Central Bedfordshire Health and Wellbeing Board

Agenda

Meeting Title:	Central Bedfordshire Health and Wellbeing Board
Date:	Thursday, 9 May 2013
Time:	1.00 p.m.
Location:	Room 15, Priory House, Monks Walk, Shefford

1. **Apologies for Absence**

   Apologies for absence and notification of substitute members

2. **Election of Vice-Chairman for the year 2013 - 14**

3. **Chairman's Announcements and Communications**

   To receive any announcements from the Chairman and any matters of communication.

4. **Minutes**

   To approve as a correct record the Minutes of the last meeting held on 21 March 2013 and note actions taken since that meeting.

Business

Item	Subject	Page Nos.	Lead
5.	**Promoting Independence and Choice** To note progress towards promoting independence, choice and control for adults and older people.	13 - 26	SM
6.	**Helping people to make healthy lifestyle choices** To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy.	27 - 40	MS

7.	**Role and responsibilities of NHS England Area Team** To receive and comment upon the role and responsibilities of the NHS Engalnd Area Team.	To follow	CF
8.	**Child Death Overview Panel Annual Report** To receive a presentation.		SW
9.	**Partnership Board Update** To receive a verbal report.	41 - 88	PH
10.	**Healthwatch Report** To note the report.	89 - 94	RF
11.	**Public Participation** To receive any questions, statements or deputations from members of the public in accordance with the Procedure as set out in Part A4 of the Constitution.		
12.	**Work Programme** To consider and approve the work plan. A forward work plan ensures that the Health and Wellbeing Board remains focused on key priorities areas and activities to deliver improved outcomes for the people of Central Bedfordshire.	95 - 104	RC

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

Dr J Baxter	Clinical Director, Bedfordshire Clinical Commissioning Group
Mr R Carr	Chief Executive, Central Bedfordshire Council
Mrs R Featherstone	Chairman, Central Bedfordshire Healthwatch
Mr C Ford	Chief Executive Bedfordshire & Luton PCT Cluster
Mrs E Grant	Deputy Chief Executive / Director of Children's Services, Central Bedfordshire Council
Dr P Hassan	Chief Accountable Officer, Bedfordshire Clinical Commissioning Group
Cllr Mrs C Hegley	Executive Member for Social Care, Health and Housing, Central Bedfordshire Council
Mr M Coiffait	Director of Community Services, Central Bedfordshire Council
Mrs J Ogley	Director of Social Care, Health and Housing, Central Bedfordshire Council
Mr J Rooke	Chief Operating Officer, Bedfordshire Clinical Commissioning Group
Mrs M Scott	Director of Public Health
Cllr Mrs P E Turner MBE	Executive Member for Economic Partnerships, Central Bedfordshire Council
Cllr M A G Versallion	Executive Member for Children's Services, Central Bedfordshire Council

please ask for	Martha Clampitt
direct line	0300 300 4032
date published	25 April 2013

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CENTRAL BEDFORDSHIRE COUNCIL

At a meeting of the **CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD** held in Room 15, Priory House, Monks Walk, Shefford on Thursday, 21 March 2013

PRESENT

Cllr Mrs P E Turner MBE (Chairman)

Dr J Baxter	Director, Bedfordshire Clinical Commissioning Group
Mr R Carr	Chief Executive
C Hegley	Executive Member for Social Care, Health & Housing
Mrs J Ogley	Director of Social Care, Health and Housing
Mrs M Scott	Director of Public Health
Mr B Smith	Chairman, Bedfordshire LINk
M A G Versallion	Executive Member for Children's Services

Apologies for Absence:
Mr G Alderson
Mrs C Bonser
Mr C Ford
Mrs E Grant
Dr D Gray
Dr P Hassan
Mr J Rooke

Substitutes:
Mrs S Childerhouse (in place of Mr G Alderson)
Mrs S Tyler (in place of Mrs E Grant)

Members in Attendance: Cllrs A L Dodwell
J G Jamieson
Miss A Sparrow,

Officers in Attendance:			
	Mrs S Childerhouse	–	Head of Public Protection (North)
	Mrs M Clampitt	–	Committee Services Officer
	Mrs J Hainstock	–	Head of Partnership Commissioning, BCCG
	Ms E Saunders	–	Assistant Director Commissioning
	Mrs C Shohet	–	Assistant Director for Public Health, NHS Bedfordshire
	Mrs S Tyler	–	Acting Assistant Director, Operational Services, Children's Services

SHWB/12/53 **Chairman's Announcements and Communications**

The Board were informed that the final meeting of the Primary Care Trust (PCT) was being held today which meant that a number of health colleagues, including the NHS Commissioning Board Area Team representative were unavailable today.

SHWB/12/54 **Minutes**

RESOLVED

That the minutes of the meeting of the Central Bedfordshire Shadow Health and Wellbeing Board held on 31 January 2013 be confirmed and signed by the Chairman as a correct record.

SHWB/12/55 **Improving outcomes for Frail Older People**

The Board considered a report which described progress with one of the priorities of the Joint Health and Wellbeing Strategy (JHWS). In November 2012, the Shadow Health and Wellbeing Board had identified improving outcomes for Frail Older People as one of its priorities. (see minute no. SHWB/12/35 refers).

The Board noted that the JHWS identified the following 8 actions:-

- promote health by increasing the uptake of established screening and prevention programmes;
- commission an expansion of the multi-dependency complex care team to deliver a case management service to reduce reliance on hospital admission;
- commission alternative models of day services, increase the number of intensive home care packages and use of personal budgets, and improve access to telecare and telehealth;
- commission comprehensive information, support and advocacy and brokerage services;
- commission improved and integrated dementia services and improve access to psychological services for older people;
- ensure that additional Village Care schemes were commissioned;
- ensure suitable accommodation options were available by improving housing and accommodation support and existing extra care housing options;
- ensure effective floating support services; providing affordable warmth, signposting and information.

The Director for Adult Social Care, Health and Housing informed the Board that whilst important progress had been made, more work was required to have the level of impact required. It was also apparent that the contribution of various organisations needed to be brought together under an effective governance arrangement. This needed to be supported by a scorecard approach to performance management to help identify areas of focus and an identification of obstacles and risks to delivery, with appropriate mitigation.

RESOLVED

1. **that the work to date in delivering improved outcomes for frail older people be noted.**

2. **that the commitment to increasing the understanding of current investment and performance in services for older people and delivering an integrated response for frail older people be supported.**

3. **that a mechanism for measuring performance and achieving targets be established.**

4. **that a report be brought to a future meeting of the Health and Wellbeing Board with proposals for taking forward the delivery of this priority, including the appropriate governance arrangements.**

SHWB/12/56 **Improving the mental health and wellbeing of adults**

The Board considered a report which outlined the work underway to deliver improved outcomes in line with the Joint Health and Wellbeing Strategy.

The Head of Partnership Commissioning, Bedfordshire Clinical Commissioning Group (BCCG) provided an overview of mental health illness and highlighted the following information:

- at least 25% of the population will experience a mental health problem during their life, 1-6 adults has a problem at any one time, and almost half of adults will experience at least one episode of depression during their lives;
- poor mental health is associated with a variety of health behaviours including smoking, drug and alcohol misuse, poor diet and unwanted pregnancy;

The BCCG had added dementia to the indicators for which data was compiled. In addition, work was underway on suicide prevention.

