Central Bedfordshire Shadow Health and Wellbeing Board

Agenda

Meeting Title:	Central Bedfordshire Shadow Health and Wellbeing Board
Date:	Tuesday, 29 May 2012
Time:	6.00 p.m.
Location:	Council Chamber, Priory House, Monks Walk, Shefford

1. Apologies for Absence

2. Election of Chairman and Vice-Chairman for the year 2012 - 2013

Business

Item	Subject	Page Nos.	Lead
3.	**Bedfordshire LINk (covering Central Bedfordshire) report** The purpose of the report is to update the Board on key work items of the LINk in Central Bedfordshire, for consideration and note as required.	5 - 8	MC
4.	**Joint Strategic Needs Assessment** The report presents the executive summary of the refreshed Joint Strategic Needs Assessment (JSNA) for Central Bedfordshire.	9 - 32	MS
5.	**NHS Bedfordshire & Luton Integrated QIPP Plan 2012-15** The PCT Cluster integrated QIPP plan is a comprehensive report of the commissioning and provider landscape in Bedfordshire and Luton for 2012/13-14/15, and prepares the way for Bedfordshire Clinical Commissioning Group's own strategic commissioning plan (due to be presented to the BCCG Board in June 2012).	33 - 42	JR

This summary report pulls out the key points from the Cluster integrated QIPP plan for Bedfordshire overall and Central Bedfordshire in particular:

- The financial pressures on NHS-funded services are likely to be greatest during 2012/13 but will continue for the duration of the plan
- Sufficient projects and workstreams have been identified to address these pressures
- There remain significant risks to the health economy's ability to deliver the outputs from these workstreams

6.	**Draft Outline for Joint Health and Wellbeing Strategy (JHWBS)** This report outlines the priorities previously identified for the Health and Wellbeing Strategy in Central Bedfordshire and a proposed structure for the report. The priorities broadly align with the needs identified in the re-freshed JSNA.	43 - 50	MS
7.	**Looked After Children's Health** The report sets out the findings of Central Bedfordshire's recent Safeguarding and Looked After Children inspection in relation to the quality of health services for looked after children.	51 - 58	AM
8.	**Healthier Together Programme (previously Acute Services Review)** To consider an update on progress against all aspects of the Healthier Together Programme.	59 - 70	SW
9.	**Work Programme 2012 – 2013** To consider details of the currently drafted Board work programme.	71 - 78	PC
10.	**Public Participation** Members of the public have the opportunity to ask questions or make statements for up to 15 minutes, at the Chairman's discretion.		
11.	**Any Chairman's Announcements**		
12.	**Minutes of the last meeting**		

To: Members of the Central Bedfordshire Shadow Health and Wellbeing Board

Mr G Alderson	Director of Sustainable Communities
Dr J Baxter	Director, Bedfordshire Clinical Commissioning Group
Mrs C Bonser	Bedfordshire Local Involvement Network
Mr R Carr	Chief Executive
Mr M Coleman	Chairman, Bedfordshire LINk
Felicity Cox	Chief Executive Bedfordshire & Luton PCT Cluster
Mrs E Grant	Deputy Chief Executive/Director of Children's Services
Dr P Hassan	Chair of Bedfordshire Clinical Commissioning Group
Mrs C Hegley	Executive Member for Social Care, Health & Housing
Mrs J Ogley	Director of Social Care, Health and Housing
Mr J Rooke	Chief Operating Officer Bedfordshire Clinical Commissioning Group
Mrs M Scott	Director of Public Health
Mrs P E Turner MBE	Executive Member for Economic Partnerships
M A G Versallion	Executive Member for Children's Services

please ask for	Martha Clampitt
direct line	0300 300 4032
date published	17 May 2012

This page is intentionally left blank

Meeting: **Central Bedfordshire Shadow Health & Well Being Board**

Date: **29 May 2012**

Subject: **Bedfordshire LINk (covering Central Bedfordshire) report**

Report of: **Max Coleman, Chair of Bedfordshire LINk**

Summary: The purpose of the report is to update the Board on key work items of the LINk in Central Bedfordshire, for consideration and note as required.

Advising Officer:	Max Coleman, Chair of Bedfordshire LINk
Contact Officer:	Charlotte Bonser, Operations Manager, LINk
Public/Exempt:	Public
Wards Affected:	All
Function of:	Council

CORPORATE IMPLICATIONS

Council Priorities:

- Supporting and caring for an ageing population
- Educating, protecting and providing opportunities for children and young people
- Promoting healthier lifestyles

Financial:

1. Not Applicable.

Legal:

2. Not Applicable.

Risk Management:

3. Not Applicable.

Staffing (including Trades Unions):

4. Not Applicable.

Equalities/Human Rights:

5. Not Applicable.

Public Health

6. The findings of the LINk will be shared with the commissioners and providers of services and contribute to intelligence gathered to help improve the public health of the communities in Central Bedfordshire.

Community Safety:

7. Not Applicable.

Sustainability:

8. Not Applicable.

Procurement:

9. Not Applicable

RECOMMENDATION(S):

The Board is asked to note the report.

Background Information

10. The LINk is working towards completing its agreed work plan and as a Healthwatch Pathfinder area working with the Council to ensure the smooth transition from LINk to Healthwatch Central Bedfordshire. In view of this, the LINk has been focussing on three main areas of work, namely:
    1. Nursing care and hospital discharge,
    2. Mental health care pathways and
    3. Care in nursing and care homes in the area.

    This report deals with the first of these areas listed and hopes to address some of the concerns raised at the last Shadow Board meeting about why issues have not always been taken directly to the providers or commissioners of services.

11. This report also gives feedback from our recent survey asking GP Practices in Central Bedfordshire if they had set up Patient Participation Groups (PPGs) and how effective they are finding these groups.

Working to improve Care and Dignity issues in secondary care

12. The LINk has focused on two key issues in this category, which have also been presented at Overview and Scrutiny:

    Standard of Care - the LINk has logged six issues concerning standard of care. These are largely related to older patients, i.e. showing a good level of nursing care or patients being treated with due regard to their dignity. These incidents relate to Lister Hospital, L&D and Bedford Hospitals.

    The problems we face as a LINk in challenging and improving the situation is that many patients do not wish to formalise their complaints, for example take their complaint through the hospital or NHS PALs process or through independent complaints advocacy.

13. In view of the reluctance of patients to make formal complaints to the acute Trusts, in order for the LINk to provide more than anecdotal information of what the issues are, and to also highlight where care is of a good/high standard, LINk members have agreed to conduct visits to the Bedford and Luton & Dunstable Hospitals during April/May 2012 to specifically observe nursing care and, if possible and appropriate, to talk to patients and staff.

    The LINk has statutory rights under the Local Government and Public Involvement Act of 2007 to conduct enter and view visits to health and social care premises, and will be writing to both Hospitals asking to visit randomly selected elderly care wards.

    Two of the incidents logged relate to the Lister Hospital and this may require a joint visit with Hertfordshire LINk. All visit reports and recommendations will be shared with the Hospitals and Commissioners concerned.

14. **Discharge from hospital** - the LINk has been logging issues on discharge from hospitals used by Central Bedfordshire residents. Responses to a survey conducted by the LINk in 2011, highlighted some issues such as failure to ask patients prior to discharge if they were able to cope after discharge, poor communication between hospital and GP practice, leading to a lack of follow up for the patient such as support from a district nurse and long waits for medication.

    The LINk would like to work with the Commissioners to help scope this area further and interview patients willing to talk about their experience of discharge from hospital.

Encouraging the creation of Patient Participation Groups within Central Bedfordshire GP surgeries.

15. It has been a long-term aim of the LINk to work closely with Patient Participation Groups in Central Bedfordshire, as these groups are able to pick up local intelligence to help the LINk find out where trends are appearing and need further investigation.

16. The LINk regularly updates the practices about its work and for help with surveys and so on, and is keeping practices up-to-date with progress towards Healthwatch in Central Bedfordshire. In February 2012, the LINk circulated a survey to ascertain if practices in the area have:
    a) set up patient groups, including virtual patient groups
    b) how successful the groups are
    c) why practices had chosen not to set up such groups.

17. The results are encouraging; out of the 40 practices contacted 16 responded indicating they had set up patient groups, both groups that meet face-to-face and virtual groups. Approximately sixty-three percent of these groups were chaired or led by a patient representative supported by Practice staff. Practices indicated that patient involvement was good with around 44% of patients giving regular feedback to the practices. In terms of the best way to communicate with practice patients, face-to-face involvement was considered the most effective method of communication with patients (81.25%) and e-mail communication second with 62.5%, some practices indicating that both face-to-face and virtual groups (by e-mail) were equally as effective. Post and texting were less effective methods.

18. Some of the achievements of PPGs recorded to date are:
    - re-developing the reception area to be more open and welcoming area,
    - developing more user friendly marketing material for patients,
    - improving services to carers,
    - implementation of suggestion/prescription box,
    - new website and implementation of new telephone system.

    Groups were also seen as a useful form of two-way communication for discussing and listening to patients as well as informing them of developments in the wider NHS.

19. The full report will be available shortly.

Conclusion and Next Steps

20. For Items 10 – 14 need further work with the Commissioners to improve patient experience for both nursing care and discharge from hospital. This issue has also been raised at the Central Bedfordshire Adult Social Care, Health and Housing Overview and Scrutiny Committee.

Appendices:
None

Meeting: **Shadow Health and Wellbeing Board**

Date: **29 May 2012**

Subject: **Joint Strategic Needs Assessment**

Report of: **Director of Public Health**

Summary: The report presents the executive summary of the refreshed Joint Strategic Needs Assessment (JSNA) for Central Bedfordshire

Advising Officer:	Muriel Scott, Director of Public Health
Contact Officer:	Celia Shohet, Assistant Director of Public Health
Public/Exempt:	Public
Wards Affected:	All
Function of:	Council and NHS Bedfordshire

CORPORATE IMPLICATIONS

Council Priorities:

The JSNA supports the following council priorities by providing an assessment of the needs of the population and the evidence for actions to meet these needs:

- Supporting and caring for an ageing population
- Educating, protecting and providing opportunities for children and young people
- Managing growth effectively
- Creating safer communities
- Promoting healthier lifestyles

Financial:

1. The development of a web based JSNA may require some additional investment and is being established currently.

2. The re-fresh of the JSNA has required resources in terms of staff time but no other additional costs.

Legal:

3. The production of the JSNA currently rests with the Directors of Public Health, Adult Social Care and Directors of Children's services. From April 2013, local authorities and CCGs will each have equal and explicit obligations to prepare the JSNA, and this duty will have to be discharged by the health and wellbeing board.

Risk Management:

4. Not applicable

Staffing (including Trades Unions):

5. Not Applicable

Equalities/Human Rights:

6. There is a particular focus on geographical areas and vulnerable groups where health outcomes are poorer to maximise health gain.

Public Health

7. The JSNA provides a joint and comprehensive assessment of the health and wellbeing needs of the residents of Central Bedfordshire. It includes the views of patients and public as well as the evidence base. It is integral to the development of the Health and Wellbeing Strategy as well as associated joint commissioning strategies which will deliver improvements in Health and Wellbeing, particularly in the most vulnerable communities.

Community Safety

8. Not Applicable

Sustainability:

9. Not Applicable

Procurement:

10. Not applicable

RECOMMENDATION(S):

That the Board consider and agree the executive summary of the Joint Strategic Needs Assessment (JSNA).

Background

11. The JSNA is more than a collection of evidence; it is an analysis and narrative on the evidence, describing what it says about the local community and its health and social care needs. The JSNA process extracts and makes sense of evidence, and then health and wellbeing board members plan on the basis of it, using that evidence to drive strategy and commissioning.

12. The first JSNA for Central Bedfordshire was developed in partnership and published in 2010. It provided a good basis for shaping the commissioning strategies and priorities within them to meet the health and wellbeing needs of the local population. It was assessed as part of the world class commissioning process and achieved a good rating.

13. The joint health and wellbeing strategy will set shared priorities based on the evidence of the greatest needs identified within the JSNA.

Refreshing the JSNA

14. The refresh of the JSNA commenced in autumn 2011 with an online survey to access any gaps in the current JSNA. The future development of the JSNA was discussed with partners and it was agreed to build on the previous JSNA, there would however be an increased focus on future needs (next three to five years), the evidence base to deliver the desired outcomes and the involvement of local communities as far as possible. The JSNA will also influence decisions regarding prioritisation of investment and the re-design of services.

15. The process has been overseen by a JSNA steering group which includes wide representation across health and social care, as well as representatives of LiNK.

16. To date over 40 authors have contributed to almost 70 different sections of the JSNA. These have been quality assured by lead individuals from health and social care and circulated to LiNK members, the voluntary sector and partnership boards to identify gaps or inaccuracies.

17. It was agreed from the outset that the JSNA would be web-based to allow ease of access and navigation. This approach would also allow the JSNA to be continually updated and improved. However since the introduction of the new website for CBC, it has become apparent that it does not provide quite the functionality required, therefore alternative solutions are being sought. Therefore whilst the executive summary is being agreed at this stage, the full document may not be available on-line until the summer. In the meantime should anyone want to see part or all of the full document they can contact dzifa.agbenu@bedfordshire.nhs.uk

Developing the Executive Summary

18. It was agreed at the outset that whilst the web based JSNA will be an evolving document, updated on a regular basis, the executive summary would provide a summary of the health and wellbeing needs of the area at a given point in time and published as a pdf document. It is likely that the Executive summary will be updated annually and more often should evidence emerge of changed needs.

19. The Executive Summary has been written using previously agreed criteria (Appendix A) and therefore identifies the main areas of success, need, inequalities and areas for development.

20. It has been reviewed by the JSNA steering group, Children's Trust, Healthier Communities and Older People Partnership Board, Bedfordshire Clinical Commissioning Group and the Corporate Management Team. The comments and suggestions have been incorporated as far as possible.

Appendices:
Appendix A – Criteria for inclusion in the Executive Summary

Appendix A

Criteria for Executive Summary of the JSNA

The detailed information contained within the JSNA will be summarised within the Executive Summary which may be the only part of the JSNA which is seen by significant numbers of stakeholders – it therefore needs to provide an accurate and balanced picture of need and priorities.

