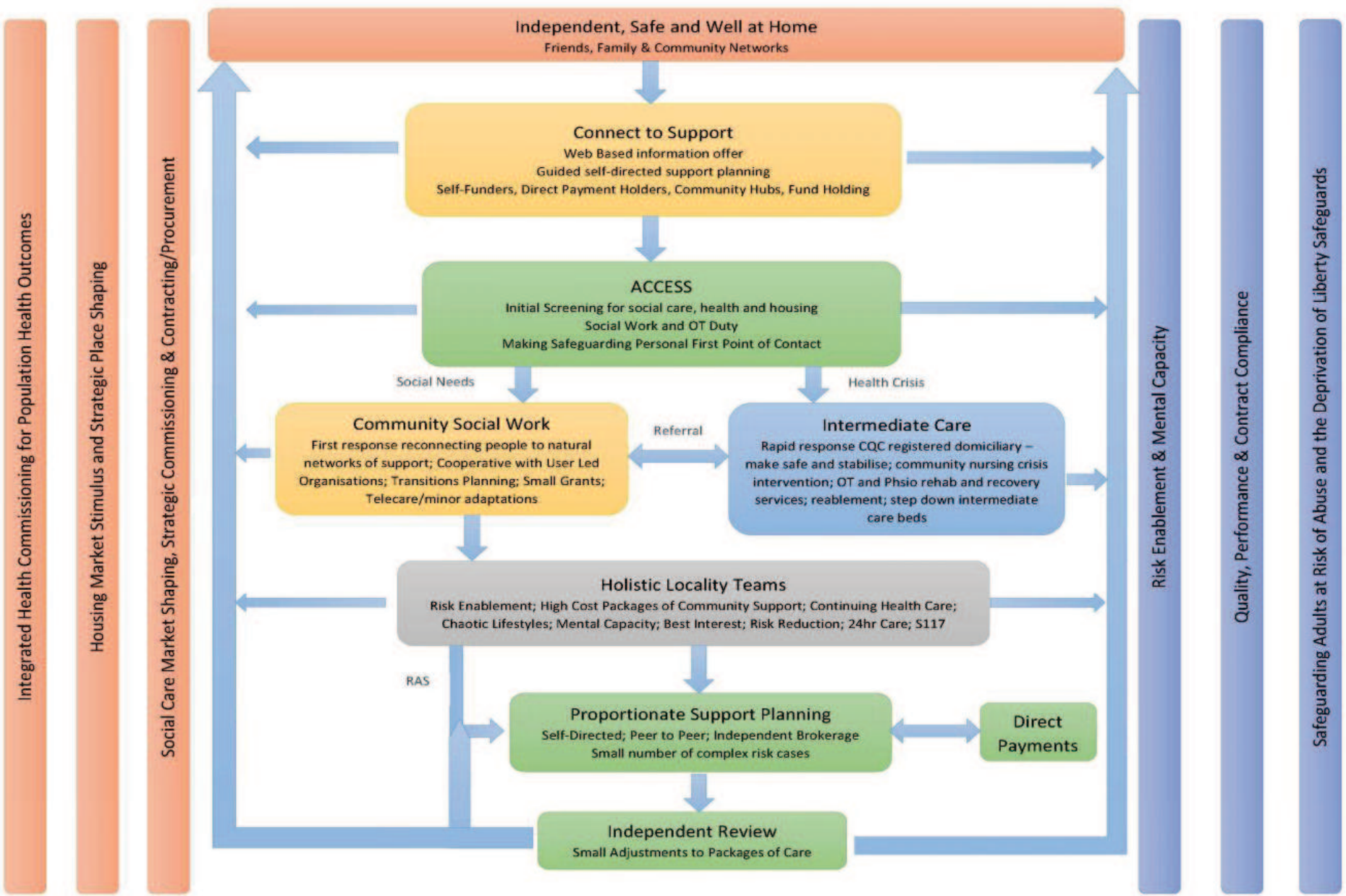
3. Delivery timeline

The table below provides a summary of key milestones for the implementation of the “To be” operating model:

Activity	Description	Timescale
Home Vision – raising awareness	Engagement with key stakeholders (staff, people receiving support and partners) on the revised offer set out in the new vision and key	April to July 2017

	implications.	
Safeguarding	Make safe and stabilise - Safeguarding / Mental Capacity Act Deprivation of Liberty Safeguards (MCA DoLS)	April to August 2017
Information Technology and Digital Platforms	Strategic review of Information Technology (IT) Systems and Digital Transformation Capacity in partnership with IT Service	March to May 2017
Personal budget	Implement Personal budget framework, which will include Direct Payments and Individual Service Funds (ISFs)	April to Sept 2017
Workforce development	Roll out of work force development programme to ensure staff have the necessary skills to implement the vision	June to Dec 2017
Governance arrangement	Review management and governance arrangements across the department to improve decision making, accountability, financial, risk and performance management	April to Sept 2017
	Review and agree performance measures to keep track on delivery progress (building on ASCOF and Public Health	May to Sept 2017
Integrated Commissioning framework	Review of strategic commissioning and procurement policies	April to Sept 2017
	Establishing a joint team between the Council and CCGs	April to July 2017
Locality infrastructure	Review and alignment of resources at a local level across Council departments and Partner services to enhance community resilience and capacity. E.g. • establishing community hubs to coordinate local level early intervention and prevention activity, • commissioning of capacity building support, • alignment of ICT infrastructure to enable system connectivity	April to Dec 2017
Information and advice	Review our information and advice arrangements to ensure we have a universal approach across all contact points that signs post people to the right information or support service to meet their needs – e.g. connect to support, council website, social media and front line access team)	May to Sept 2017