The Central Bedfordshire Joint Commissioning Strategy for Mental Health Services for Adults and Older People 2011-14 identified 6 actions which were reflected too in the Joint Health and Wellbeing Strategy. The actions were detailed in paragraph 3 of the report and were overseen by the Healthy Communities & Older People Group.

The Board were concerned that the report suggested that Central Bedfordshire was behind benchmark for the following indicators:-

- proportion of people with mental illness in settled accommodation
- proportion of people with mental illness in paid employment
- the proportion of people with anxiety and/or depression who receive psychological therapies (DSR per 100,000)

The Board asked for further insight for its July 2013 meeting into why Central Bedfordshire was behind benchmark and what specifically was proposed to address this.

RESOLVED

1. **that the progress made during 2012/13 in planning services that seek to improve outcomes for people with mental health conditions, be noted.**

2. **that the current position and the work underway through the Healthy Community Older People Partnership and the Mental Health and Learning Disability Change Programme Board (formerly QIPP Board) to modernise the current mental health system, be noted.**

3. **that the baselines of the indicators agreed by the Board last year be noted with the addition of dementia indicators, which would enable the Board to monitor improvement in access to memory services and to good/quality dementia care.**

4. **that an additional report be brought to the July 2013 Health and Wellbeing Board, detailing why Central Bedfordshire is behind benchmark and the actions proposed to address this.**

SHWB/12/57 **Health and Wellbeing Board becoming a formal Committee of the Council - Assumption of Statutory Powers**

The Board considered a report which outlined the arrangements being made to establish the Health and Wellbeing Board as a formal Committee of Central Bedfordshire Council, including the Terms of Reference of the Board and its proposed membership.

The Monitoring Officer provided the Board with an overview of the legislative requirements for Health and Wellbeing Boards. It was noted that Central Government had introduced regulations to allow a Committee formed under section 102 of the Local Government Act 1972 to meet the requirements of the legislation relating to local authority committees and the statutory arrangements for membership of a Health and Wellbeing Board.

The Board would comprise Councillors, Council Officers and external representatives. All members of the Board would be entitled to vote.

The normal requirement for political balance would not apply to this Committee.

The Monitoring Officer confirmed that the membership would be appointed by the Council at its Annual General Meeting on 18 April 2013. The Board noted that the statutory membership for Health and Wellbeing Boards did not reflect the current Shadow Health and Wellbeing Board composition. The Board offered its advice as follows:-

- The Chairman of the Board would be a Councillor;
- The Vice-chairman of the Board would be a representative from Health;
- There should be three (3) representatives from the Bedfordshire Clinical Commissioning Group;
- There should be one (1) representative from the NHS Commissioning Board Area for Hertfordshire & South Midlands.
- In addition to the Directors provided for statutorily, the Board should include the Chief Executive and Community Services Director.

RESOLVED

1. that the governance arrangements that will apply to the Health and Wellbeing Board from 1 April 2013, be noted.

2. that the Monitoring Officer be asked to reflect the advice of the Board in the Terms of Reference.

SHWB/12/58 **Bedfordshire Plan for Patients 2013/14**

The Board considered a report which requested feedback on the Draft Bedfordshire Plan for Patients 2013/14, which the Clinical Commissioning Groups was required to prepare at the start of each financial year. The Area Team had broadly approved the Plan prior to the Shadow Health and Wellbeing Board considering it.

The Plan highlighted three strategic aims: Care right now, Care for my condition into the future and Care when it's not that simple.

The Board provided the following feedback on the proposed Plan:-

- it would be helpful to identify how the Council could assist with the Plan's implementation;
- the distinct needs of Central Bedfordshire (CB) and Bedford Borough (BB) should be more clearly identified;
- the figure shown on page 58 of the Plan need to be validated;
- the Plan should give notice to acute trusts of the BCCG's intention to focus on prevention and the concomitant implications for resource allocation. The BCCG would work with the patients to prevent hospital stays and change attitudes towards use of hospitals, including A&E.

Work on the 2014/15 Plan would begin earlier and provide a greater opportunity for consultation.

RESOLVED

1. **that the stage of the Plan development be noted.**

2. **that the feedback detailed in the preamble above, be provided to the BCCG as requested.**

SHWB/12/59 **The Implications for High Dependency Children and Young People of the Special Educational Needs Reforms**

The Board considered a report which explained the implications for Health Services of the Special Educational Needs Reforms in Central Bedfordshire.

By 2014, an Education, Health and Care Plan (EHCP), will set out for each child identified with SEN from birth to the age of 25. The EHCP would replace the existing arrangements and was intended to streamline the exchange of information between service providers.

The Acting Assistant Director for Children's Services Operations informed the Board that currently 20 Pathfinders were testing the reforms. Central Bedfordshire Council has moved forward with the support of the Aspiration Board which was chaired by the Assistant Director Learning, Commissioning and Partnerships.
The Aspiration Board was designed to:-

- enable a multiagency approach to assessment and planning with clear lines of accountability;
- facilitate joint planning and decision making arrangements;
- ensure Links between support planning and strategic commissioning, particularly through the Health and Wellbeing Board;
- work towards pooled and aligned budgets.

The Aspiration Board would also need to consider the establishment of a Common Delivery Framework (CDF).

The key requirements of Children's Services and the Bedfordshire Clinical Commissioning Group (BCCG) were detailed in paragraph 7 of the report.

The Pathfinders had identified seven (7) key elements to the future of a single assessment process and an EHCP:-

- establishing governance/project board arrangements
- mapping onto existing procedures/ building new systems
- determining service accountability / responsibility
- developing effective partnerships between education, health, social care and commissioning
- considering and developing the Key Worker role (including training)
- training/staff development to support successful multiagency working
- defining the role of the voluntary and community sector.

The Board noted the significant shift in the approach.

There would be another paper brought to the Board which would detail the work to be done for the Post-16 transition from Children's Services to Adult Social Care. The report would focus on the changes to benefits, healthcare and the impact of the transition.

RESOLVED

1. **that the implications for Health of the Special Educational Needs and Disability (SEND) reforms be noted.**

2. **that a paper detailing the transition arrangements for high dependency children be brought to a future meeting.**

SHWB/12/60 **Partner Board Update February 2013**

The Board agreed to defer discussion until the next meeting on 9 May 2013 as key Board Members were not present for the discussion today.

SHWB/12/61 **Report from LINk**

The Chairman thanked the Chairman of the Central Bedfordshire LINk for his dedication and work over the years and his commitment to residents and patients across Central Bedfordshire.

The Chairman of the Central Bedfordshire LINk informed the Board that the annual report of the LINk would be circulated after the meeting.

The Board congratulated LINk on the inclusion of the Bedfordshire LINk website on the British Library's NHS Reform area.

SHWB/12/62 **Public Participation**

A member of the public requested an update on Healthwatch and when the Directors would be appointed. The Director of Social Care, Health and Housing informed the Board that a Chairman had been appointed in the short term and would be involved in the interviews for the Directors.

SHWB/12/63 **Work Programme**

The Board considered a report from the Chief Executive, Central Bedfordshire Council that set out a suggested work programme for 2013 - 2014 for the Board.