The previous executive summary gave a summary of 'what we know' – the headline findings and the priorities for further improvement – some of which (but not all) linked to the findings. The suggestion for this Executive Summary is that it is predominantly focused around what we need to improve / do better. However there should also be a section which celebrates where we are doing well / needs are being met and also the characteristics of Central Bedfordshire as a place.

The following criteria have been agreed to determine which needs are included in the executive summary:

What are we doing well

- Significantly above England, ONS cluster, Statistical neighbours
- Meeting targets

What needs to be improved

Poor outcomes

- Significantly below England / ONS cluster or other statistical neighbour or are showing deterioration over time e.g. > 2 years

Inequalities identified

- Outcomes at a population level may be good but the JSNA reveals that there are inequalities by geography, ethnicity, vulnerable groups etc.

Major Demographic changes which will impact upon demand for future services

These might include areas such as population changes, employment and education.

Areas where evidence base shows that action now will impact upon demand at a later point

Examples might include the need to invest in early intervention and preventative services, housing support, educational attainment etc. The JSNA would need to show firm evidence that investment now would result in either reduced demand or halting current rising demand.

Central Bedfordshire

NHS

Bedfordshire Clinical Commissioning Group

Joint Strategic Needs Assessment

Executive Summary for Central Bedfordshire

Table of Contents

Introduction

The Joint Strategic Needs Assessment (JSNA) brings together what we know about the health and wellbeing of the people living in Central Bedfordshire.

It is a process that identifies the current and future health and well-being needs of the population; assembling a wide range of quantitative and qualitative data, including local views. It leads to agreed commissioning priorities that will improve outcomes and reduce inequalities.

Although the JSNA has been in existence since 2007, it has been evolving, and it is now a central part of the Health and Social Care Act (2012). The JSNA has a key role in underpinning and informing Central Bedfordshire's new Health and Wellbeing Strategy.

The JSNA is an on-going process which requires regular updating and challenge regarding it's fitness for purpose. This refresh has been underpinned by feedback from key stakeholders and recent JSNA guidance. It will be published electronically making it easier to use and update.

The JSNA has been developed jointly by a working group with membership from Central Bedfordshire Council, NHS Bedfordshire and was informed through the engagement of statutory and voluntary groups. In excess of 40 authors have contributed to its development.

The Executive Summary has been written using previously agreed criteria which identifies the main areas of success, need, inequalities and areas for development. The detail behind all of these will be published online.

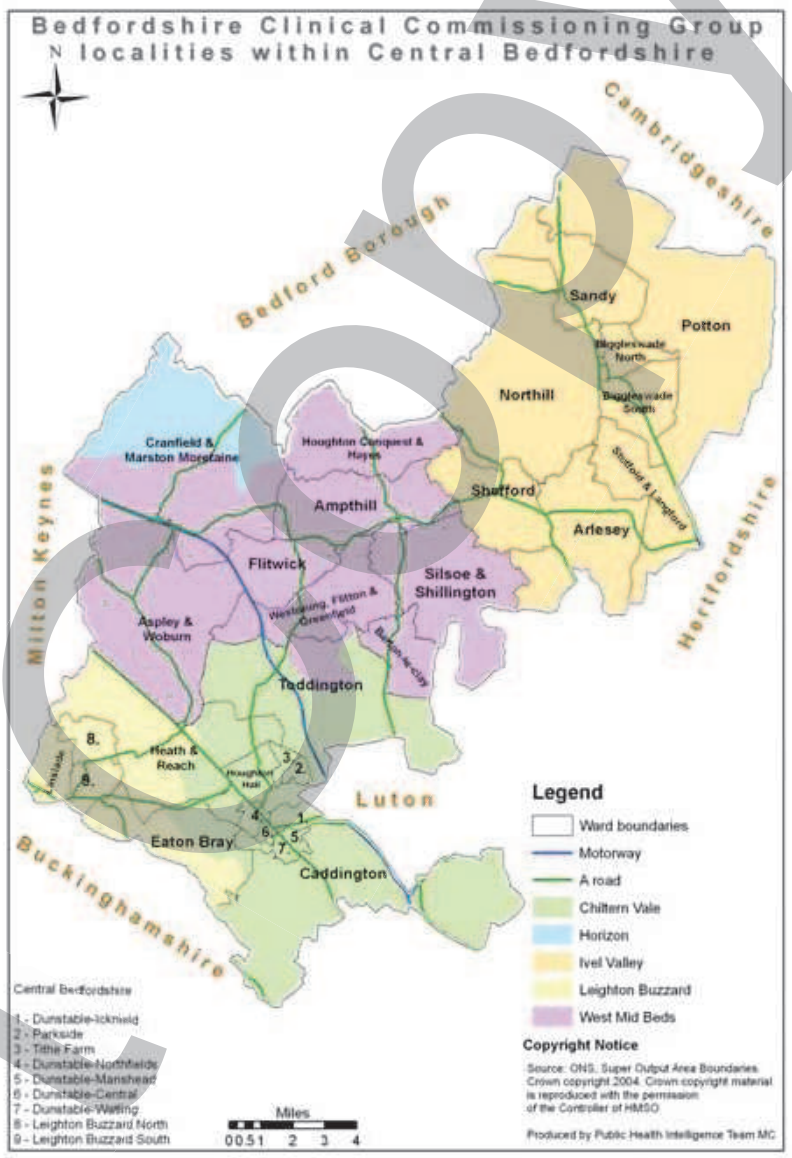
Whilst the Executive Summary pulls out the key issues for Central Bedfordshire, there are some common themes emerging.

- Investing in early intervention and prevention (at all ages) will help increase lifetime opportunities for all, ultimately reducing the need for health and social care support in later life, particularly for frail older people
- There is no health without mental health, therefore improving mental health and wellbeing remains a high priority
- Improving educational attainment and all-age skills will have a significant impact upon a wide range of outcomes
- There needs to be a continued focus on reducing inequalities by improving the social determinants of health such as housing, employment and the built environment, to give residents greater control over their life choices.

Demography

Central Bedfordshire, a mainly rural location was, in 2010, home to about 255,200 residents an increase of 9.2% since 2001. Central Bedfordshire has a growing and ageing population which is expected to increase to 274,400 by 2016. The biggest increase of around 30% will be in the number of people aged 65 and over, which has implications for future health and social care needs.

Health care is commissioned by Bedfordshire Clinical Commissioning Group, which also covers Bedford Borough. It is organised by localities, as shown in the map opposite.



The population of Central Bedfordshire is growing due to increasing life expectancy, a rising birth rate and inward migration. The number of births in Central Bedfordshire increased steadily between 2002 and 2008, before falling back slightly in 2009. There were just fewer than 3,200 births in 2010.

The number of migrant workers entering Central Bedfordshire more than doubled between 2002 and 2007 and then had a decreasing trend after this peak. There was a large increase in the number of migrant workers from the European Union (EU) Accession States between 2004 and 2008, although this decreased in 2009 and 2010.

Average life expectancy at birth in Central Bedfordshire is increasing and is currently 79.5 years for men and 83.0 years for women. These are similar to East of England and better than the England averages. Life expectancy is increasing at the rate of about 2.5 years for men and 1.5 years for women every decade.

Geographically there is a range of life expectancy within Central Bedfordshire: the gap between the most affluent and most deprived areas is on average 5.5 years for women and 7.4 years for men. Also, some disadvantaged groups have low life expectancy. People in the more deprived areas die earlier predominantly due to diseases of the circulatory system, especially coronary heart disease; cancers, especially lung cancer; diseases of the respiratory system, especially bronchitis, emphysema and chronic obstructive lung diseases; and diseases of the digestive system.

In 2009 an estimated 13% of people in Central Bedfordshire were from ethnic minority communities compared to 17% in England. The largest of these groups are Asian (3.9%); White Other (3.5%); Black (1.9%); and White Irish (1.2%). The black and ethnic minority (BME) populations have a higher proportion in younger age groups.

Wider Determinants

The social, economic and environmental circumstances in which people live impact significantly on their health and well-being.

Overall, levels of deprivation in Central Bedfordshire are relatively low. However, when deprivation is assessed for the small areas known as Lower Super Output Areas (LSOAs), three LSOAs are in the most deprived 10-20% in England. These are within Dunstable, Parkside and Houghton Hall and a further six LSOAs are in the most deprived 20-30% in England.

Income deprivation affects 13% of older people in Central Bedfordshire, compared to 18% in England, but in 7 LSOAs over 30% of older people are affected. Older people are also more likely to suffer from fuel poverty; four LSOAs in Central Bedfordshire are in the worst 20% in England for fuel poverty.

Income deprivation affects 13% of children in Central Bedfordshire, compared to 22% in England. In three LSOAs, over 40% of children are affected and in a further nine 30% or more suffer income deprivation. Children who grow up in a low income household are more likely than others to become unemployed and to do low paid jobs – there is evidence of an intergenerational cycle of poverty.

In 2011 there were 108,162 dwellings in Central Bedfordshire, an increase of 11.6% from 2001. Compared to England and the East of England a larger proportion is privately owned. In Central Bedfordshire the average house costs about £170,000 and affordability remains an issue, as the average house costs 6 times the gross average annual earnings. Over 80% of homes are under-occupied.

Around 17% of the private sector housing stock poses serious health and safety issues to residents; more than half of these have an excess cold hazard, meaning health could be affected. 28% of private homes fail to meet the decent homes standard and 3.7% of dwellings do not have a central heating system.

The level of skills attainment at all levels has increased in Central Bedfordshire in each of the past four years. The percentage of people with Level 2 and above has increased from 63% to 73%. The number of those with no qualifications has almost halved from 14.3% in December 2006 to 8.7% in December 2010.

Overall, Central Bedfordshire has relatively high employment rates 76.1% compared to 73.4% in the East of England and 70.4% in England. However, the area has seen growing levels of unemployment across all sectors, most notably women and young people, as a result of the recent recession. The highest levels of unemployment are in urban wards in Houghton Regis and Dunstable. Unemployment in Central Bedfordshire in 2010/11 was relatively low at 6.1%, compared to the region (6.7%), and England (7.7%). Unemployment is higher in those aged 16-24 years at 16%.

The gross average weekly earnings of Central Bedfordshire residents in 2010 (£550) compares well with the regional average (£523), however this has fallen from £558 in 2009. A major factor in Central Bedfordshire is the difference between what residents earn (£550) and what people who work in Central Bedfordshire earn (£457). The difference is £93.10 per week, much higher than the regional level of £34.60 and considerably higher than neighbouring local authorities.

Due to the general rural nature of Central Bedfordshire, there are relatively large areas where the availability of public transport is limited leading to poor accessibility to services and an increasing need to use cars rather than more sustainable or healthier forms of transport. This impacts predominantly on older people; of pensioner households 34.9% were without a car in 2001. Food shopping can then be a problem if the choice is limited and the cost high; currently 31 out of 69 rural parishes have no food shops at all.

Although Central Bedfordshire is predominantly rural, not everyone lives close to natural open spaces. To maximise health and wellbeing, it is recommended that everyone should live within 300 metres of a 2 hectare (Ha) or larger natural green space; only 26.5% of households in Central Bedfordshire are that close. It is also recommended that everyone live within 2km of a 20 Ha or larger natural green space; 89.6% of households in Central Bedfordshire attain this. Air quality in Central Bedfordshire is generally good although there are air quality management areas in Dunstable Town Centre, Sandy (near the A1), Chalton (near the M1) and Marston Vale (historical due to emissions from Stewartby Brickworks).

Central Bedfordshire is a safe place to live and work, although as is common in all areas, it does have pockets where crime and community safety issues are higher. Levels of serious acquisitive crime have decreased, except for theft from motor vehicles. Between April 2011 and September 2011 there were 5,906 incidents of Anti-Social Behaviour reported to Bedfordshire Police. This is a 13% decrease on the number of incidents during the same time period in 2010. Hotspot areas within Central Bedfordshire continue to be the town centres with Dunstable Town Centre remaining the largest generator of incidents with a significant number of the incidents being related to the night time economy and are related to drinking alcohol.

Between April 2011 and September 2011 there were 1354 incidents of domestic abuse in Central Bedfordshire, 25% of these werein the Dunstable area.

In summary the social, economic and environmental circumstances in Central Bedfordshire are good compared to England averages. However further improving the social determinants of health will enable people to take greater control of their health and wellbeing, making positive choices rather than being passive recipients of support.

Children and Young People

The chapters of the Children's JSNA illustrate the range of interrelated factors which influence and determine children's health, wellbeing and life chances. Deprivation, education, family and health are all closely interlinked and for this reason the structure of the Children and Young People's Plan (CYPP) has been used here to describe the findings for Central Bedfordshire.

Emerging Common Themes

In general for children in Central Bedfordshire outcomes are fairly good, with a couple of notable exceptions. However, this masks variation across Central Bedfordshire and there appears to be a clustering of issues in areas of higher deprivation and in the most vulnerable groups of children.

The demands on children's services are going to increase with the numbers of children increasing and the likely effects of the economic downturn.

There are clear intergenerational patterns of health which require a family approach, and seamless services across child and adult services to break patterns of poor health and wellbeing.

PRIORITY 1:
Helping children and young people achieve more

What are we doing well?

The performance target for young people Not in Education Employment or Training (NEET) was achieved in 2011 with the level (4.6%) well below regional, national and statistical neighbour averages.

Key stage 1 performance is better than the national average and similar areas in both 2010 and 2011 despite a fall of 1% this year in reading and writing.

2011 figures for the percentage of pupils in Central Bedfordshire achieving five or more A* to C grades at Key Stage 4, including maths and English were nearly ten per cent up on results recorded in 2009 . The proportion of students achieving five or more GCSE grades at A* - C including English and mathematics improved by 5% this year, rising from 54% in 2010 to 59% in 2011 and placing Central Bedfordshire in line with the national average.

What needs to be improved?

In 2011, there was a 3 percentage points improvement in children achieving a good level of development in the Early Years Foundation Stage but Central Bedfordshire remains 3 percentage points lower than England and statistical neighbours.

At Key Stage 2 (achieving level 4 in English and Maths), results declined in 2011 by 7% to 66%. This was influenced by a large school not taking the SATs and the Department for Education publishing figures which included this school. This worsened the result by around 5%. The national average remained static at 74%. This means that the performance gap between Central Bedfordshire and the national percentage figure for this

indicator has changed from 1% below the national figure to 8% below the national.

A-level performance in Central Bedfordshire is about average and students complete a reasonable number of subjects to enter University or other progression routes. However, the percentage achieving A*-B grades appears to be lower than the national figure.