Health and Wellbeing Department – "To Be" operating model



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Report of the City Solicitor to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 2 March 2017

AG

Subject: Health and Social Care Overview and Scrutiny Committee Work Programme 2016/17

Summary statement:
This report presents the work programme 2016/17

Parveen Akhtar
City Solicitor

Portfolio:

Health and Wellbeing

Report Contact: Caroline Coombes
Phone: (01274) 432313
E-mail: caroline.coombes@bradford.gov.uk

1. **Summary**

1.1 This report presents the work programme 2016/17.

2. **Background**

2.1 The Committee adopted its 2016/17 work programme at its meeting of 14 July 2016.

3. **Report issues**

3.1 **Appendix A** of this report presents the work programme 2016/17. It lists issues and topics that have been identified for inclusion in the work programme and have been scheduled for consideration over the coming year**. Appendix B** lists items for inclusion in the work programme that have not yet been scheduled.

4. **Options**

4.1 Members may wish to amend and / or comment on the work programme at **Appendix A** and **B**.

5. **Contribution to corporate priorities**

5.1 The Health and Social Care Overview and Scrutiny Committee Work Programme 2016/17 reflects the ambition of the District Plan for 'all of our population to be healthy, well and able to live independently for a long as possible' (District Plan: Better health, better lives).

6. **Recommendations**

6.1 That the Committee notes the information in **Appendix A** and **B**

7. **Background documents**

7.1 Constitution of the Council

8. **Not for publication documents**

None

9. **Appendices**

9.1 **Appendix A** – Health and Social Care Overview and Scrutiny Committee work programme 2016/17

9.2 **Appendix B** – Unscheduled items for inclusion in Committee's work programme 2016/17

Democratic Services - Overview and Scrutiny

Appendix A

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 23rd March 2017 at City Hall, Bradford			
Chair's briefing 08/03/2017. Report deadline 10/03/2017			
1) Care Quality Commission	12 month update on inspection activity in the District	Rachel Bowes	resolution of 3 March 2016
2) Respiratory Health in Bradford and Airedale	Report to cover the high level areas outlined in the 'Bradford Breathing Better' programme and to include an update on self care	Andrew O'Shaughnessy	resolution of 3 March 2016
3) Great Places to Grow Old programme	Update	Lyn Sowray	resolution of 3 March 2016
4) Update on the progress made by Airedale and partners enhanced health in care homes Vanguard	Update	Helen Bourner	resolution of 24 March 2016
Monday, 27th March 2017 at City Hall, Bradford (informal)			
Chair's briefing 13/03/2017. Report deadline 15/03/2017			
1) Joint Children's Services and Health and Social Care OSCs informal sub-group meeting on children and young people's mental health	This report will respond to the young people's 'Help Today's Youth to Help Tomorrows Bradford' recommendations	Mark Vaughan, Bradford District Care Trust	resolution of the Joint Children's Services and Health and Social Care OSC - 27 October 16
Thursday, 6th April 2017 at City Hall, Bradford			
Chair's briefing 22/03/2017. Report deadline 24/03/2017			
1) Outcome Of Consultation On The Proposed Change To Bradford Council's Contributions Policy For Non-Residential Services	Update including consideration of ways to improve consultation with vulnerable groups.	Bev Maybury (Bev Tyson)	resolution of 8 Sept 2016
2) Safeguarding Adults	Details to be confirmed	Bev Maybury	
3) Bradford District Suicide Prevention Plan 2017 - 2021	A draft Bradford District Plan has been produced in line with Public Health England Guidance	Sarah Muckle	

Democratic Services - Overview and Scrutiny
Scrutiny Committees Forward Plan
Unscheduled Items

Health and Social Care O&S Committee

Agenda item	Item description	Author	Management comments
0 111 service / out of hours primary care	Update on performance and previous resolution around tagging of patient notes and promotion	Commissioners (Greater Huddersfield CCG)	
0 Independent Complaints Advocacy Team (ICAT) Bradford & District	Annual update	Andrea Beever	
0 Home B - Residential Care Home	Consultation to decommission Home B - Residential Care Home	Lyn Sowray	
0 Diabetes	Details to be confirmed	Public health / CCGs	
0 Domiciliary Care	See resolution of 21 Jan 2016	Bernard Lanigan	