The Board noted that the following items would be added to the programme:

- Improving Outcomes for Frail Older People: Delivery and Governance arrangements - date to be confirmed

- Mental Health - July 2013
- Transition arrangements for High Dependency Children - date to be confirmed

RESOLVED

That the work programme for the Shadow Health and Wellbeing Board be approved.

(Note: The meeting commenced at 1.00 p.m. and concluded at 3.10 p.m.)

Chairman……

Dated……

Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	Progress report on Promoting Independence, Choice and Control for Adults and Older People .
Meeting Date:	9 May 2013
Responsible Officer(s)	Julie Ogley Director of Social Care, Health and Housing Stuart Rees Assistant Director of Social Care
Presented by:	Julie Ogley Director of Social Care, Health and Housing

Action Required: The Board is asked to:

1. To note progress towards promoting independence, choice and control for adults and older people.

Executive Summary	
1.	Promoting Independence and Choice is one of the priorities of the Health and Wellbeing Board. Supporting people to live independent lives and encouraging greater choice and control is seen as fundamental. It is important that vulnerable people have access to services which are person-centred, promote and sustain independent living. The Joint Health and Wellbeing Strategy sets out some key actions required to deliver improved outcomes. Important progress is being made in promoting independence and choice in adult social care, health and housing. This report sets out current progress on promoting independence, choice and control and identifies some fundamental changes to the way in which services are being designed and commissioned to maximise opportunities for greater independence, choice and control for adults and older people in receipt of care and support.

Background	
2.	The Health and Wellbeing board is committed to delivering improved outcomes for those in receipt of care and support. Fundamental to this is the promotion of independence and choice.

3.	The Council and the Clinical Commissioning Group are committed to helping people to live independently, in their own homes and in their communities for as long as possible and to reduce reliance on the use of institutional care.
4.	There is a commitment to helping all residents, including those who fund their own care, to access high quality care and support as well as ensuring greater choice and control.
5.	Securing high quality care for all in a climate of economic downturn and changing demography requires a fundamental shift in how care is provided. Early loss of independence often leads to increased social care spending. For example, residential care represents £29 million or 34% of net spend on adult social care in Central Bedfordshire. Early use of residential care depletes the resources of those who fund their own care, which then leads to greater demand and pressure on publicly funded support. Proposals on the future funding of adult social care will have significant implications for the council if opportunities for prolonging independence are not maximised. Loss of independence can also mean increased use of acute care services
6.	Promoting independence and choice requires a shift in the ways services are provided.
7.	The Health and Wellbeing Strategy sets out the following key actions:
	• Shift the balance of care from institutional to personal solutions with more effective support for people in their own homes, including widening the use of Telecare, extra care and specialist equipment to promote independence
	• Ensure that people are able to access information and support to help them to manage their care needs enabling them to regain and retain their independence
	• Ensure people are able to manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs. Work with Community and Voluntary organisations to enhance the support available locally to people and their carers
	• Continue to support timely discharge from hospital and adopt a whole systems approach to delivering rehabilitation and reablement to promote independence
	• Ensure that Carers receive the care and support they need to enable them to continue in their caring role as well as maintaining their own health and well being

Progress to date	
8.	**Shift the balance of care from institutional to personal solutions with more effective support for people in their own homes, including widening the use of Telecare, extra care and specialist equipment to promote independence**
8.1	The aim is to move services closer to people and reduce dependency and pressure on institutional care. This requires strengthening reablement through more effective coordination of services and investment in community based options to enhance care closer to home.
8.2	The Council has been reducing its usage of general residential placements through the use of reablement services and access to step up/step down in Dunstable (intermediate care beds). These services have enabled people to leave hospital sooner and have prevented admission to care homes as well as assisted some people to leave residential care homes and return home.
8.3	The expansion of reablement and closer working with health services in the community is helping people to maximise their independence, enabling them to remain in or return to live in their own homes.
8.4	In 2011/12 a total of 1,626 customers were supported by the reablement service. Of these only 25 were unable to stay at home. 296 customers were supported following a discharge from hospital. The reduction in care hours achieved as a result of the reablement service was 3,185 in 2011/12, compared to 2,139 in 2010/11. 34% of customers that benefited from the reablement service in 2011/12 required no further care from the Council, compared to 28% in 2010/11
8.5	Reablement is being further extended through an Urgent Homecare and Falls Response Service. The service which has been developed in partnership with the Clinical Commissioning Group became operational in January 2013. It provides timely, effective support to adult residents (particularly older people) with the aim of maintaining them independently at home. Support following a fall might include confidence building, providing guidance and training on the use of equipment (such as a walking frame or bath board), or signposting/referral to appropriate agencies for further support (e.g. physiotherapy, chiropody or assistive technology). Urgent homecare support is provided within 2 hours on a 24/7 basis to customers with social care needs for up to 72 hours, whilst ongoing care arrangements are made.
8.6	The Number of older people permanently admitted to residential care decreased from 525 as at 31st March 2012 to 506 as at 1st March 2013. Central Bedfordshire Council was an outlier in terms of the number of people placed in residential care. This has now been mitigated by actions taken to ensure people are not being inappropriately placed in residential care and that community alternatives are being sourced appropriately.

8.7	To support this work the Integrated Community Equipment Service was retendered in 2012 and now has additional service provision which includes: Trusted Assessor technicians working for the provider so as to speed up Community assessments for such things as kitchen and bathing aids.
8.8	A system fast tracking provision of simple items of equipment and minor works, which enable independence at home, such as grab rails and stair rails has been introduced. The Disability Assessment Services in the Community provides the equipment following an initial Occupational Therapy assessment.
8.9	The Council has introduced a new framework agreement for Home Care Service Providers. From May 2013,all domiciliary care providers who wish to provide services on behalf of the council will have to bid to join a new supplier framework, with a commitment to delivering high standards of care at a fixed price. The framework will help the council to shape the market so that it can provide a higher quality of care with more flexible and personalised services.
8.10	As part of an Adult Social Care Sector Led Improvement event, Central Bedfordshire was successful in securing the development of a new Facebook style assistive technology which will enable people to keep in touch with loved ones. Alongside this, the expansion of Telecare is progressing with over 800 customers now using Telecare to enhance their independence.
8.11	**Next steps:**
	• Central Bedfordshire Council, as part of its medium term plan has began a programme of expansion of extra care homes. The development of new Extra Care Housing schemes up to 2016 will create opportunities to develop more inclusive, community hub, day opportunities for residents whose needs are less complex and who do not require specialised facilities for reasons of dignity or safeguarding. The Council is on course to deliver 50 additional extra care units by 2014 and will continue to commission real alternatives to residential care such as extra care and step up/step down care, particularly in the north of Central Bedfordshire.
	• Ensure access to good quality care to prevent unnecessary hospital admission and to support people on discharge from hospital. This would need to be underpinned with support in the community with access to a wide range of community based services. In relation to Stroke patients, Bedfordshire CCG are currently procuring an Early Supported Discharge Team to support patients discharged from Bedford and Luton and Dunstable hospitals. The team will provide intensive rehabilitation at home to mild/moderate stroke patients with the same intensity as inpatient rehabilitation.