Inequalities identified

Deprivation is well known to have an impact on a pupil's attainment at school. Assessment at Key Stage 1 (7 year olds) shows that nationally Free School Meal pupils are on average 2 terms behind the attainment of their peers. For pupils living in Central Bedfordshire that difference is nearly a whole year.

There are inequality gaps in achievement for Looked After Children, Gypsy/Roma and travellers of Irish Heritage, those from a Black Caribbean background, pupils eligible for a free school meal and those with statements of Special Education Needs.

Young people in rural areas often do not have the same opportunities to access transport as those in towns and larger villages. This is a significant pressure for young people looking to access post 16 education or training.

There is a need to ensure volunteering opportunities are accessible to vulnerable young people including those who are looked after and those in the youth offending system.

Current actions for future benefits

Certain lower schools in areas of demographic growth are now full and children are being allocated places at the next nearest school with spaces available, often a rural school. This is increasing the number of pupils of lower school age for whom the Council must provide transport.

Consultation has identified further improvements such as increasing activities and opportunities for teenagers with disabilities including those designed to develop life skills and independence.

PRIORITY 2:
Protecting children and keeping them safe

What are we doing well?
The overall effectiveness of the Council's safeguarding services is rated as good and the Council's performance in protecting vulnerable children and young people is also rated as good.

What needs to be improved?
Health issues in young people who offend are prevalent, and frequently undiagnosed as a result of the chaotic lifestyles of the young person and their wider family.

Inequalities identified
33% of domestic abuse incidents in Central Bedfordshire were noted to have a child present at the time of abuse occurring (12 month period as August 2011).

A growing number of young children are now subject to Child Protection Plans.

While everyone is susceptible to obesity, levels are disproportionally higher in the lower socio-demographic, socially disadvantaged groups and some ethnic groups. Obesity is almost 4 times more common in Asian children than white children.

Sexual health problems affect all age groups, ethnicities and gender, however, those most at risk include young people, and vulnerable groups such as; black and minority ethnic groups, men who have sex with men and sex workers.

Current actions for future benefits
For children who are looked after, there is a need for more placement choice and also provision for adolescents and children with significant emotional or behaviour needs.

There is a need to continue to tailor support for children present at domestic abuse incidents, with specialist training for officers.

Action is required to break inter-generational paths to alcohol dependency through the delivery of family based interventions.

The uptake of seasonal flu vaccination by pregnant women has remained low. Variation in uptake between GP practices is very wide, indicating potential inequity in service provision, but potential causes of this variation need to be established.

Parenting support is needed for parents of children aged 14+ with challenging behaviour and additionally those young people displaying violence towards their parents.

PRIORITY 3:

Reducing child poverty and the effects on those living in poverty and improving early intervention and prevention

What are we doing well?

This priority is difficult to assess in the short term as this is a long term objective. Good progress has been made in implementing the plans to deliver the Child Poverty Strategy 'From Poverty to Prosperity: A Strategy to Reduce Child Poverty and alleviate its effects in Central Bedfordshire'.

What needs to be improved?

The proportion of children who live in relative low income households are lower compared to East of England and England. Central Bedfordshire has 13.1% of its children living in poverty (2009) and there are some high levels of poverty within particular areas.

Inequalities Identified

Whilst there is clearly a concentration of poverty and deprivation across the areas within Dunstable and Houghton Regis there is no ward in Central Bedfordshire which does not have some child poverty and levels of deprivation.

By the age of six, a less able child from a rich family is likely to have 'overtaken' a more able child from a poor family.

Current actions for future benefits

There are 4 main priorities within the Child Poverty Strategy (with both immediate and medium term actions to be identified) concerning getting families working; accessing income whilst seeking work; early intervention to raise aspirations and improving health and well-being for children and families in poverty.

Performance in relation to young people not in education, employment or training is good, however there is a lack of vocational education opportunities, including apprenticeships, and young people need numeracy and literacy skills to be able to progress into the world of work. There are too few opportunities for young people to learn these skills in an applied way.

PRIORITY 4:
Targeting the most deprived areas and vulnerable groups to improve children's emotional and physical health

What are we doing well?
Childhood obesity remains stable and below regional and national levels, even with increase participation in our measurement programme. However 1 in 7 children in Central Bedfordshire are obese by 10-11 years of age.

90% of pregnant women access antenatal services before thirteen weeks of pregnancy.

There has been a continued upward trend in childhood immunisations with levels largely above national and East of England averages. Targets for HPV immunisation of over 90% of year 8 girls have been met for the second year.

What needs to be improved?
To help give children the best start in life more women should breastfeed their babies and fewer women should smoke during their pregnancy. This is a particular issue for women delivering at the Luton and Dunstable hospital.

Health outcomes for Looked After Children have been poor compared to statistical neighbours and the national average, although they are improving.

Although teenage pregnancies remain in line with the national average, they are higher than statistical neighbours. Children and young people who are already disadvantaged have an increased risk of teenage pregnancy. The links between teenage pregnancy, deprivation and poverty are inextricable with each of the teenage pregnancy hotspot wards falling within the 20% most deprived in Central Bedfordshire.

Inequalities Identified
Rates for breastfeeding are lowest amongst families from lower socio-economic groups, those with low educational achievement, and teenage mothers, who are half as likely as older mothers to initiate breastfeeding. Lower rates in these groups result in poorer health outcomes for the mother and child, adding to inequalities in health and continuing the cycle of deprivation.

Socially disadvantaged children experience disproportionately high levels of dental disease.

Some children are more vulnerable to mental illness including children who have one or more of the following factors: low income households/parents who are unemployed, looked after children, disabilities, Black and other ethnic minority, lesbian/gay/bisexual or transgender, those in the criminal justice system, those who have a parent with mental health problems, refugees and asylum seekers, gypsy and other traveller communities.

The proportion of children, who are obese, come from families where a parent smokes, and or have a parent with a mental health problem are higher in the most deprived areas.

Current actions for future benefits
Increasing the focus on all the opportunities for early intervention in mental health issues, such as recognising eating disorders early on, diagnosing and treating postnatal depression consistently, providing a co-ordinated multi-agency approach to behaviour problems and focused support for looked after children.

Prevention work with vulnerable children has been shown to be cost effective in preventing later alcohol issues.

There is good evidence that work to support improving aspirations and opportunities for education, employment and training can reduce teenage pregnancy.

There is a need for a significant increase in the places available in day care providers and child minders (particularly in our most disadvantaged areas) in order to extend the offer of 15 hours of free early education a week for disadvantaged two year olds. This equates to approximately 500 two year olds from September 2013 rising to 1,000 in September 2014.

The problem of substance misuse among certain groups of the population including young people, together with their treatment needs and engagement with services, is not yet fully understood locally.

Major Demographic Changes that will impact upon demand for services

The population of children in Central Bedfordshire is expected to increase by 6% by 2016.

With an average of 2,000 new homes expected to be completed each year over the next ten years, forecasts for school planning show an increase in numbers each year both as a result of the naturally changing demographics with an increase in pre-school numbers and the impact of housing growth. At post 16 years, there has also been an increase.

There will be increasing demands on health and social care because of the growing population of children in Central Bedfordshire and the likely effects of the economic downturn on health and wellbeing. Historically there are higher levels of mental health problems and obesity during an economic downturn. Levels of domestic abuse could also increase.

Implications for future commissioning

The commissioning of services for children needs to focus resources proportionate to need, to ensure that we are reducing and not widening health inequalities, and taking a whole family approach.

There needs to be a focus on improving maternity services outcomes, particularly on reducing the number of mothers who smoke and increase breastfeeding rates at the Luton and Dunstable Hospital.

Services for disabled children and their families need to be accessible, consistent, focused on their needs and delivered more locally.

The Commissioning of services to address behaviour problems needs to be more co-ordinated, including parenting support.

There is a need for more vocational educational opportunities including apprenticeships.

Adults and Older People

The general health of adults and older people in Central Bedfordshire is similar to or better than England, however there is some way to go to match the healthiest parts of the country.

Some geographical areas and disadvantaged groups experience much poorer health and greatly reduced life expectancy. To reduce these health inequalities requires tackling the wider determinants of health to enable people to have greater control and increased ability to make decisions about improving their life-style.

Healthy life expectancy is not increasing at the same rate as life expectancy with people spending more years at the end of their life in poor health which has significant consequences for those affected and demand upon health and social care. Consequently considerable emphasis is placed upon early intervention and prevention. Taking action now to promote physical and mental health and well-being throughout life will benefit the whole of society by maintaining adults and older people's social and economic contributions, minimising the costs of care and improving quality of life.

Three common themes emerged for adults and older people:

- The need to enable people to improve lifestyles choices and the early identification of risk factors for diseases which cause premature ill health or mortality
- The need to improve outcomes for frail older people through early intervention and prevention (which overlaps with improving lifestyle choices)
- The need to pay particular emphasis on improving the health of vulnerable groups

The executive summary for adults and older people is therefore structured around these themes.

Lifestyle and Early Identification

What are we doing well?

The prevalence of smoking in Central Bedfordshire is lower than the regional and national averages and has associated lower rates of smoking related mortality than England. This is likely to be a contributory factor to the falling mortality from all cancers in people aged less than 75 years. Cancer survival rates are also increasing although they still remain poor compared to other comparable countries.

Fewer people are being admitted to hospital as a result of drug use and we are doing better than others in meeting their housing needs.

The rates of sexually transmitted diseases have declined year on year for all infections apart from Syphilis which has very low rates of infection already.

The years of life lost due to premature mortality from stroke and overall death rates at all ages due to stroke are lower compared with the regional or national rates. In addition premature mortality in males from diabetes and from bronchitis, emphysema and other respiratory diseases is significantly lower than the rate in England.

What needs to be improved?

Rates of smoking are higher in the most deprived areas and are higher still in some vulnerable groups such as people with poor mental health and offenders.

Drinking to harmful levels is an issue with the rates of admissions to hospital as a result of alcohol are rising. In 2009/10 there were over 4,000 admissions to hospital as a result of alcohol related harm, an increase of by 13% compared with the previous year. The rate of alcohol-related crime is higher than the national average. Heavy drinking is not confined to the young; 20% of adults aged 65 years and over were estimated to be heavy drinkers in 2008, which is higher than the regional average.

The prevalence of problem drug users aged 15-24 years is significantly higher than the regional average. Almost a third of the people in drug treatment live with children and unsurprisingly parental drug use is a factor for around one-third of the most troubled families. Levels of problematic drug use are higher in the more deprived areas, with the added risk that people living in poor accommodation are also more likely to share injecting equipment leaving them at higher risk of blood borne and other infectious diseases.

Although the rates of sexually transmitted infections are declining, the number of people diagnosed with HIV and seen for care is increasing year on year. In 2010 there were almost 200 people diagnosed with HIV and seen for care in Central Bedfordshire. The proportion of terminations of pregnancies undertaken before 10 weeks gestation is below regional and national rates.

Chlamydia diagnosis rates in Central Bedfordshire have increased over the years but are significantly lower than regional and national rates. Whilst this may relate to a lower underlying prevalence, it is also likely to reflect a greater proportion of undiagnosed Chlamydia infection.

It is estimated that in Central Bedfordshire about 24.8% or 49,000 adults are obese; the East of England average is 23.6%.

It is estimated that 27.8% of the population have hypertension but only 13.5% are currently diagnosed, leaving 47,500 people potentially unaware and untreated, therefore at increased risk of cardiovascular disease. There is also a gap between diagnosed and expected prevalence for atrial fibrillation, another risk factor for stroke. These gaps may help to explain the higher rates of admissions for stroke.

Diabetes has been diagnosed in 4.97% of the population aged 17 and above in Central Bedfordshire, however the expected prevalence is 6.03%, equating to 2,700 people potentially with undiagnosed diabetes. The prevalence of diabetes in Central Bedfordshire is expected to increase from 6% to over 8% within the next 20 years, driven partly by an ageing population and partly by rising prevalence of obesity.

Current actions for future benefits

Helping people to stop smoking is one of the most cost effective ways to improve healthy life expectancy and importantly to reduce health inequalities. It is never too late to stop smoking; stopping smoking at age 65 years can add 2-3 years to life expectancy. Each year in Central Bedfordshire the societal costs from smoking are approximately £61.6m driven primarily by reduced productivity and the costs of treating ill health.

It is estimated that the benefits of drug treatment outweigh the costs of treatment by 2.5 to 1. Therefore investing in effective services now should save costs associated with decreased crime, drug-related deaths and blood-borne disease transmission.

Over 750 staff within health and social care across Bedfordshire have been trained to deliver interventions and brief advice (IBA) to people with problem drinking. Evidence suggests that on average every person who receives IBA will make 0.5 fewer visits to A&E over the next 12 months. The evidence to support investing in interventions to reduce harmful drinking is high and benefits the individuals, their families and society in general through lower levels of crime and disorder.

Only 11% of adults in Central Bedfordshire are physically active enough to benefit their health. There is considerable evidence to show that increasing levels of physical activity benefits both physical and mental health.

It is estimated that each infection prevented would save between £280,000 and £360,000 in lifetime treatment costs.

Obesity in middle-age shortens life expectancy on average by 2-4 years, or by 8-10 years in those who become morbidly obese. This is as a result of the significant health risks associated with obesity such as diabetes, high blood pressure, cardiovascular disease and some cancers. It is estimated that in Central Bedfordshire there are nearly 9,000 adults who currently have high blood pressure, 4,000 with cardiovascular disease and almost 3,000 with diabetes as a result of obesity. Clearly reducing obesity now will have significant benefits to the health of our population, including our workforce. The national Foresight report suggests that without effective action and if current trend continues, almost nine in ten adults and two in three children will be overweight or obese by 2050.

NHS Health checks provide an assessment of an individual's future risk of vascular disease and referral on to preventative services or treatment for those at high risk. This check is offered 5- yearly to every person aged between 40 – 74 years who has not already been identified as at high risk e.g. because of diabetes. At present around 50% of the registered population in Bedfordshire do not take up this offer. However this provides an ideal opportunity to find those who have undiagnosed hypertension and those with undiagnosed diabetes. Early identification and treatment will prevent or delay the consequences of disease.

Implications for future commissioning

The redesign of sexual health services over the last four years has improved access and outcomes. The responsibility to commission sexual health services will be shared across a range of commissioning bodies from 2013 and it will be crucial to develop strong local arrangements across these bodies to best meet the needs of the population.