	• Commence work in March 2013 to support staff working in the four CBC Older Peoples Day Centres to engage more creatively and effectively within their communities. The emerging joint strategy for dementia will inform how services need to develop for the growing population of residents with complex or intensive needs in the future. The focus will be on commissioning a wider range of day activities which are tailored to the requirements of the individual and based within the wider community rather than traditional forms of building based day care.
9.	**Ensure that people are able to access information and support to help them manage their care needs enabling them to regain and retain their independence**
9.1	Access to information and advocacy is improving. From 1 April there will be a single provider of advocacy services across health and social care, ensuring a more simplified pathway for service users and carers.
9.2	A new service providing information and help with planning, including an online cost planning tool for older people, who fund their own care has been established. This responds to the lack of awareness and understanding of the care options available which can result in people who fund their own care going into residential care when other care options may be more appropriate. To ensure self funders have access to this service, Council staff have been trained to refer customers to PayingForCare so they can obtain information and advice. This began in January and 12 referrals were made in the first month.
9.3	The Council's 'Customer First' programme aims to make innovative use of technology so that residents can access council services 24 hours a day, 7 days a week. The website has been relaunched and a wide range of social care information can be accessed by a variety of entry points, i.e. 'Where you are' postcode search, 'Life Events' and 'Do it online', as well as a category menu and general search facility.
9.4	Customer services will also signpost to other organisations and advice on where to find relevant information, e.g., rating information for care homes. Website information includes details such as "Guidelines on selecting a care home". Information is also available about community events such as "Just Ask" and the "Older People's Festival".
9.5	Social Care has a 'golden number' 0300 300 8303 for telephone enquiries and Customer Service Centre Advisors have received training to enable them deal with all types of enquiries including equipment/adaptations, changes to existing support packages and information for those people who fund their own care, as well as signposting residents to voluntary groups or services which can help people stay independent or provide more specialist information.

9.6	Central Bedfordshire Council delivered a project to promote the development of brokerage support. Brokerage is a term used to describe the types of support that people can use to help them plan and arrange for the care and support they need. This links in to the development of more personalised services in the field of health and social care.
9.7	A Grant facility of £35,000 to stimulate brokerage activity by local community groups and agencies was made available through the Transforming People's Lives Grant. £15,000 of which was used to support a range of training activities for local agencies and groups; and £10,000 to provide publicity materials and to deliver a range of awareness raising events
9.8	Right Track - a Community Interest Company (CIC) run by people with learning disabilities has been established. Right Track supports people with Learning Disabilities to access clear and accurate information around personalisation and other changes in social care.
9.9	In the 2011/12 Adult Social Care survey, 73.7% of customers who took part in the survey said that it was easy to find information and advice, compared to only 47.4% in 2010/11.
9.10	**Next steps**
	• The development of a web based resource directory or customer portal via which customers, workers and agencies could gain access to information about adult social care services and signposting, including Home Care provider information.
	• The production of clear information about the customer pathway provided by the Council's care management process; brokerage activities, and how the functions work; and the roles and responsibilities of the Council's in-house services and external providers.
	• To continue to expand and ensure provision of timely and robust information and advice to all service users including self funders.
	• Work closely with Healthwatch Central Bedfordshire as well as other Voluntary and Community Groups to ensure wider access to information and support.
	• To continue to promote the Ageing Well principles of an asset based approach and widening community capacity through initiatives such as Timebanking.

10.	**Ensure people are able to manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs. Work with Community and Voluntary organisations to enhance the support available locally to people and their carers.**
10.1	There is an increasingly upwards trend in the overall number of people using self-directed support with greater numbers of people using personal budgets and Direct Payments to manage their care and support needs. Central Bedfordshire has exceeded the national target of 70%. An in-house team of Support Planners is available to support people through the process. Discussions are underway to increase the numbers of people receiving direct payments and to establish a new target.
10.2	A survey has been sent to approximately 400 Central Bedfordshire customers (excluding carers) who use Direct Payments to pay for the care and support services they receive. The survey asks these customers for their views on how the Service is working for them and the results will be used by the council to improve the service offer for customers using Direct Payments. To assist this a further survey will be undertaken to measure the success of the change
10.3	A range of training and awareness activity has also taken place to provide people with more information to promote choice and control through Self Directed Support.
10.4	Work on the review of Direct Payments processes is on-going. This will lead to a broader range of support being available for people using direct payments. Changes to the rates for personal assistants will help to stimulate the availability of this form of support. A framework for developing a range of support options is being considered.
10.5	Supported living schemes for adults with learning disabilities, which enable individuals to move from residential care into their own homes, are being introduced in Central Bedfordshire. The 'My Place' project, in partnership with local housing associations, is opening independent living schemes throughout Central Bedfordshire, one of which is Bensons Court, which comprises 10 flats for 12 people, aged over 55 years. A DVD has been produced about this initiative.
10.6	Work is taking place within the Council on the development of specifications for a web-based information hub which will provide a broader range of information to people who are looking for support, and enable new and existing providers to publicise the services they have on offer. Links have been made with the Voluntary Works Consortium (Transforming Local Infrastructure Project) and their development of a similar model for the voluntary and community sector.

10.7	Work with a range of community and voluntary organisations has led to a better understanding of the ways in which brokerage support can be developed locally. This collaborative approach has enabled us to pilot new ways of working and to develop service specifications for various forms of brokerage support. This has helped to inform some of the work on the review of direct payment processes.
10.8	The Council has provided small grants to support a range of local agencies and groups to deliver various training and awareness-raising activity, which has either already taken place or is currently being delivered, with a focus on informing people about the use of personal budgets and self-directed support. This work includes:
10.9	A number of organisations have been funded to raise awareness for carers, older people, people with learning disability and tenants about the opportunities for personal budgets and direct payments.
	• Carers in Bedfordshire – is delivering training courses on personalisation and personal budgets/updating a carers information booklet to include reference to self-directed support.
	• Bedfordshire Rural Communities Charity – has delivered training on personalisation and personal budgets for Village Care Schemes volunteers, and has distributed information on personalisation via libraries and community events, including the distribution of support planning booklets.
	• Older Peoples Reference Group – will be delivering information and training on personalisation and personal budgets via a series of roadshows and other activities linked to providing older people with guidance on support planning.
	• 'ROAR' tenants group - 'Connect All' project (supported by Aragon Housing) – A group of local people supported to deliver training and support to encourage older people to access the internet and to use the World Wide Web as a source of information.
10.10	The Council is also promoting independence through a number of organisations.
	• Alzheimer's Society has reconfigured the service in Central Bedfordshire and now provides:
	○ Peer support groups across Central Bedfordshire offering practical advice and information to the person with dementia and their cares on how to live well with dementia
	○ Information advice line now extended to cover all of Central Bedfordshire with a one stop telephone number