Public sector employees can help support people to improve their lifestylesby Making Every Contact Count, which equips health and social care staff to provide very brief interventions and signpost onto a range of relevant services and support. Workplaces therefore need to be exemplars by encouraging employees to adopt healthy lifestyles.

It is likely that the capacity for weight management programmes across Central Bedfordshire will need to be increased, particularly in the most deprived areas.

Frail Older People

What are we doing well?

We are helping frail older people to retain their independence in a number of ways, for example by enabling more people to return to their home following a health or social care crisis through a 'Step Up Step Down' scheme based at Greenacres home in Dunstable. The scheme provides people with intensive care in a homely environment for up to six weeks while they regain their independence by building their confidence and mobility.

Evidence is also demonstrating that the Reablement Service is maintaining people's independence to a high level and a good percentage of customers leave the service with either no requirement for an on-going care package or a greatly reduced package of care.

Thankfully the rate of Clostridium difficile infections has continued to fall and the latest data shows a significant drop in the number of excess winter deaths over the past two winters, compared with the previous five years. This is now significantly lower than the England average.

An increased proportion of people at the end of their life are now dying in their usual place of residence.

What needs to be improved?

There are 17.6 care home places per 1,000 people aged over 65 in Central Bedfordshire, compared with a regional average of 41.9 places. The demand for places exceeds supply primarily in Ivel Valley and the West Mid Beds area.

Although the uptake of seasonal flu vaccination for people aged 65 and over has been maintained for the previous 4 years, it remains below the England average and shows wide variation between GP Practices.

There are estimated to be over 14,000 people aged 65 years and older living alone in Central Bedfordshire and at higher risk of social isolation which can lead to a deterioration in health. This number is likely to increase as the population ages and transport costs rise. In 2011 there were an estimated 3,500 people aged 65 and over suffering with depression, expected to rise to almost 4,000 people by 2015.

Current actions for future benefits

Falls are a major cause of loss of independence in older people with 10% resulting in an admission to care homes. The number of people aged 65 and over predicted to fall in Central Bedfordshire is forecast to rise from 10,500 in 2011 to over 12,000 by 2015. Secondary fractures are common with 50% occurring within 6-8 months of the first fall, the evidence base is strong for falls and fracture prevention. Telecare and community alarms, disabled facilities grants, training and information for care homes are all examples of initiatives to prevent falls in Central Bedfordshire.

Early diagnosis, appropriate treatment and supporting people to live in their own homes for as long as possible are cost effective in the longer term. It is estimated that investment is offset within 6 years through the delayed or avoided admission into care homes e.g. reablement services can reduce the long term costs of care by 15%.

Increasing the uptake of seasonal flu vaccination to 75%, the level recommended by the World Health Organisation will help reduce excess winter deaths.

Implications for future commissioning

It is estimated that additional extra care places need to be developed alongside lifetime homes and community based support.

The development of reablement services is expected to prevent 300 people being admitted to a care home and with increased extra care housing, this should reduce care home places required for this group of residents, from 469 to 163 by 2020. The available capacity could be used to meet the needs of the increasing numbers of people with dementia. An estimated 1,000 older people will develop dementia each year; who need access to early diagnosis and support in order to help them maintain their independence as long as possible.

It is expected that the number of people with sight loss will increase dramatically as the population ages. Older people with sight loss are almost three times more likely to experience depression than people with good vision, and will therefore be in a position to access the ageing well initiatives. These include developing community services and building capacity within local communities through the use of volunteering for older people, such as village care schemes, and meaningful day opportunities to help reduce the impact of social isolation. These themes have all been included in the Ageing Well Programme piloted within Ivel Valley.

The development of a fracture liaison service would assess those with a new fragility fracture or at high risk of a fracture in the future andthen signpoststhem to falls prevention services.

It is critical that safeguarding remains a core component of services commissioned and provided.

Vulnerable Groups

What are we doing well?

Provision for carers has improved since the last JSNA with a new single point of entry for support and advice for carers. In addition, awareness of and knowledge of support for carers within primary care has increased significantly.

The number of safeguarding alerts made and the proportion subsequently being investigated has increased since the last JSNA from an average of 19 per month in 2010 to 35 investigations a month in 2011. This should be viewed as a measure of success in terms of raising the awareness of the safeguarding, providing the opportunity to then deliver a more preventative approach.

What needs to be improved?

It is estimated that less than 50% of older people who could be registered as blind, are actually registered in Central Bedfordshire.

Adults with learning Disabilities are more likely to suffer from inequalities driven by a lack of employment opportunities, social exclusion, difficulty accessing services and discrimination.

It is estimated that currently 26,000 people in Central Bedfordshire have common mental health disorders and this will rise to over 27,000 by 2020. There is a strong association between mental illness and deprivation, also between mental ill health and reduced life expectancy.

There are over 7,000 people in Central Bedfordshire with a physical disability who are permanently unable to work, therefore unlikely to have the same opportunities and level of income as those people in work.

Gypsy and traveller communities have a life expectancy of 10-12 years lower than average, poor educational attainment, poor access to services and difficulty in negotiating services once a health problem is identified.

Current actions for future benefits

The number of people with sight loss is expected to increase as the prevalence of diabetes increases, however with good diabetes care and importantly the reduction of the prevalence of obesity, this could be reduced.

Continuing to support carers now will minimise the number of breakdowns in care arrangements which can result in costs of around £460 per week.

Implications for future commissioning

To improve outcomes for people with Learning Disabilities they will need to have more choice and control over their lives, including where they live: have meaningful activities during the day and in the evenings, including having paid employment and being able to access support to improve their health and wellbeing.

1 in 4 adults experience mental illness at some point in their lifetime and 1 in 6 at any one time. There is a significant link between physical and mental health, therefore to increase healthy life expectancy, improving outcomes for people with poor mental health must remain a commissioning priority. This includes improving mental health through the social determinants of health, offering timely assessment and treatment and by maintaining people's mental health after treatment through better primary and community care services.

The supported housing strategy due for publication in September 2012 will identify the best possible mix of housing related support services including both accommodation-based support and floating support. This will include the needs of vulnerable groups such as Gypsies and Travellers as well as people in need of housing support due to ill health, disability or older age.

If you require an excerpt of the document in a different format, email: jsna@bedfordshire.nhs.uk.

Dzifa Agbenu
JSNA Programme Manager
Public Health
NHS Bedfordshire

Tel: 01234 276842
Email: dzifa.agbenu@bedfordshire.nhs.uk

For any Local Authority data queries please email: insight@centralbedfordshire.gov.uk

Designed by Public Health Information and Resources Design Studio | design@bedfordshire.nhs.uk

Meeting: **Central Bedfordshire Shadow Health and Wellbeing Board**

Date: **29 May 2012**

Subject: **NHS Bedfordshire & Luton Integrated QIPP Plan 2012-15**

Report of: **Dr Diane Gray, Assigned Director of Strategy & System Redesign, Bedfordshire Clinical Commissioning Group**

Summary: The PCT Cluster integrated QIPP plan is a comprehensive report of the commissioning and provider landscape in Bedfordshire and Luton for 2012/13-14/15, and prepares the way for Bedfordshire Clinical Commissioning Group's own strategic commissioning plan (due to be presented to the BCCG Board in June 2012).

This summary report pulls out the key points from the Cluster integrated QIPP plan for Bedfordshire overall and Central Bedfordshire in particular:

- The financial pressures on NHS-funded services are likely to be greatest during 2012/13 but will continue for the duration of the plan
- Sufficient projects and workstreams have been identified to address these pressures
- There remain significant risks to the health economy's ability to deliver the outputs from these workstreams

Advising Officer:	Dr Diane Gray, Assigned Director of Strategy & System Redesign, Bedfordshire Clinical Commissioning Group
Contact Officer:	Dr Diane Gray, Assigned Director of Strategy & System Redesign, Bedfordshire Clinical Commissioning Group
Public/Exempt:	Public
Wards Affected:	All
Function of:	Council

CORPORATE IMPLICATIONS

Council Priorities:

- Supporting and caring for an ageing population
- Promoting healthier lifestyles

Financial:

1. This report sets out the financial context in which Bedfordshire Clinical Commissioning Group will operate.

Legal:

2. Bedfordshire CCG is a statutory partner of the Health & Wellbeing Board and the Board will need to be aware of the commitments on BCCG from financial and performance management perspectives.

Risk Management:

3. Not Applicable

Staffing (including Trades Unions):

4. Not Applicable.

Equalities/Human Rights:

5. The original plans, which this report summarises, are based on understanding the needs of the whole population and ensuring equality of care. An Equality Impact Assessment will be undertaken on the BCCG strategic commissioning plan on its completion. The implementation of the plans will also involve appropriate and due regard for the NHS Equality Delivery System.

Community Safety:

6. Not Applicable.

Sustainability:

7. Not Applicable.

Procurement:

8. Not applicable.

RECOMMENDATION(S):

The Board is asked to:

1. note the contents of this report as it sets out the financial and quality parameters for the local health economy over the next three years.

2. be aware that commissioning responsibility for much of the plan's delivery moved in April 2012 from NHS Bedfordshire (the Primary Care Trust) to sit with Bedfordshire Clinical Commissioning Group (BCCG).

Background

9. Each year, health economies are required to refresh their strategic approach and set out their operating priorities for the financial year ahead.

This year, the structural changes to NHS administration and the priority placed on delivering QIPP (the shorthand name for plans to improve Quality, Innovation, Productivity and Prevention within the local NHS) have made the production of the strategy and operating plan for our local health economy more difficult to produce. In common with health economies across England, the 2012-13 strategic and operating plans for Bedfordshire and Luton PCT Cluster have been condensed into a single integrated plan covering the health economies of both geographies. The final version of the plan was submitted to NHS Midlands and the East (the Cluster Strategic Health Authority) on March 9, 2012.

10. In April 2012, BCCG took on delegated authority as the main commissioner of NHS-funded care in Bedford Borough and Central Bedfordshire. BCCG is drafting its own strategic commissioning plan (which will – like the earlier Cluster one – integrate both a strategic plan and an operating plan), based on the financial assumptions of the main Cluster plan, but adding greater and more specific detail. The BCCG integrated strategic commissioning plan will be presented for sign-off at the June 2012 BCCG board and will then come to the subsequent CBC Health & Wellbeing Board.

11. Therefore, this paper summarises the main points relevant to BCCG from the PCT Cluster integrated plan, picking out especially those that are being incorporated into the BCCG-specific strategic commissioning plan and highlighting their relevance to Central Bedfordshire's population.

PCT Cluster priorities and vision

12. Across Bedfordshire and Luton, the PCT Cluster has a vision to reduce the health inequalities within the populations served and increase healthy life expectancy in conjunction with partner unitary authorities. This will be achieved by building a system that delivers consistently high quality, safe and integrated health and social care.

13. The Cluster Integrated plan reflects the national and regional priorities set out in relevant policy documents:

    (a) National priorities:
        i. Dementia and the care of older people
        ii. Carers
        iii. Military and veterans' health
        iv. Health visitors and Family Nurse Partnerships

    (b) NHS Midlands and East SHA Cluster priorities:
        i. Elimination of avoidable grade 2,3 and 4 pressure ulcers
        ii. Significantly improving quality and safety in primary care
        iii. Create a revolution in patient and customer experience
        iv. Making every contact count through systematic healthy lifestyle advice delivered through front line staff
        v. Radically strengthened partnerships between the NHS and local government

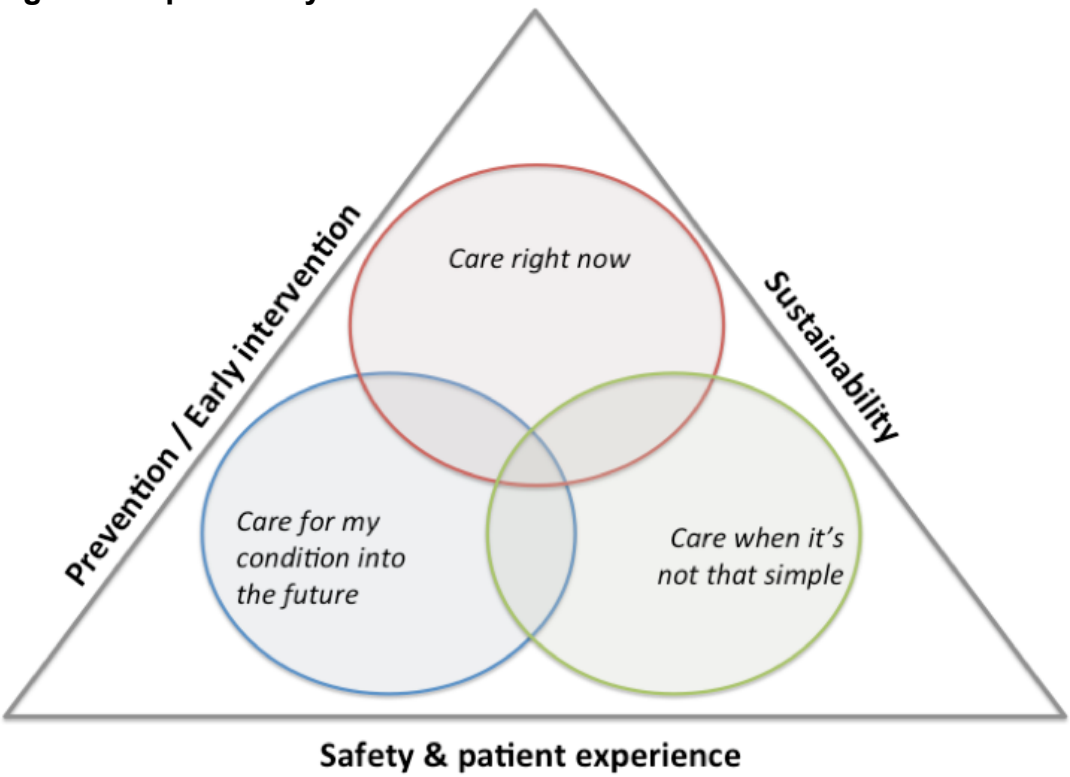
Bedfordshire Clinical Commissioning Group vision and priorities

14. To invigorate change towards better value in healthcare locally, Bedfordshire Clinical Commissioning Group (BCCG) must adopt a fresh approach to commissioning which focuses on outcomes from both the patient and clinical perspective. This section sets out that approach and the priorities in the early years of the organisation.

15. BCCG's Vision is: "To ensure, through innovative, responsive and effective clinical commissioning, that our population had access to the highest quality healthcare providing the best patient experience possible within available resources."

16. The proposed strategic approach to commissioning better value healthcare for Bedford Borough and Central Bedfordshire residents breaks down the totality of the healthcare we must commission into three key areas of focus with three cross-cutting themes, each of which have associated priority outcome indicators (taking into account the NHS Outcomes Framework and local Health & Wellbeing priorities) that we aim to achieve. The three key areas of focus with their crosscutting themes are set out in the figure below.

Figure: Proposed key areas of focus and themes



17. Cross-cutting themes:

(a) Prevention and early intervention: we will work in conjunction with partners, especially the unitary authorities, and see our role as reinforcing public health messages, leading by example, identifying those that need extra help to change and directing them towards suitable support.

(b) Sustainability: The CCG has a role as a corporate citizen, committing to promote sustainability of environmental and fiscal resources internally through its actions as a corporate body and externally by the way in which it commissions. Efforts to ensure sustainability can be integrated with improving outcomes for patients, improving productivity, and ensuring financial balance.

(c) Safety and patient experience: Our patients expect care to be provided safely and we must ensure that it is. But more than that, patients should expect to be treated courteously and with respect and dignity, with services fitting around them rather than vice versa.

18. Key areas of focus:
BCCG commits to looking at the care people need in three broad ways, with outcome indicators to monitor our progress for each. The outcome indicators are based on the NHS Outcomes Framework 2012/13 and reflect areas highlighted in the Joint Strategic Needs Assessment and priorities of the Health & Wellbeing Board.

(a) **Care right now:** We will improve patients' experience of urgent care services, including walk-in centres, GP out of hours services and A&E services, so that more than 85% patients rate their overall experience as good or very good by 2015.

(b) **Care for my condition into the future:** We will increase the proportion of people with a long term condition who feel they have had enough support from local services to help manage their condition from 66% (in 2011) to 80% by 2015.

(c) **Care when it's not that simple:** We will work with social care to increase to at least 85% the proportion of people aged 65 and over who are still at home three months after leaving hospital for rehabilitation in the community.

19. The starting point for BCCG is the health needs of the people of Bedford Borough and Central Bedfordshire. With the knowledge of local clinicians, working through locality structures, and the experience and support of our patients, we will build on what works well and change what needs to work better. We will do this by:

(a) Working in partnership with our member practices and localities, with patients and the public, with Central Bedfordshire Council and other partners, and with other healthcare providers

(b) Using clinical leaders to challenge and champion, and to develop new ways of providing care outside hospitals

(c) Focusing on outcomes by using our purchasing power to improve the co-ordination of patient care and make services more joined up

Financial savings: the "productivity challenges"

20. Over the foreseeable future, cost inflation rises faster than our financial allocation. "Productivity challenge" describes the estimated gap between our expected financial allocations and future costs if we do nothing differently. Figures for BCCG from the Cluster Integrated Plan are set out in the table below, and demonstrate that the greatest challenge (in financial terms) is in 2012/13.

NHS Bedfordshire

£ Millions	2012/13	2013/14	2014/15	Total
Assumed PCT Allocation	624.73	640.35	656.36	
Resource Growth	(16.28)	(15.62)	(16.01)	(47.91)
Pay & Price Pressures	5.62	5.62	5.62	16.87
Demand & Quality Pressures	18.69	19.26	19.26	57.21
Tariff Benefit Derived from NHS Providers	(6.52)	(6.52)	(6.52)	(19.56)
Debt Repayment	0.00	0.00	0.00	0.00
Underlying 2011/12 Pressure c/f	12.17	0.00	0.00	12.17
Size of PCT Challenge	13.68	2.75	2.35	18.78

21. This financial challenge is being met in Bedfordshire largely through four programmes of activity, with progress overseen by the Bedfordshire QIPP Leadership Board.

	£'000 2012/13	£'000 2013/14	£'000 2014/15
Planned care	4,975	4,277	844
Urgent Care	2,216	2,194	2,480
Prescribing	1,357	917	330
Mental Health	111	0	0
Primary care (led by PCT Cluster/NCB)	480	0	0
Prevention (led by public health)	589	0	0
Other (incl. PCT workforce cost savings)	8,345	3,355	970
Subtotal	18,073	10,743	4,624
QIPP Challenge	13,677	2,748	2,358
Headroom / (Gap)	2,396	7,995	2,266

22. The planned care programme takes two approaches to improving the quality and efficiency of care across Bedfordshire. Firstly, it aims to reduce unwarranted clinical variation in general practice using peer comparison and support. Secondly, it uses a programme budget approach to bring together providers in the redesign of sustainable systems of care. Both are underpinned by access to accurate and timely data on activity, finance and outcomes and strong clinical leadership and engagement.

23. The urgent care programme has two main workstreams:
- improving public access to information on and services for urgent care (such as improving triage at A&E front doors and developments in the falls service)
- improving integration of care for, and focusing delivery on, people with complex needs (such as sub-acute service pilot in Central Bedfordshire and extending use of telehealth and support to care homes)

24. A notable success has been the transformation in care for frail older people in Dunstable. This has shown that it is possible to reduce admissions from care and nursing homes by over 30% by implementing fundamental changes in the way that primary care and community matron services support and work with care and nursing homes. A 50% reduction in urgent admissions has been achieved by transforming the support to patients in their own homes. This approach will be rolled out across the rest of Central Bedfordshire in 2013.

25. Prescribing/medicines management: In Bedfordshire, objectives will move increasingly towards optimising the use of medicines so that patients are adhering to safe and cost-effective treatments. Each locality and each practice within a locality will continue to have a clear prescribing plan so that each practice has up to 5 specific objectives that they are committed to achieving. Together these build up into the Bedfordshire CCG Prescribing QIPP plan. The 'big ticket' lines include continuing to use generically available drugs within cardiovascular, diabetes and mental health treatments where they have the strongest evidence base for safety and effectiveness. With key patents expiring, we have an opportunity to save £1m in 2012/13 by prescribing in accordance with our policies and guidelines already agreed by the Joint Prescribing Committee and supported by local clinical leaders.

Implications for the way care is delivered

26. Primary care: Whilst technically outside the remit of the CCG (since primary care will be commissioned directly by the NHS Commissioning Board), it is in the interests of BCCG that its local practices deliver high quality safe healthcare that is clinically and cost effective. With the continued shift in care out of hospitals and into the community, it is likely that practices will need to consider the best ways they can offer a complete and robust service to their patients. This may involve providing more services in-house and partnering with neighbouring practices to deliver a broader range of care within the same locality.

27. Community-based care: The current provider in Bedfordshire of both community care and mental healthcare is South Essex Partnership Foundation Trust (SEPT). Their vision is that, by 2015, they will become an integrated care organisation, providing a range of care services, not just mental health or traditional community health services

28. Community Health Services are being restructured into service provision based on the primary care locality model that exists in Bedfordshire. This model will ensure that all localities have core services with named staff per GP practice and that care is delivered closer to home, which will reduce emergency admissions as well as reduce new and follow up out-patients. This will deliver efficiencies, increase productivity and more importantly improve patient satisfaction through personalisation and choice.

29. Community Mental Health Teams are being redesigned to provide a focus on primary care liaison, assessment and short-term treatment, and longer-term recovery.

30. Specialist care: The Luton & Dunstable Hospital NHS Foundation Trust has an ambitious vision for the future. It is currently undertaking a strategic service review which will embed its vision of a high quality hospital providing care for is local residents both at the main site and increasingly within community settings, further developing its specialist services to a sub-regional population, creating a thriving environment for teaching and research. Allied to this, the Trust is embarking on a programme to redevelop the hospital's estate in order to create a top-class physical environment to match the quality of its clinical care.

31. Across the South East Midlands health system, there is a recognition that healthcare organisations cannot continue to work in isolated silos. There is a need to work together, in different ways. “Healthier Together” is a commissioner-led programme, initiated in partnership with the Northamptonshire & Milton Keynes PCT Cluster, the five acute hospitals at Bedford, Kettering, Luton & Dunstable, Milton Keynes and Northampton and the five CCGs from within Bedfordshire, Luton, Northamptonshire and Milton Keynes. It is focusing on services currently provided in acute settings and how they should be delivered differently – either in the community or in acute hospitals. Proposals, to be consulted on later in 2012, will be built around four pillars:

    i. Care closer to home
    ii. A range of services available on all existing hospital sites
    iii. Centralisation of some specialities
    iv. Making the most of specialist care in the area

32. As the Health & Wellbeing Board is all too aware, the Central Bedfordshire population have no local acute provider and currently use a range of acute providers outside the council boundaries. Therefore, the future delivery of specialist care to the population is of particular importance. Patient groups are actively engaged in the “Healthier Together” programme and an active programme of public engagement is underway. BCCG is aware of, and its commissioning plans take account of, the significant implications on commissioning intentions for community-based services as the implications of the “Healthier Together” programme – such as centralisation – become clearer. BCCG is also cognisant of the impact of similar acute services reviews in Buckinghamshire and Hertfordshire on access to hospital services for the Central Bedfordshire population.

Other changes to the NHS landscape

33. The PCT Cluster integrated plan also includes sections on the transition of public health from NHS to local authority and the development of commissioning support services. Given the relatively rapid nature of transition and development of new teams and organisations, further more up-to-date information on these areas can be provided to the Health & Wellbeing Board at a later meeting.

Risks to delivery

34. The full Cluster integrated plan contains a comprehensive table of risks and mitigating actions, which are reviewed by the programme boards and the QIPP leadership board. The two key themes of the highest graded risks are:

(a) Instability in structures and lack of clarity in roles and responsibilities as commissioning structures change as a result of the implementation of the Health & Social Care Act 2012.

In response: BCCG has moved as quickly as it can to establish and fill a staff structure, start significant pieces of redesign work, and start to build relationships with partners and providers that will be necessary to commission successfully in the future. There is more to do, however, and the Act will not be fully implemented until 2015, so managing through instability and uncertainty will remain a necessary skillset.

(b) The financial 'productivity challenge' may not be achievable, especially given Bedfordshire's starting position as a relatively underfunded area.

In response: BCCG's challenge will be to continue to push acute providers (through both the "Healthier Together" programme and local commissioning intentions) to reduce their cost base and free up resource that can instead be invested in upstream community-based care, including social care, to produce better patient and clinical outcomes.

Summary

35. The PCT Cluster integrated plan aims to set out in one place the challenges and plans for the health economies of Bedfordshire and Luton in 2012/13-14/15. This is further refined for our local geographies within the forthcoming BCCG strategic commissioning plan. The greatest challenge will be in addressing the financial pressures on the health economy: identifying the right commissioning actions to take, translating those into activity implications on providers, supporting providers to make the necessary changes to workforce and infrastructure, and involving patients and the public throughout. Throughout all this, the Health & Wellbeing Board's role as a 'critical friend' to BCCG will be invaluable.

This page is intentionally left blank

Meeting: **Shadow Health and Wellbeing Board**

Date: **29 May 2012**

Subject: Outline Health and Wellbeing Strategy

Report of: Muriel Scott, Director of Public Health

Summary: This report outlines the priorities previously identified for the Health and Wellbeing Strategy in Central Bedfordshire and a proposed structure for the report.

The priorities broadly align with the needs identified in the re-freshed JSNA.

Advising Officers:	Muriel Scott, Director of Public Health, Julie Ogley, Director of Adult Social Care, Health and Housing, Edwina Grant, Director of Children's Services and Dr Judy Baxter, Director, Bedfordshire Clinical Commissioning Group
Contact Officer:	Celia Shohet, Assistant Director of Public Health
Public/Exempt:	Public
Wards Affected:	All
Function of:	Council

CORPORATE IMPLICATIONS

Council Priorities:

The Health and Wellbeing Strategy should support all of the council priorities:

- Enhancing Central Bedfordshire – creating jobs, managing growth, protecting our countryside and enabling businesses to grow.
- Improved educational attainment.
- Promote health and wellbeing and protecting the vulnerable.
- Better infrastructure – improved roads, broadband reach and transport.
- Great universal services – bins, leisure and libraries.
- Value for money – freezing council tax.

Financial:

1. None at present. The priorities within the strategy should however influence resource allocation within the constituent organisations of the board.

Legal:

2. Duties and powers relating to the functions of the Health and Wellbeing Boards are as detailed in the Local Government and Public Involvement in Health Act 2007 ('the 2007 Act') and as amended by the Health and Social Care Bill 9'the Bill'_ which will come into force on 1st April 2013.

Risk Management:

3. None at present.

Staffing (including Trades Unions):

4. Not Applicable.

Equalities/Human Rights:

5. Reducing inequalities is fundamental to the work of the shadow board.

Public Health

6. The Health and Wellbeing Strategy outlines the immediate priorities for improving health and wellbeing within Central Bedfordshire. This is based upon the needs identified within the JSNA.

Community Safety:

7. Not Applicable.

Sustainability:

8. Not Applicable.

Procurement:

9. Not applicable.

RECOMMENDATION(S):

The Board is asked to:

1. Consider whether the priorities identified to date remain those that the board wishes to proceed with in the medium term.

2. Agree that the strategy is developed further in the proposed format prior to the next board meeting.

3. Agree the timescale for both the strategy and the priorities

Background

10. The priorities for improving outcomes for children were agreed by the shadow health and wellbeing board in November 2011. These are the same as those identified within the Children's and Young Peoples Plan and are:

- Reducing teenage pregnancy
- Reducing childhood obesity
- Improving mental health for children and their parents
- Improving the health of looked after children.

11. The priorities for adults and older people were agreed by the shadow board in March 2012 and are:

- Prevention and Early Intervention
- Improving outcomes for frail older people
- Improving mental health and wellbeing
- Safeguarding and Patient Safety
- Promoting Independence and Choice

12. The Joint Strategic Needs Assessment (JSNA) has recently been re-freshed and helps to identify gaps in provision, identifies where inequalities exist and should inform future investment and disinvestment decisions to maximise health and wellbeing at optimum cost.