	○ Singing for the Brain groups now been set up to cover the whole of Central Bedfordshire
	○ Closer working with Carers in Bedfordshire to offer a more seamless level of support for people with dementia and their carers to minimise people falling between the gaps between the two organisations.
10.11	Emphasis is being given to the development of Micro-enterprises. Micro-enterprises are small-scale flexible services that respond to local need, providing opportunities for new and innovative approaches to be developed.
10.12	The Council is working with health colleagues on the implementation of Personal Health Budgets from April 2014 for people in Continuing Health Care situations. An interface requiring further development is the linkage between personal budgets and personal health budgets. This will require further work to set targets for the future.
10.13	An Adult Social Care market position statement has been published. It describes the current and potential demand and supply for adult social care services. It also outlines the model of care Central Bedfordshire wishes to secure for its population. The Council is keen to ensure availability of access to a diverse range of high quality care and support services and is adopting an approach to commissioning services which help to facilitate supply so that the market is fit for purpose and able to respond to future care needs. This is the beginning of the Council's dialogue with its care providers to assist in shaping the market.
10.14	**Next Steps**
	• The review of Direct Payment processes will result in a more streamlined and accessible approach, and a broadening of support options for people using, or being supported to use, direct payments
	• The on-going review of Direct Payment processes will result in a more streamlined and accessible approach, and a broadening of support options for people using, or being supported to use, direct payments. A range of recommendations emerging from the 5 workstreams on the review of the Council's Direct Payment processes will be implemented. This will include improved rates for Personal Assistants; a structure for a more diverse range of support options for people using direct payments; improved communication on the responsibilities of employing personal assistants; a more streamlined monitoring system; and updated policy and practice guidance.
	• The development of timebanks will continue with groups being supported to set themselves up in local communities.
	• Continue support for the development of micro-enterprise/social enterprise models exploring the potential for new and innovative forms of service delivery.

	• Continue support for development of personal health budgets by sharing the experience and expertise developed in social care around the implementation of personal budgets.
	• To refresh the Adult social Care Market Position Statement to give a clear steer to all care and accommodation providers across all sectors.
11.	**Continue to support timely discharge from hospital and adopt a whole systems approach to delivering rehabilitation and reablement to promote independence**
11.1	The challenge in meeting this objective are the number of hospitals discharging patients into Central Bedfordshire and thus requiring flexible systems that offer a consistent experience.
11.2	The Reablement service aims to maximise a customer's independence by providing a period of assessment of up to 6 weeks which is free of charge. In 2012/13 the service received an additional investment of close to £1m.The service works closely with NHS colleagues to ensure referrals are timely and appropriate. Some customers have a period of reablement following rehabilitation.
11.3	As a result of the strengthening of the Council's Reablement Service, there are improved outcomes for older people, with fewer people needing further care following a period of reablement. 72 clients completed reablement support in January 2013, 50% of which have no need of further care.
11.4	The Council has commissioned 8 step up /step down beds at Greenacres in Dunstable to provide a period of reablement in a residential setting prior to people moving back home following admission to hospital.
11.5	Short stay medical unit, Houghton Regis (SSMU): This is a sub acute unit, managed by the South Essex Partnership Trust (SEPT), which has 16 beds for the residents of central Bedfordshire. It aims is to prevent customers going into mainstream hospital wards and, if they do, to facilitate their early discharge from these. It has a maximum stay of 7 days. The unit has 3 designated social workers who link closely to the clinical navigation team and Greenacres.
11.6	**Next Steps**
	• There are some key gaps in the emergency and urgent care pathway within Central Bedfordshire, especially within the North area and over 2013/14, the Council and health partners need to plan to ensure that there is a consistent offer across Central Bedfordshire area. It is intended that the community bed review will assist in setting the direction of future provision.

	• The need to have a “Greenacres” type facility in the North of Central Bedfordshire (data from admissions to residential care in 2012/13 infers 30% of these were customers placed from respite care. A reablement facility would reduce this figure significantly)
	• The need for slower track recuperation facilities for patients for whom rehabilitation may not be fully achieved but require time to regain their health and well being outside of a formal hospital setting
12.	**Ensure that Carers receive the care and support they need to enable them to continue in their caring role as well as maintaining their own health and well being**
12.1.	An increasing number of carers are being supported in their caring role and to maintain their own health and wellbeing through advice and information, and a carer’s break.
12.2	In response to need identified in the south of Central Bedfordshire and changes to services offered by the Alzheimer’s Society, carers now have more access to practical, emotional and social support through the establishment of an additional NHS Carers Café in Eaton Bray. This is in addition to the existing NHS Carers Café and NHS Breaks and Training grants administrated by Carers in Bedfordshire as part of the joint NHS and CBC contract for carers support services.
12.3	A variation on the carers support service has been agreed for 2013-14 to ensure that siblings of young carers and people caring for someone with Dementia have access to appropriate support.
12.4	Carers continue to receive advice, information, networking and opportunities to feedback about local services through the quarterly CBC Carers Forum including feedback from NHS colleagues.
12.5	The Adult Learning Disability Team (ALDT) is working with older family carers of adults with a learning disability where support between the carer and the cared for is often inter-dependant. Work is undertaken with them to identify contingencies in the event that one of them becomes less able including the possibility of them both being able to access extra care. Work is also ongoing in supporting older carers and their adult son / daughter / family member to support them in the transition of the cared for person in moving on from the family home.
12.6	Annual Health Checks are also progressing well, especially targeting adult siblings with a learning disability living with older carers. Some GP practices are now sending out a further invitation to remind those who have yet to respond. Most difficult group to reach appear to be those who live on their own or with family; effectively those having little contact with care providers, health or social services.

12.7	The Health Facilitation Service co- located within the ALDT has started to personally visit all practices in Central Bedfordshire, reminding clinicians and patients of the need for Annual Health Checks as well as the support that Health Facilitation can provide. Health Facilitation Service will identify those GP's patients that may have little routine contact with Health and Social Services and seek to encourage and support their attendance. Health Facilitation Service will contact all major service providers in Central Bedfordshire area to emphasis need for health checks and offer support.
12.8	**Next Steps**
	• To monitor the impact and outcomes of the varied contract for 2013-14 including reporting to the Carers Delivery Partnership and feeding into the refresh of the JSNA."
	• Health facilitators continue to support service users to book and attend the Annual Health Checks and where appropriate direct individuals to the NHS Health Check (40 -74 year old) and offering support with these.
13.	**Conclusion and Next Steps**
13.1	Achieving the vision and commitments of the Health and Wellbeing Strategy for promoting independence, choice and control for adults and older people in receipt of care and support in Central Bedfordshire requires a robust partnership framework which will create and oversee the delivery mechanism for this priority. This will require reframing of the Healthier Communities and Older People Partnership and a further report to the Health and Wellbeing Board in this respect.
13.2	There needs to be a more detailed analysis of the key drivers and opportunities within the service re-design and commissioning approaches for promoting independence and embedding greater choice and control across health and social care will be required in the first instance.
13.3	Further work needs to be undertaken to establish a performance framework which will underpin the delivery of this priority.
14.	**Detailed Recommendation**
	It is recommended that the Health and Wellbeing Board:
14.1	Note the work to date in promoting independence and choice
14.2	Approve the reframing of existing partnership arrangements to create a delivery mechanism for this priority which will be reported to the September meeting of the Health and Wellbeing Board.

Issues	
Strategy Implications	
33.	Promoting independence and choice is one of the priorities of Health and Wellbeing Board
34.	Bedfordshire Clinical Commissioning Group's Plan for Patients 2013/14 sets out a commitment to promoting independence and choice through: • Patient choice and the ability for patients to chose the provider of their care, when and where it place and who provides it. • Improving services for older people to support independence and avoid emergency admissions • System redesign, creating primary care-based multidisciplinary teams that interface with specialist care services in order to support carers and maintain patients' independence for as long as is safely possible and ensure a good quality of life and a good quality end of life
Governance & Delivery	
35.	Delivery and progress will also be reported to through the joint commissioning group, HCOP and the Health and Wellbeing Board.