13. The emerging themes from the JSNA are that:
    - Investing in early intervention and prevention (for both adults and children) will help increase lifetime opportunities for all, ultimately reducing the need for health and social care support in later life
    - There is no health without mental health, therefore improving mental health and wellbeing remains a high priority
    - Improving educational achievement and all-age skills will have a significant impact upon a wide range of outcomes
    - There needs to be a continued focus on reducing inequalities by improving the social determinants of health such as housing, employment and the built environment, to give residents greater control over their life choices.

Scope of the Health and Wellbeing Strategy

14. The Health and Wellbeing Strategy (HWBS) aims to improve the health and wellbeing of all but importantly to reduce inequalities by improving the health of the poorest fastest. The timescale for the strategy has not been established but it is proposed that it covers the period 2012-16 but the priority areas cover 2012-14 initially and are reviewed after one year.

15. Bedfordshire Clinical Commissioning Group will need to take account of the strategy when developing its own strategy and commissioning plans.

16. The HWBS will contribute to one of the priorities within the MTP, to promote health and well being and protect the vulnerable.

Structure and development of the Strategy

17. It is not intended that the health and wellbeing strategy is a lengthy document, details will be within associated delivery plans for each priority and relevant commissioning plans. The proposed structure is set out within appendix A and has some similarity with the structures used for the MTP and the Sustainable Communities Strategy.

18. The strategy will be presented to the shadow board in July 2012, followed by a period of public consultation. The forward plan indicates that the final strategy will be agreed by the board in September 2012, but this will be dependent upon the consultation period.

Success Criteria

19. The health and wellbeing outcomes (which will be identified for each priority) will be regularly reported to the board, although the process for this has not yet been determined. The board should also require evidence that inequalities are being reduced over the period of the strategy.

20. There should also be evidence that services to address the priorities have been commissioned effectively to deliver integrated care across the NHS and local government. This could be through assessing whether those using / in receipt of services are receiving effective integrated and personalised care.

Appendices:
Appendix A – Proposed structure of the strategy

Foreword

By Cllr Tricia Turner and Dr Paul Hassan
Including purpose of the strategy

Health and Wellbeing in Central Bedfordshire

A brief overview of Central Bedfordshire as a place from the JSNA

Vision

What will health and wellbeing look like for the residents of Central Bedfordshire? By 2014, this will mean that – illustrated with each priority

Our Priorities 2012-14

A one summary page – see last page of report for illustration

Then for <u>each</u> priority – one page detailing (illustrated by childhood obesity – these are currently being completed for the other priorities prior to going to the HWB)

Our Priority

Headline for each 'Promoting / Reducing / Ensuring'
Increasing the number of children who are a healthy weight from xx to yy
(to be provided later)

Why it's important

Key facts and figures from the JSNA (or other source) - why this is an identified priority
Currently 1 in 5 children in the most deprived areas are obese by the time they reach year 6. In the rest of Central Bedfordshire 1 in 7 children are obese by year 6.

Conditions linked with obesity in childhood include low self esteem, depression and musculo-skeletal problems. As overweight and obese children are more likely to go on to become obese adults, they are then at increased risk of type 2 diabetes, cardiovascular disease, respiratory conditions, and certain cancers. There is an exponential rise in risk as the level of obesity increases.

Preventing and reducing obesity in childhood will increase healthy life expectancy and reduce health inequalities.

What we will do

Describing the difference they will see by broadly what we will have done e.g. increased / addressed / developed / improved / supported
We will have provided family based treatment programmes for managing childhood obesity targeted in the areas where obesity levels are highest (BeeZee Bodies and BeeZee Tots)

We will support schools to provide high quality physical activity and healthy eating through programmes such as Making the Most of Me and Change 4 Life
We will support pregnant women who are overweight or obese to introduce healthy living choices and reduce weight gain in pregnancy
There will be an active travel plan which encourages higher levels of physical activity

How we will measure our progress

Outcome measure to be used and target associated with each – timescales may vary according to target. These must include inequalities measures wherever possible to check that we are improving the health of the poorest fastest.
Levels of Obesity in children in reception and year 6
Inequalities in levels of obesity between the 20% most deprived wards and the rest
Children and young people's participation in high quality PE and sport
Numbers enrolled in BeeZee Tots and BeeZee Bodies

How we will report on progress and delivery

CENTRAL BEDFODRSHIRE HEALTH & WELLBEING STRATEGY PRIORITIES 2012/14

Teenage Pregnancy	Childhood Obesity	Looked After Children	Mental Health	Prevention and Early Intervention	Frail Older People	Safeguarding and Patient safety	Independence and Choice

WHAT WE WILL DO

We will Increase the number of children who are a healthy weight

INDICATORS

Levels of Obesity in children in reception and year 6
Inequalities in levels of obesity
Children and young people's participation in high quality PE and sport

This page is intentionally left blank

Meeting: **Central Bedfordshire Shadow Health and Wellbeing Board**

Date: **29 May 2012**

Subject: **Looked After Children's Health**

Report of: **Children's Trust**

Summary: The report sets out the findings of Central Bedfordshire's recent Safeguarding and Looked After Children inspection in relation to the quality of health services for looked after children.

Advising Officer: Anne Murray, Director of Nursing and Quality
Edwina Grant, Deputy Chief Executive/Director of Children's Services

Contact Officer: Sylvia Gibson, Health and Special Projects Coordinator
Emma de Zoete, Assistant Director Public Health

Public/Exempt: Public

Wards Affected: All

Function of: Council and NHS Bedfordshire

CORPORATE IMPLICATIONS

Council Priorities:

The report relates to the following Council priorities:

- Educating, protecting and providing opportunities for children and young people
- Promoting healthier lifestyles

The report also supports the following priority of the Children and Young People's Plan:

- Targeting the most deprived areas and vulnerable groups to improve children's emotional and physical health.

Financial:

1. NHS Bedfordshire Looked After Children's health services are currently funded from the NHS Bedfordshire commissioning budget. Any additional resource implications will be identified as part of the development of the post inspection action plan.

Legal:

2. The Ofsted Inspection of Safeguarding and Looked After Children is carried out under the Children Act 2004.

Risk Management:

3. Failure to deliver effective health services that support looked after children will negatively impact on their health and wellbeing.

Staffing (including Trades Unions):

4. Any required adjustments to staffing will be addressed as part of the development of the post inspection action plan. Any immediate adjustments involve increasing the number of staff working on the health of looked after children.

Equalities/Human Rights:

5. It is important that the health needs of Looked After Children, who are a vulnerable group, are met.

Public Health

6. This is a key Public Health priority, as previously agreed through the shadow Health and Wellbeing Board.

Community Safety:

7. Not Applicable.

Sustainability:

8. Not Applicable.

Procurement:

9. Not applicable.

RECOMMENDATIONS:

The Committee is asked to:

- **comment on the information within the report.**
- **note the action to be taken to address the issues raised in the inspection report.**
- **agree to receive reports on progress at future meetings of the Health and Wellbeing Board.**

Background

10. The Children Act 2004 requires Ofsted to provide an evaluation of the contribution made by relevant services in the local area towards ensuring that children and young people are properly safeguarded and to determine the quality of service provision for looked after children and care leavers. This report looks at the specific contribution of Health Services to the health and wellbeing of looked after children.

11. The Council has a lead role in providing services for children, and works with its partners, other agencies and the private and voluntary sectors to improve outcomes for children and young people. The inspection was carried out between 20 February and 2 March 2012. The report was published on 10 April 2012.

Health Outcomes for Looked After Children

12. Ofsted judged that Health outcomes for looked after children are poor and that outcomes to enable looked after children to be healthy are inadequate.

13. Ofsted found that health outcomes for looked after children in Central Bedfordshire had declined over the 12 months preceding December 2011 compared to the East of England and England averages. Health assessment rates were low at 73%. Immunisation rates were low at 52% and lower than the general population rates for non looked after children in the area, which are between 77% and 89%. In 2010/11 87.3% looked after children received dental checks.

14. Alongside the decline in health outcomes the report highlighted a number of specific weaknesses including:

- Health agency awareness of their responsibilities towards looked after children.
- Access to health information by looked after children.
- No specific health service for care leavers or health after care service.
- The content and quality of health files.
- No permanent designated doctor or nurse for looked after children in place.

15. Other areas of weakness included:

- Health action plans poorly monitored due to the lack of specific or measurable objectives being set.
- No quality control or quality assurance of health assessments.
- Insufficient choice of venue or appointment times for health reviews to increase take up by looked after young people.

- Health practitioners not routinely enabled to discuss the needs of looked after children in supervision meetings.
- Case planning is not of a consistently high standard and so that case records support good quality practice across the partnership.
- Delays in getting signed consent for health assessments from social work teams.
- A need to improve information sharing when children move placement so that health teams have up to date information.

Improvement Planning

16. Ofsted concluded that health services face significant challenges in ensuring that the health needs of looked after children are addressed. Ofsted highlighted some issues which should be addressed in the three to six months following the inspection and others which will take longer term planning and service redesign. For the longer term aspects, the Council and NHS Bedfordshire and Luton will be working with the Eastern Region on a peer support and challenge programme to ensure that action leads to sustainable improvement (see paragraph below).

17. The following sets out the actions planned and taken to address:

    a) the issues which Ofsted requires to be addressed in the 3-6 months following inspection (stage 1),
    b) the longer term planning (stage 2).

Stage 1 action: in the 3-6 months following the inspection

Ofsted areas for improvement	Action taken
Ensure all LAC have prompt access to appropriate health services which promote good outcomes for them. NHS Bedfordshire and Luton should ensure that all care leavers are enabled to access health services and receive a copy of their health histories to ensure they are able to make future life choices	Funding for a Designated LAC Nurse, a Designated LAC Doctor, two additional LAC nurses and 0.5fte administrative support has been agreed for this year. This includes nurse capacity for a leaving care health service. An interim Designated Doctor has been identified and we anticipate will be in place in the next few weeks. An interim designated nurse is now in place and the permanent position will be advertised week commencing 30th April. An interim Leaving Care Nurse has been appointed to improve the Leaving Care Service and a consultation is underway with CiCC (Children in Care Council) and the Social Care Leaving Team to shape the Leaving Care Services.

Ofsted areas for improvement	Action taken
NHS Bedfordshire and Luton should ensure that all looked after children and young people have access to age appropriate health education and promotion information.	An age appropriate health promotion information pack for LAC has been developed, printed and is being distributed at all initial and review health assessments Core training for foster carers is now in place for the rest of the year and includes Public Health input on health promotion.
NHS Bedfordshire and Luton and Central Bedfordshire Council should ensure that the strength and difficulties questionnaire outcomes are reviewed as part of the emotional health and well-being assessment during review assessments.	British Association of Adoption and Fostering (BAAF) Carers paperwork has been introduced to assess the emotional health and wellbeing of looked after children and young people.
NHS Bedfordshire and Luton must ensure that all GPs and independent health contractors are aware of their statutory responsibility to looked after children.	We are working with Clinical Commissioning Group to put together a plan to address this issue with GPs and Dentists. This will be a key area of work for the Designated Doctor when in post.
Delays in getting signed consent for health assessments from social work teams.	Guidance will be circulated to social work teams about who is responsible for giving consent for a health assessment.

18. We will know if the service has improved by looking at::

- Existing performance management information including national measures on health assessments completed in the last 12 months, and the proportion of LAC with up to date immunisations and dental checks. Other local measures are also used specifically to assess if initial and review health assessments are undertaken within the statutory timeframe.

- An audit of initial and review assessment files by the Designated Doctor and Nurse, including monitoring quality of assessments, health action plans and if health plans are implemented.

19. Early performance management information already indicates an improvement since 2011 in immunisation rates, with health assessment and dental check rates just below the 2010/11 levels. The percentage of Looked After Children with up to date immunisations has risen from 51% in 2010/11 to an approximate figure of 83% for 2011/12.

Stage 2: Longer term service redesign

20. The Council and NHS Bedfordshire and Luton will be working with the Eastern Region on a peer support and challenge programme to ensure that action leads to sustainable improvement. Funding has been secured for initial work to identify common development areas for Health identified through the recent inspections of Central Bedfordshire, Bedford Borough and Luton Borough Councils, and to agree areas for peer support from the region. A peer challenge will take place in February 2013 supported by the Children's Improvement Board focused on areas self assessed as requiring further acceleration to secure "good".

There are a number of themes which have emerged in the inspection, and post inspection discussions, which will need to be addressed in the service redesign. These include

- Ensuring that the LAC health team is optimally located to work in partnership.
- Ensuring that IT is used to maximise communication.
- Ensuring that there is a choice of venue and appointment times for older looked after children and that the review assessment addresses relevant issues for this group.
- Having clear commissioning arrangements for health assessments for all children placed out of Central Bedfordshire.
- A clear strategy for developing the designated doctors of the future, and additional expertise amongst GPs.
- Ensuring that the views of Looked After Children influence the redesign of the service.
- Regular checks to ensure that health assessments, health plans and the monitoring of health plans are of high quality and improving outcomes.
- Ensuring that Child and Adolescent Mental Health Services (CAMHS) work supports placement stability.
- Ensuring that health reviews, such as disability, LAC and adoption are combined or held at the same time.
-

Conclusion and next steps

21. A full action plan is being put together to address all the issues raised in the inspection. The plan will go to the Council's Overview and Scrutiny Committee, to the Council's Executive and to the Children's Trust Board.

An update on actions and progress will be provided for the Health and Wellbeing Board at its meeting on 6 September 2012 and at its meeting on 21 March 2013.

Appendices:

Appendix A – Ofsted Record of Main Findings

Appendix A

Record of main findings:

Safeguarding services	
Overall effectiveness	Good
Capacity for improvement	Good
Safeguarding outcomes for children and young people	
Children and young people are safe and feel safe	Good
Quality of provision	Good
The contribution of health agencies to keeping children and young people safe	Adequate
Ambition and prioritisation	Good
Leadership and management	Good
Performance management and quality assurance	Good
Partnership working	Good
Equality and diversity	Adequate
Services for looked after children	
Overall effectiveness	Adequate
Capacity for improvement	Adequate
How good are outcomes for looked after children and care leavers?	
Being healthy	Inadequate
Staying safe	Adequate
Enjoying and achieving	Adequate
Making a positive contribution, including user engagement	Good
Economic well-being	Adequate
Quality of provision	Adequate
Ambition and prioritisation	Adequate
Leadership and management	Adequate
Performance management and quality assurance	Good
Equality and diversity	Adequate

This page is intentionally left blank

Meeting: **Shadow Health & Wellbeing Board**

Date: **29 May 2012**

Subject: **South East Midlands Healthier Together Programme – Progress Report**

Report of:

Summary: The report provided an update on progress against all aspects of the Healthier Together Programme.

Advising Officer:	John Rooke, Chief Operating Officer, Bedfordshire Clinical Commissioning Group
Contact Officer:	Mrs Sally-Anne Watts, Head of Communications and Engagement, Healthier Together
Public/Exempt:	Public
Wards Affected:	All
Function of:	NHS

CORPORATE IMPLICATIONS

Council Priorities:

The Healthier Together Programme supports the following priorities:

- Supporting and caring for an ageing population
- Managing growth effectively

Financial:

1.

Legal:

2.

Risk Management:

3.

Staffing (including Trades Unions):

4. Not Applicable.

Equalities/Human Rights:

6.

Public Health

7.

Community Safety:

8. Not Applicable.

Sustainability:

9. Not applicable.

Procurement:

10. Not applicable.

RECOMMENDATION(S):

The Board is asked to note this report

South East Midlands Healthier Together Programme – Progress Report

11. Please find attached the progress report at Appendix A.

Appendices:

Appendix A – South East Midlands Healthier Together Programme – Progress Report

South East Midlands
Healthier Together Programme

Progress Report
For
Central Bedfordshire Health and Well Being Board
Prepared 8th May 2012

1. Introduction

This paper provides a progress report against all aspects of the Healthier Together Programme.

The aim of the programme is to deliver improved quality and outcomes for the population of the South East Midlands and ensure clinical and financial sustainability of the health economy through the reconfiguration of acute services provided in Northamptonshire, Bedfordshire, Luton and Milton Keynes.

The programme is driven by a Programme Board made up of representatives from all partner organisations, the Clinical Lead and the Chair of the Patient and Public Advisory group (PPAG). There is a shared understanding among partners that the current pattern of hospital provision is unsustainable, particularly given the research regarding the effect of critical mass on patient outcomes for complex procedures. This research has shown that there is more likely to be a positive outcome for a patient undergoing a complex procedure if it is completed in a hospital whose staff team have undertaken the procedure repeatedly and regularly.

With an increasing and ageing population, due to rise from 1.6m to 2.2m by 2031, and finances becoming more constrained the five hospitals wish to work collaboratively to improve efficiency and effectiveness as well as increasing quality of care and improved clinical outcomes for patients.

There are twelve NHS partner organisations leading this review, with another twelve key stakeholders engaged in the programme:

Five acute trusts

Bedford General Hospital NHS Trust
Kettering General Hospital NHS Foundation Trust
Luton & Dunstable University Hospital NHS Foundation Trust
Milton Keynes Hospital NHS Foundation Trust
Northampton General Hospital NHS Trust

Clinical commissioning groups

Bedfordshire Clinical Commissioning Group
Corby Healthcare
Luton clinical Commissioning Group
MK Commissioning
Nene Commissioning (covering most of Northamptonshire except Corby)

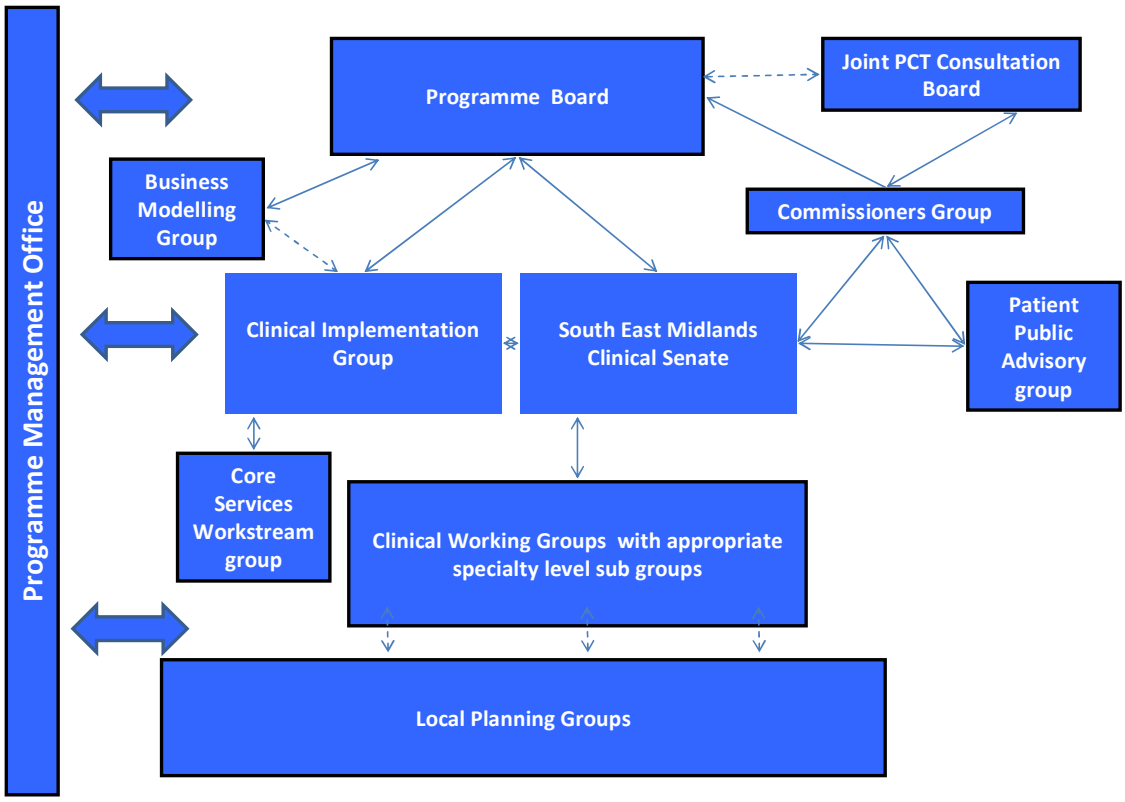
Key stakeholders

Local Authority	Community Service Provider	Ambulance Trust
Northamptonshire County Council	Northamptonshire Healthcare NHS Foundation Trust	East Midlands Ambulance Trust
Milton Keynes Unitary Council	Milton Keynes Community Health Services	South Central Ambulance Trust
Bedford Borough Unitary Council	South Essex Partnership University NHS Foundation Trust (Bedfordshire)	East of England Ambulance Trust
Central Bedfordshire Unitary Council	Cambridgeshire Community Services NHS Trust (Luton)	
Luton Unity Council		

2. Governance structure

The governance arrangements for the programme are summarised below:

Healthier Together Governance Structure



A Joint Health Overview and Scrutiny Committee (JHOSC) has been established to scrutinise the process. Each local authority has three representatives on the JHOSC and neighbouring local authorities have been invited to join with observer status. Representatives from Local Involvement Networks (LINks) are also included as observers.

Patient and public representation is established throughout the governance structure. All feedback received from the different methods of patient and public engagement outlined in this report is being fed back into the six Clinical Working groups and Clinical Senate so that the views of local residents can help shape the development of possible options for new models of care.

Commissioning Group

The Commissioner Group has been established and has met several times with good consistent representation from all the CCGs. The group is now co-chaired by two of the CCG Clinical Chairs, Dr Paul Hassan from Bedfordshire and Dr Darin Seiger from Northamptonshire.

On a quarterly basis the group is opened up to a wider membership including the wider health economy commissioners, Directors of Adult Social Care and Chairs of Health and Wellbeing Boards. The first of these Wider Commissioner Group meetings took place on 12th April and provided a useful opportunity to bring Local Authorities and the Health and Wellbeing Boards into the discussion.

A draft commissioner concordat between the five CCGs and two Clusters has been agreed on how they will work together through the programme.

The group has a clear workplan that includes development of a commissioner vision focused on improvement of clinical outcomes. This is being developed and will be brought together through two half day workshops in May/June.

2. Clinical Groups

Clinical Senate

The Clinical Senate is chaired by the Programmes Clinical Leader – Mr Ed Neale and its membership includes the Chairs of the CWGs, Acute Management and Nursing Director reps, Community Nursing Director rep, Ambulance Service Medical Director rep, Public Health Director, Patient & Public Advisory Group reps and CCG GPs reps. The Senate has met three times so far to review, challenge and co-ordinate the work emerging from the six Clinical Working Groups (CWGs).

Clinical Working Groups

Six Clinical Working Groups (CWGs) have been established. Each CWG is chaired by a practising clinician from within the South East Midlands. The CWGs are made up of hospital consultants, GPs, nurses, health and social care and patient and public representatives.

The Chairs of the CWGs are:

Clinical Working Group	Chair
Cancer	Dr Christine Elwell, Consultant Oncologist, Northampton General Hospital
Children	Dr Beryl Adler, Consultant Paediatrician, Luton & Dunstable Hospital
Emergency Care	Dr Naeem Shaukat, Consultant cardiologist, Kettering Hospital Foundation Trust
Long Term Conditions	Dr Monica Alabi, General Practitioner, Luton
Maternity	Mr Paul Wood, Consultant Obstetrician & Gynaecologist, Kettering Hospital Foundation Trust
Planned Care	Mr Rob Hicks, Consultant Vascular Surgeon, Northampton General Hospital

Each CWG has met at least 4 times to review clinical evidence and best practice and to start to develop models of care. A summary of thinking to date has been produced by each group and reviewed by the Clinical Senate. The Clinical Senate was able to identify areas which needed more discussion and potential overlaps between groups. This has led to a number of sub-group and task and finish group meetings to focus on specific clinical specialities and conditions which impact across more than one CWG.

Core Services Group

The Core Services Group comprises the Medical Directors for the five acute trusts. This group has begun to draft a list of core services which they will recommend are provided on all five hospital sites.

Clinical Implementation Group

The Clinical Implementation Group (CIG) has discussed some of the early feedback from the Clinical Senate. The group consists of the five Medical Directors of the Acute Trusts and the Clinical Chairs of the five CCGs plus the PPAG Chair and a representative Ambulance Trust Medical Director. The CIG will be chaired by an external Clinical Advisor but has so far been chaired by the Programme SRO.

Clinical service models – next steps

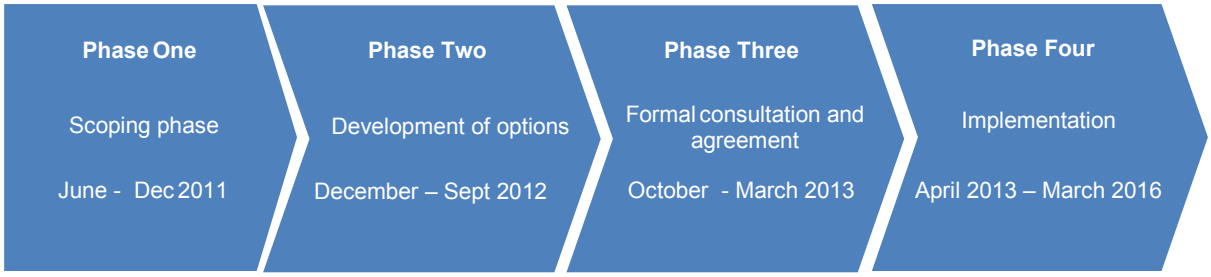
The following are key next steps for the development of clinical service models:

- Continued work to test emerging clinical models through the Clinical Senate

- CWGs and sub-groups continue to meet. Their first draft reports will be ready for discussion with the Clinical Senate on 15th June
- Establishment of a Diagnostics Group to consider the impact and requirements of service models on diagnostic services
- Start to test emerging models with stakeholders and the wider public from the end of June.

3. Revised Timeline

In March the Programme Board recognised that, in order to allow sufficient time for the CWGs to develop strong, evidence-based proposals and engage effectively with patients and the public to help shape the developing options that will be put forward for public consultation, it was necessary to revise the timeline for going out to formal public consultation. It has now been agreed that the formal public consultation will begin in October 2012.



Key Milestones for the Programme Board for Phases Two and Three

- Commissioner vision and health outcomes to Programme Board – late June
- Proposals from Clinical Senate on recommendation for core services and options for clinical models to Programme Board – late June
- Options for clinical models to Clinical Implementation Group (CIG) – late June
- Joint Health Overview & Scrutiny Committee – mid July
- First draft of options on models and locations from CIG and Clinical Senate to Programme Board – late July
- Final draft Consultation document to the Programme Board – late August
- Final consultation document (having been through JHOSC and Plain English group) to Programme Board – mid September
- Final consultation document to Joint PCT Consultation Board – mid September
- Consultation starts – Monday 1st October 2012

4. Communications and Engagement

This section gives an update on progress against the Communications and Engagement strategy for Phase 2 of the programme and feedback received to date from patients and the public. It also outlines the draft strategy for public consultation.

Objective 1: Ensuring engagement at all levels of the programme

The Patient and Public Advisory Group has met on four occasions. There are now approximately 30 members of the group with good representation from local community groups as well as members/ Governors from each hospital and LINks. In addition there is patient and public representation and involvement across most of the governance structure, including the CWGs.

Tailored communications and engagement plans have been developed for each group. We are also working with local voluntary and community sector organisations to improve our engagement with harder to reach groups

Two independent engagement specialists who are also members of the Independent Review Panel have checked our communications and engagement strategy against best practice.

Objective 2: Raising awareness and understanding of the Case for Change
The following is a sample of the communications and engagement activity undertaken to date:

- The Case for Change leaflet, *'Why we need to change'* has been distributed widely via hospitals, who have distributed them to staff and members, GP surgeries, pharmacies, libraries, LINk groups and third sector groups.
- A telephone survey in February 2012 with a representative sample of the local population
- A full set of communications materials provided to partner organisations to ensure local audiences and staff are kept informed and aware of the opportunities to get involved
- Regular monthly Update newsletter
- An extensive programme of public, stakeholder and third sector meetings/presentations
- Roadshows in April in busy areas such as shopping centres and train stations
- Local radio advertisements for a 3 week period during April with seven advertisements a day and an audience reach of 600,000 people, a third of all adults in the South East Midlands area
- Week long feature on BBC Three Counties Radio/BBC Radio Northampton from 21st May
- New media strategy with a reach of more than 28,000 Twitter and Facebook accounts
- An interactive website, with online surveys, DVD and vox pops films, which has had more than 3,800 visitors
- A DVD of the case for change circulated to GP surgeries and hospitals for use in public areas
- Information screen slides developed for GP surgeries and main Post Offices from April
- Posters *'What do you think?*' in GP surgeries, libraries, Post Offices and other public areas
- Regular MP briefings

Feedback from stakeholder and public engagement
Feedback from the **five public deliberative events** has been captured in a full report and series of infographics all of which are available on the website. The aims of the deliberative events were to explore:

- Awareness of and views on the Case for Change
- Views on the vision for the future
- Views on the draft criteria for the options appraisal process and how they could be weighted

As well as small group discussions and plenary sessions there were two rounds of electronic voting.