Management Responsibility	
36.	Responsibility for the delivery of the outcomes rests with Director for Social Care, Health and Housing. This responsibility may be delegated for day to day operational delivery.
Public Sector Equality Duty (PSED)	
37.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.. The JHWS has had an equality impact assessment undertaken. Equality Impact assessements are an integral part of any service redesign
	Are there any risks issues relating Public Sector Equality Duty **No**
	No Yes *Please describe in risk analysis*

Risk Analysis
There is a risk that some issues and data may get lost as it cross-cuts several themes and priorities within the Health and Wellbeing Strategy. It is recommended that a delivery plan with RAG-rating is produced to give oversight of progress across all outcomes.

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
			.

Source Documents	**Location (including url where possible)**

Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	**Helping people to make healthy lifestyle choices**
Meeting Date:	9 May 2013
Responsible Officer(s)	Muriel Scott, Director of Public Health
Presented by:	Muriel Scott, Director of Public Health

Action Required:	To update the board on the position and progress against priority 7 of the Health and Wellbeing Strategy; helping people make healthy lifestyle choices. However further action is required and next steps have been identified in addition to suggested actions for the Board. However further action is required and next steps have been identified .

Executive Summary	
1.	Helping people make healthy lifestyle choices is one of the priorities of the Health and Wellbeing Board. This report highlights the progress that has been made to enable people in Central Bedfordshire to adopt healthy lifestyle behaviours and further action required by the Board.

Background	
2.	Promoting health and wellbeing of the people of Central Bedfordshire is a key priority within 'Delivering Your Plan- our plan for Central Bedfordshire 2012-2016'. Bedfordshire Clinical Commissioning Groups' (BCCG) Commissioning Plan is also underpinned by a focus on prevention, delivered in part through helping people to make healthy lifestyle choices.
3.	Adopting healthy lifestyles can prevent or delay ill health. On average a person who adopts a healthy lifestyle and therefore doesn't smoke, eats 5 portions of fruit and vegetables a day, drinks moderate amounts of alcohol and is physically active, will live 14 years longer than a person who adopts none of these behaviours.
4.	Lifestyle behaviours such as smoking, lack of physical activity, poor diet, heavy alcohol consumption and substance misuse are the leading causes of cardiovascular disease, cancers, obesity and diabetes. These non-communicable diseases (non infectious) are now the biggest cause of death and ill health in the developed world.

5.	Smoking is the primary cause of preventable ill health and premature death in England. Increasing access to stop smoking support to assist people to quit will reduce the health burden associated with smoking related illness and death in Central Bedfordshire.
6.	Physical activity provides important health and wellbeing benefits across the life course and a lack of sufficient physical activity is associated with premature death.
7.	Alcohol misuse is the third greatest overall contributor to ill health after smoking and raised blood pressure. Alcohol consumption is a contributing factor to hospital admissions and deaths from a range of conditions such as liver disease as well as contributing to anti-social behaviour and domestic and sexual violence.
8.	Substance misuse can significantly impact upon individuals, families and the wider community. For the individual, the physical and psychological impact can lead to impaired health and premature death. The impact upon families and the wider community can range from increased risks of transmission of blood borne viruses, reduced parenting capacity and increased offending behaviour.

Update on delivery	
	Support people to stop smoking through good access to services and tobacco control.
9.	Good progress has been made towards the target to reduce the smoking prevalence in Central Bedfordshire and this has been assessed through a number of measures. In particular; the 4 week quit target, quits among routine and manual workers and smoking at time of delivery. Targeted work to reduce health inequalities associated with smoking has been delivered to groups within the population who tend to experience higher rates of smoking. Routine and manual workers make up about 40% of all smokers and smoking prevalence is often higher among those living in the 20% most deprived areas.
10.	Smoking during pregnancy can cause serious health problems for both mother and baby. The effects of smoking during pregnancy is considerable in terms of illness and potential death and associated risks with complications during labour. There is also an increased risk of miscarriage, premature birth, still birth, low birth weight and sudden infant death syndrome.

Progress to date

11.

Measure	Progress to date	Comments
Four week quitters **(2012/13 target- 1850 quits)**	Q3 data showed that 1268 people had stopped smoking	This is 102% of the projected annual target
Quits among routine and manual workers	450 people from these groups have stopped smoking	This is an overachievement of the period (Q3) target by 120%
Smoking quits among the 20% most deprived	355 people from these areas have stopped smoking	This represents 96% of the period (Q3) target
Smoking in pregnancy- reported at provider level	Luton and Dunstable Hospital- 22.4% prevalence	The target is to reduce this to 15% by Q4
	Bedford Hospital- 11.2%	The target is to ensure prevalence remains below 13%

12. The Balding Health Related Survey was completed by year 10 pupils (aged 14-15 years) across 12 schools in Central Bedfordshire in 2012 and indicated an 8% smoking prevalence. In comparison, the smoking prevalence in England in 2011 was 11%. A school based prevention programme called KICK ASH which aims to stop young people from taking up smoking has been piloted in All Saints Academy, Dunstable and the middle schools that feed into the Academy. Year 10 pupils have been trained to support their peers to stop smoking through the programme.

Next Steps

13. Targets for smoking quitters in 2013/14 within General Practices have been weighted to ensure that greater numbers of quitters are achieved in the areas of higher deprivation, thereby helping to reduce health inequalities.

14. Establish a referral pathway from adult social care to stop smoking support and to the smoke free homes initiative. Increase referrals from hostels, residential settings and
care homes to reach vulnerable groups such as those with poor mental health or disability who may find it difficult to access health services.

15. Continue to increase access to stop smoking support and the smoke free homes initiative for more vulnerable families through Children Centres where a number of staff have been trained to deliver stop smoking interventions.

<table>
<tr><td>16.</td><td>The successful delivery of making every contact count will ensure that smokers are given brief interventions and signposted on for further support by a range of health and social care professionals with whom they may come in contact with.</td></tr>
<tr><td>17.</td><td>Continue to focus on the wider Tobacco Control agenda prioritising the prevention agenda through the following:
Expanding the delivery of KICK ASH in two more Upper Schools during the 2013/14 academic year
Reducing the use of illegal tobacco by building upon the 2012/13 campaign to raise awareness through a local marketing campaign
Additional clinics will also be offered in areas of high deprivation.</td></tr>
<tr><td>18.</td><td>Monitor the 2013/14 contracts with acute and community health providers which have included targets which will contribute towards reducing smoking prevalence. These are shown below;
<table>
<tr><th>Measure</th><th>Luton and Dunstable Hospital</th><th>Bedford Hospital Trust</th></tr>
<tr><td>Smoking status at time of delivery</td><td>Q1- 24% Q2-21% Q3- 18% Q4- 15%</td><td>13%</td></tr>
<tr><td>Smoking quitters at 4 weeks</td><td>160 first time attendees at stop smoking services</td><td>800 referrals with a 40% conversion rate form referral to first time attendee</td></tr>
</table></td></tr>
<tr><td></td><td>Support people to access free weight loss programmes in the community and ensure that the built environment and leisure services support people to be physically active</td></tr>
<tr><td>19.</td><td>Reducing obesity is a major challenge due to the wider and indirect factors that influence its development. Interventions to reduce obesity among adults currently focus on two specific programmes which are initiated within primary care and accessed in the community through leisure centres. Tackling the wider determinants will require other strategies such as the Leisure Strategy, Planning (Green spaces) and the Built Environment to support people being physically active.</td></tr>
<tr><td>20.</td><td>The Weight Management Referral Scheme is commissioned by Public Health Shared Function and is delivered by Weight Watchers and Slimming World through GP Practices. In 2011 only 19 of 31 surgeries were participating in the scheme whilst in 2013 all 31 surgeries are participating.</td></tr>
<tr><td>21.</td><td>The exercise referral scheme is delivered by the Central Bedfordshire physical activity team through GP practices. GPs will refer patients whose health will benefit from structured physical activity. Qualitative evidence is collected on all patients before and after the exercise referral programme and individual patients are tracked throughout the programme to monitor their progress.</td></tr>
</table>