At the **stakeholder event** there was a high awareness of the Case for Change with 90% of attendees agreeing that they were very aware of the need to change. There was also broad support for the programme's vision. When asked to choose which of the three strands of the vision attendees supported the most:

- 37% voted for properly co-ordinated care for frail elderly and LTC
- 36% voted for moving services closer to where people live
- 26% voted for creating specialist centres of excellence

At the **public deliberative events** there was a considerable shift in awareness in the need for NHS hospital services to change at each event. For example at the Bedford event awareness levels moved from 60% to 90% by the end of the event and 77% of participants agreed with the need for an ongoing conversation. In addition:

- People tended to be most aware of the economic pressures on the health system, fairly well aware of demographic pressures and slightly less aware of the pressures resulting from the need to ensure high quality services
- When asked to vote on which of the three strands of the vision attendees supported the most, there tended to be equal support for creating specialist centres of excellence and moving services closer to people's homes and approximately a quarter of attendees felt most supportive of properly co-ordinating services for frail elderly and people with long term conditions
- At each event only 1%–2% of people did not support any of the three strands of the vision and did not see the need for change
- Following table top discussions about the draft criteria, attendees tended to vote for 'quality and safety' as being the most important criteria. Travel was raised at each meeting as an issue of concern, particularly for elderly people and those who are reliant on public transport; however, when asked to rank the five criteria, 'access' repeatedly came fourth or fifth.

The representative sample of participants at the deliberative events enabled engagement with many people who had not previously engaged with the NHS; a significant percentage of attendees asked to be kept informed of developments over the coming months. In addition some members of the Patient and Public Advisory Group were recruited from these events. Vox pops from two of the events are available to view on the website.

Feedback from the **telephone survey** of 1,600 local residents:

- 3 out of every 4 people rated services as 'very good' or 'good'; significantly more felt services are felt to be 'very good' in Northants
- 4 of the top 6 positive mentions focused on quality/expertise
- When asked what was most important to them when using local hospital service, 43% people highlighted:
    - Expertise/specialist care
    - High quality care
    - High quality treatment
    - Experienced/highly competent staff
    - How people is treated was also important – 28% mentioned 'caring staff' and 'being treated with respect'
- When asked how people travelled to hospital, 86% said they used their car; there was more emphasis on car travel in rural areas as opposed to Luton
- Bus travel was important to over 65 year olds, significantly more so than other groups. In Luton, taxi travel is also used by the 65s, far more so than in other areas
- Awareness of Healthier Together was 8% in February at start of the programme; this will be retested to measure levels of awareness at a later stage in the programme as part of the evaluation of the communications and engagement strategy

Feedback from the **Case for Change questionnaire and online survey** has increased steadily with 1287 responses to date. This number is expected to increase as our engagement activity continues. Analysis is ongoing and the following themes are emerging:

- A wish to see improvements around weekends, 24/7
- The importance of caring, qualified staff
- People want to access to expertise and the best possible treatment
- There is support for centres of expertise but people do have concerns about travel

A **final report** summarising all the pre-consultation engagement will be prepared to provide assurance that best practice has been followed ahead of the formal public consultation.

Draft strategy for public consultation

A draft communications and engagement strategy for the public consultation process has been prepared and shared with the Programme Board. The objectives are to:

- Maintain a robust approach and process influenced by stakeholders that stands up to external scrutiny including the production of a clear, accessible and widely distributed consultation document;
- Raise awareness of the consultation and how to respond to it;
- Communicate to build understanding of the options for change - based on clear evidence;
- Use clinical champions to engage with internal audiences during consultation so staff feel informed and able to take part in the process;
- Enable scrutiny of the options for change before a decision is made, by those who will be affected;
- Listen and record stakeholder views accurately during engagement events
- Ensure evaluation of the consultation displays that best practice guidelines have been followed

This strategy will be developed over the next few weeks and taken to the Programme Board for sign off at the end of May.

6. Evaluation criteria and principles

The **draft evaluation criteria**, which will be used to assess possible options for new models of care, is being amended following feedback received from clinical groups, patients and public and the Patient and Public Advisory Group. Currently they are:

Criteria	Description
Affordability	Is the service model achievable within current and future financial resources? Does it provide the best value for tax payers money? Are assumptions about transitional funding and capital funding realistic? Is the capital expenditure affordable (including its revenue consequences)?
Deliverability	Will the proposed model receive support from NHS staff/clinicians as well as from local stakeholders? Does it meet clinical commissioners' strategies for the future shape of health services for their population? Can the model be supported by a workforce/staffing model which is realistic?
Equity of Access	Does the model allow for equity of access for all sections of our diverse population including vulnerable people and those with specific needs? Does the model enable patients to exercise their right to Choice when considering treatment options?
Quality / Safety	Does the service model improve the clinical standards for quality and safety? Does the service model sustain or enhance the patient experience? Does the service model improve clinical outcomes? Does the service model meet national best practice guidelines? Does this service model enable patients to be transported safely by emergency vehicles?

Travel Access	Are there sufficient transport options to allow all patients and their families to access relocated services within a reasonable time?
Sustainability	Does the service model address the increased demands that will result from a growing and ageing population over the next two decades? Is it clinically and financially sustainable over the foreseeable future? Are the medium term workforce implications sustainable? Does the proposed model offer better value for money across the health and social care economy?

The final version of the evaluation criteria and the weightings will be signed off by the Programme Board at the end of May.

In addition to the evaluation criteria, a suggested set of **underpinning principles** has been widely discussed by the PPAG. The latest draft is as follows:

1. We will provide high quality care that is safe, effective and delivers measureable improvement in health outcomes throughout South East Midlands
2. We will improve patient experience and maintain patient choice
3. We will ensure services are delivered by the most appropriate person in the most appropriate place
4. We will provide care more locally wherever possible
5. Where there is good evidence to show that centralised clinical services could save lives or improve the quality of care we will do so
6. We are committed to providing best value for tax payers money and the most effective, fair and sustainable use of available resources
7. We will identify and where possible reduce health inequalities
8. We will ensure that all options are generated by and discussed widely with local clinical leaders
9. Options will address the need for clinical pathways that cover early identification of health needs, self-management and timely and appropriate interventions
10. We will be transparent and clear with public, patients and staff and engage them throughout the process
11. We will ensure that proposals for change have the support of Clinical Commissioners and Health and Wellbeing Boards
12. We will ensure that services are provided by a flexible, skilled and motivated workforce

The draft principles will be taken to the Programme Board at the end of May for further discussion and sign off.

7. Travel and transport

Work has started to develop a strategy for managing travel and transport issues. Concerns about the impact of the programme on the travel distance and time for patients has been raised at all public events.

A steering group is being established with local authority, patient and partner representatives. A key area of work at this stage is to analyse, understand and articulate the impact on patient flows from a

potential change in location of a service. This is not just about distance but also about patient behaviour and will need to incorporate:

- Travel distance and time
- Usual access modes - car bus train etc and availability to the new location
- Car parking and its availability and influence on patient behaviour
- Cultural issues around transport –acceptability of travelling from A location to B location

This requirement is part of the contract for business modelling support and will be undertaken in line with all other modelling of options.

Next steps are to:

- Set a date for the first steering group meeting
- Meet with travel and transport leads from local authorities to understand current situation and future plans/strategy
- Meet with travel and transport leads from each acute trust to understand current situation and strategy/plans for the future including sustainability and 'green' issues

Further information

If anyone would like further information please contact us at:
healthiertogether@miltonkeynes.nhs.uk
or telephone the programme office on: 01908 278735

Meeting: **Shadow Health and Wellbeing Board**

Date: **29 May 2012**

Subject: Work Programme 2012 – 2013

Report of: Chief Executive

Summary: The report provides Members with details of the currently drafted Board work programme.

Contact Officer:	Patricia Coker, Head of Service, Partnerships – Social Care, Health and Housing
Public/Exempt:	Public
Wards Affected:	All
Function of:	Council

CORPORATE IMPLICATIONS

Council Priorities:

The work programme of the Shadow Health and Wellbeing Board will contribute indirectly to all 5 Council priorities.

Financial:

n/a

Legal:

n/a

Risk Management:

n/a

Staffing (including Trades Unions):

n/a

Equalities/Human Rights:

n/a

Community Safety:

n/a

Sustainability:

n/a

RECOMMENDATION(S):

that the Shadow Health and Wellbeing Board considers and approves the work programme attached, subject to any further amendments it may wish to make.

Work Programme

1. Attached at Appendix A is the currently drafted work programme for the Board.

2. The Board is now requested to consider the work programme attached and amend or add to it as necessary. This will allow officers to plan accordingly but will not preclude further items being added during the course of the year if Members so wish and capacity exists.

3. Attached at Appendix B is a form to be completed to add items to the work programme.

Appendices:
A – Shadow Health and Wellbeing Board Work Programme
B – Item request form for Shadow Health and Wellbeing Board Work Programme

Background Papers: (open to public inspection)
None.

Location of papers: Priory House, Chicksands

Appendix A

Work Programme for Shadow Health and Wellbeing Board

Ref	Indicative Meeting Date	Report Title & Author	Sentence stating what Board is asked to do	Comment
1.	TBA	Pharmaceutical Needs Assessment		
2.	TBA	Substance Misuse		
3.	TBA	Mental Health Advocacy		
4.	29 May 2012	Priorities to Inform Joint Health and Wellbeing Strategy (JHWBS) (first considered at 15/03/12 meeting) MS		
5.	29 May 2012	Public Health Transition Plan (first considered at 15/03/12 meeting) SF		Update on Public Health Transition
6.	29 May 2012	Work Programme	To note the Work Programme.	Standing Item
7.	29 May 2012	PCT Cluster Plan SF		Primary Care Trust cluster is required to have an integrated plan, submitted through its Strategic Health Authority cluster to the Department of Health by the 5 April 2012, which reflects the outcomes of the local Joint Strategic Needs Assessment, and ensures the public health transition elements have been developed with local authorities. Strategic Health.
8.	29 May 2012	Joint Strategic Needs Assessment (JSNA) CS		The JSNA is currently being refreshed. This will form the basis for the Health and Wellbeing Strategy

Ref	Indicative Meeting Date	Report Title & Author	Sentence stating what Board is asked to do	Comment
9.	29 May 2012	Quality, Innovation, Productivity and Prevention (QIPP) JR		
10.	29 May 2012	Board Development Needs JO		
11.	29 May 2012	Report from LINK/HealthWatch MC	To note the report.	Standing Item
12.	29 May 2012	Looked After Children's Health SG/EZ	To note and comment on the Ofstead report on looked after children's health	
13.	29 May 2012	Joint Strategic Needs Assessment (JSNA) CS		
14.	29 May 2012	Healthier Together Programme NB		
15.	29 May 2012	Board Development and Work Plan JO		
16.	5 July 2012	Safeguarding Children YC/EG	To secure the commitment of the Health & Wellbeing Board to children's safeguarding.	
17.	5 July 2012	Agree Joint Health Wellbeing Strategy (JHWBS) Draft for Consultation CS		There is a statutory requirement to develop a Health and Wellbeing Strategy
18.	5 July 2012	Health Wellbeing (HWB) Partnership Framework PC		

Ref	Indicative Meeting Date	Report Title & Author	Sentence stating what Board is asked to do	Comment
19.	5 July 2012	Work Programme		
20.	5 July 2012	Report from LINk / HealthWatch		
21.	6 September 2012	Annual Report of the Local Safeguarding Children Board EG	For discussion and comment	
22.	6 September 2012	Joint Health Wellbeing Strategy (JHWBS) agreed and published CS		
23.	6 September 2012	Local HealthWatch JO		Update progress towards a Local HealthWatch
24.	6 September 2012	Clinical Commissioning Group - Authorisation Process JR		
25.	6 September 2012	Equality Delivery System		The Shadow Board should be invited to comment on the EDS implementation plans for both NHS Commissioners and Providers. Furthermore embedding the EDS within Clinical Commissioning Group is a key requirement of the authorisation process.
26.	6 September 2012	Commissioning NHS Complaints Advocacy MS		
27.	6 September 2012	Clinical Commissioning Group (CCG) Engagement Plans JR		
28.	6 September 2012	Acute Services Review DR PH		
29.	6 September 2012	Work Programme		
30.	6 September 2012	Report from LINk / HealthWatch		

Ref	Indicative Meeting Date	Report Title & Author	Sentence stating what Board is asked to do	Comment
31.	8 November 2012	Stakeholder Engagement PC		
32.	8 November 2012	Work Programme		
33.	8 November 2012	Report from LINk / HealthWatch		
34.	31 January 2013	Bedfordshire Clinical Commissioning Group (BCCG) Commissioning Plans/Strategy JR		
35.	31 January 2013	Work Programme		
36.	31 January 2013	Report from LINk / HealthWatch		
37.	21 March 2013	Annual Report of Director of Public Health MS		
38.	21 March 2013	Assumption of Statutory Powers JA		
39.	21 March 2013	Work Programme		
40.	21 March 2013	Report from LINk / HealthWatch		

Shadow Health and Wellbeing Board

Work Programme of Decisions

Title of report and intended decision to be agreed by the Shadow HWB	Indicative Meeting Date	Consultees and Date/Method	Documents which may be considered	Contact Members and Officers (Method of Comment and Closing Date)
Insert the title of the key decision and a short sentence describing what decision the Shadow HWB will need to make e.g. To adopt ……	Insert the date of the Shadow HWB meeting	Insert who has been consulted e.g. stakeholders, the date they were consulted and the method.	Insert the documents the Shadow HWB may consider when making their decision e.g. report.	Insert the name and title of the relevant Shadow HWB Member, the name of the relevant Director and the name, telephone number and email address of the contact officer. Also insert the closing date for comments, if no date is supplied, then the closing date will be a month before the Shadow HWB date e.g. the closing date for the Shadow HWB meeting on 8 November will be 11 October.

This page is intentionally left blank