	Progress to date
22.	There are 5 out of 6 leisure centres participating in the exercise referral scheme and plans are in place to bring the final leisure centre into the programme. In September 2012 an Exercise Referral Coordinator was appointed to ensure effective communication and delivery of the programme through improved monitoring and reporting of the scheme.
23.	

Number of people referred to weight referral scheme between 2011 & 2013	**% achieving a 5% weight loss**
1226	41-53%

24.	Q3 2012/13 is the first quarter where data is reported due to a new coordinator in post under the new Service Level Agreement.
25.	

Exercise Referral Scheme Figures 2012/13	**Q3 2012/13**
Referred	35
Completed	20
Dropped out	7
DNA	5
Males	15
Females	20

	Next Steps
26.	Reporting activity and outcomes from weight watchers and slimming world will be monitored at a GP practice level on a monthly basis to encourage further uptake of the scheme among patients.
27.	A training programme for leisure centre activity staff will continue to be delivered to ensure that exercise referrals can be taken by all leisure centres within Central Bedfordshire. Activity and outcomes will be monitored on a bi monthly basis by the public health obesity lead.
28.	Ensure that tackling obesity is addressed within the leisure strategy (currently in draft format) including a continued commitment to deliver exercise referral programmes in leisure centres across Central Bedfordshire.
29.	Refresh the Central Bedfordshire Obesity Strategy and establish a cross department Obesity Strategic Group to deliver further improved outcomes.

30	It is anticipated that the re-procurement of the Leisure Management Contracts (for Sandy, Saxon Pool, Flitwick and Houghton Regis Leisure Centres) from April 2014 will include incentives for providers to actively work with specific groups to improve access and reduce inequalities. In addition each year providers will produce an annual health and wellbeing plan, signed off by CBC, which will contribute to increase levels of physical activity and reduce obesity.
	Helping people who want to make changes to their lifestyle by making every contact count
31.	Equipping staff across a range of services with the skills and confidence to identify and make the most of every opportunity to Making Every Contact Count (MECC). This will enable them to promote and signpost people to a range of support including weight management, stopping smoking, alcohol and substance misuse, mental health and dementia.
32.	An action plan is in development for 2013/14 and will prioritise the expansion of the MECC train the trainer model. Supporting resources have also been developed and will continue to be distributed among staff from across a range of services in Central Bedfordshire.
	Progress to date
33.	A post has been created in public health to coordinate and develop MECC and Health Checks in Central Bedfordshire.
34.	MECC targets have been included in the 2013/14 contracts for the Acute Trusts, SEPT Mental Health services and SEPT Community Services.
35.	170 front line staff have been trained to deliver MECC including social care, children centre staff, parenting advisors and health visitors.
36.	MECC is now an element of Year Two Nurse training at the University of Bedfordshire.
	Next steps
37.	Capacity to deliver MECC has increased through the new MECC and Health Checks post in the public health team.
38.	Broaden out the staff groups that are trained to deliver MECC using the train the trainer model.
39.	Continue to promote the ethos of MECC and support the delivery of MECC in health, social care and wider setting.

<table>
<tr><td></td><td>Early identification and treatments to prevent or delay the consequence of disease through NHS Health Checks to all 40-70 year olds</td></tr>
<tr><td>40.</td><td>Central Bedfordshire NHS health checks are 5 yearly health checks offered to every person between the ages of 40 and 74 years who have not been identified as at high risk of vascular disease such as heart or kidney disease. The health check assesses an individual’s risk of cardiovascular disease through measuring blood pressure, weight (including body mass index) and blood cholesterol level. The majority of checks are delivered by GPs in their practices. Increasing the number of Health checks is important to identify early signs of poor health leading to opportunities for interventions.</td></tr>
<tr><td>41.</td><td>The target represents 20% of the eligible population (40 to 74 years old without a pre-existing cardiovascular condition, diabetes or chronic kidney disease) each year on a rolling 5 year programme. Since the programme began in 2010/11, 25,394 people have accessed health checks in Central Bedfordshire.</td></tr>
<tr><td></td><td>Progress to date</td></tr>
<tr><td>42.</td><td>
<table>
<tr><th></th><th>Target</th><th>Projected outturn based on 2012/13 data up to the end of February</th></tr>
<tr><td>Health checks offered 2012/13</td><td>23, 312</td><td>25, 394</td></tr>
<tr><td>Health checks delivered 2012/13</td><td>11, 656</td><td>9, 939</td></tr>
</table>
</td></tr>
<tr><td>43.</td><td>During the first six months of 2012/13, as a result of health checks, 1088 Cardiovascular Disease (CVD) risk factors were identified.</td></tr>
<tr><td>44.</td><td>Nationally there is a significant challenge in reaching targets set for this year which are substantially higher than last year. Central Bedfordshire is one of the better performers nationally and significantly ahead in terms of quality assurance.</td></tr>
<tr><td>45.</td><td>A community outreach team from Horizon Health Choices, a private company formed from clinicians and managers previously working within Bedfordshire, deliver a number of Health Checks in the community at pre-arranged events such as village halls and religious centres. These events are targeted at areas of higher need such as within lower socio-demographic areas.</td></tr>
</table>

46.	Horizon Health Choices also deliver health checks in GP Practices that request additional support, particularly out of normal working hours and through the Active Transport Hub in Dunstable as part of a joint venture with CBC sustainable transport team.
47.	More health checks have been delivered this year than last but the percentage of people accepting an offer is declining. This is because as the programme expands, encouraging the more hard to reach and at risk groups to participate is a continuing challenge.
48.	Questions regarding dementia and alcohol, including awareness and signposting have recently been included within the health check assessment.
	Next Steps
49.	A detailed plan is in development and will incorporate information from the learning event and feedback from GPs and the Clinical Commissioning Group (CCG).
50.	Manage the new Service Level Agreement (SLA) with GPs and ensure poor performing Practices are supported, or subsequently that the task of delivering Health Checks in that locality is passed to alternative provider.
51.	Develop and deliver a concerted and sustained social marketing programme, increasing public recognition and promoting uptake of Health Checks when offered.
52.	Internal CBC communications should promote all eligible staff to take the offer of a Health Check and actively promote the programme. A health checks session specifically for CBC members and staff has been arranged for the 17th May.
	Supporting people to reduce their drinking to safe levels through community based support
53.	Whilst Central Bedfordshire is a relatively safe place to live, understanding the risks and effects of alcohol can make it an even safer place. Alcohol is strongly related to crime and disorder and in particular violent crime, including child abuse, youth violence, intimate partner violence, sexual violence and elder abuse. Violence that occurs under the influence of alcohol can also result in more serious injury. Other crimes that can be attributed to alcohol include anti-social behaviour, under-age drinking and drink driving.

54. There is a two pronged approach to reducing the impact of alcohol misuse in the local community. Firstly early intervention and prevention to reduce the number of individuals experiencing the health and social related problems associated with alcohol misuse and therefore reduce the need for specialist treatment services. Secondly, ensuring that alcohol treatment interventions are available when and where individuals require them.

55. To ensure that progress is made towards reducing alcohol related harm, implementation of the recommendations from the Central Bedfordshire Alcohol Strategy will be assured through the delivery of a comprehensive action plan. Governance of which will be through the Acting Early and Reducing Poverty Group, the Healthy Communities and Older People Partnership Board and Central Bedfordshire Community Safety Partnership Board.

Progress to date

56.

Number of alcohol related admissions in Q2 (Target)	Number of alcohol related admissions in Q2 (actual)	Comments
4,799	4,987	Central Bedfordshire is currently RAG rated amber in respect of alcohol related admission/attendances in 2012/12. This increase in numbers has been anticipated, in part due to an improvement in data collection within the Accident and Emergency department.

57. CAN (the new drug and alcohol provider) have been commissioned to deliver the community alcohol liaison service (CALS). The CALS workers are based in GP surgeries and healthcare settings across Central Bedfordshire and provide an 'in reach' service to the hospital.

58. The Audit C Screening tool is used by professionals as a means of identifying harmful levels of drinking and guide onward referral to CALS or CAN. A range of front line workers such as police, Accident and Emergency staff, social workers and children's centre staff have been trained to use the tool with their service users.

	Next Steps
59.	Commit investment to increase the capacity of the CALS workers to provide alcohol advice/treatment and support in the community of Central Bedfordshire.
60.	CALS data has shown that the majority of patients (from Central Bedfordshire) being seen at Bedford Hospital for alcohol related issues are men and women aged between 40-52 years. In order to target this group, training on the Audit C tool will be delivered within workplaces so that managers and HR staff can implement the tool where appropriate in addition to frontline professionals.
61.	Alcohol will be included in health checks from 1st April 2013 therefore training on the Audit C tool will be offered to primary care staff in order to identify and signpost individuals with alcohol issues.
62.	Public health, in partnership with Bedsafe will gather and collate evidence on the patterns and degree of alcohol misuse within Central Bedfordshire to understand what type of drinkers there are (for example home drinkers, professional drinkers) and how best to support them.
63.	Replicate the data collection process (in place at Bedford Hospital) at the Luton and Dunstable Hospital to capture information about where people have been drinking prior to their arrival at the Accident and Emergency Department. This will enable public health to map the extent of local alcohol related problems to inform decisions regarding developing or reviewing licensing policy. There is currently a national consultation to add a health related indicator for local responsible authorities to consider in regards to licensing.
	Supporting people with substance misuse difficulties through access to effective substance misuse services
64.	Substance misuse treatment services are delivered by CAN and incorporate and an approach to reduce harm, which is used with individuals still using drugs with a view to motivating them to change. Treatment for people experiencing substance misuse has to be accessible to all and tailored to the specific needs of the presenting individual.
65.	Effective treatment, including substitute prescribing and talking therapies are provided to those seeking to reduce their drug use.
66.	CAN provides wrap around support to clients to ensure that their wider needs are addressed and supported. A client who has sustainable housing and improved relationships is more likely to sustain recovery than someone who has just stopped using drugs.

67. Peer support is a strong component and this is being prioritised and developed within the treatment system so that there is an emerging recovery community.

Progress to date

68. There is a comprehensive action plan to ensure that all aspects of the treatment system are aligned to facilitating the process of having an efficient treatment system that reduces harm, effectively engages clients in treatment and has recovery accessible at every stage of the treatment journey.

69.

Successful completions of treatment- Opiate clients	**Q2 2012/13**	**Q3 2012/13**	**Comments**
	6.7%	8.5%	This is represented as a proportion of all in treatment. The treatment system has been reconfigured and following the appointment of a new provider, an increased number of clients leaving treatment drug-free.
Re- presentations for Opiate clients	25.7%	7.9%	Re-presentation is the term given to clients who leave treatment drug free and return with six months of their last treatment episode.
Successful completions of treatment- Non-Opiate clients	37.2%	38%	
Re- presentations for Non-Opiate clients	No re presentations	No re presentations	

Next Steps

70. There is additional work being undertaken following the appointment of the new provider, through regular meetings, to ensure that all work streams are on track. As alcohol treatment has now found a place within the treatment system, an attractive and successful treatment system will mean that there is an increased likelihood for more people to come forward for alcohol treatment. The impact of this increased demand upon service capacity will be closely monitored.

71.	Continue to explore the potential of accessing additional funding for residential support. A briefing paper for the provision of inpatient detoxification from substance misuse has been put forward to the BCCG for consideration and a number of Health Needs Assessments have been undertaken over the years, the most recent in 2012. Unless other resources are identified and made available the risk is that this specialised treatment that supports people to gain and maintain a robust recovery, will only remain available to a small proportion of the treatment population.
	Detailed recommendations
	It is recommended that the Health and Wellbeing Board:
72.	Recognise the progress to date to deliver priority 7: Helping people make healthy lifestyle choices.
73.	Promote MECC across organisations by supporting front line staff to training and creating a MECC ethos within teams. This will help embed a preventative approach across organisations and support individuals to make healthy lifestyle choices.
74.	Ensure that the delivery of a preventative approach by promoting healthy lifestyle choices is embedded within strategies and commissioning across the health, social care, community and voluntary sectors.
75.	Continue to challenge perceptions around harmful and hazardous drinking, which effects all elements of society and is not confined to vulnerable groups and young people.
76.	The Board is asked, via its BCCG representatives, to support and actively encourage all practices to meet stop smoking and Health Check targets.
77.	Ensure that CBC and Health staff are supported to make healthy lifestyle choices

Issues	
Strategy Implications	
78.	Helping people make healthy lifestyle choices is one of the priorities of the Health and Wellbeing Strategy.
79.	There is clear alignment with the BCCG Strategic Commissioning Plan and the Central Bedfordshire Delivering your priorities plan through the focus on early intervention and prevention of ill health.

Governance &Delivery	
80.	Delivery and progress are reported through the following groups; the Healthy Communities and Older People Partnership Board, the Acting Early, Reducing Poverty and Improving Health group and the Bedfordshire Drug and Alcohol Team Board (BDAT).
Management Responsibility	
81.	Responsibility for the delivery of the outcomes rests with the Director Of Public Health. This responsibility may be delegated for day to day operational delivery.
Public Sector Equality Duty (PSED)	
82.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
	Are there any risks issues relating Public Sector Equality Duty **No**
	No Yes *Please describe in risk analysis*

Risk Analysis
Briefly analyse the major risks associated with the proposal and explain how these risks will be managed. This information may be presented in the following table.

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

Source Documents	**Location (including url where possible)**

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March 2013

HEALTHIER TOGETHER PROGRAMME (SOUTH EAST MIDLANDS ACUTE SERVICES REVIEW)
PROGRESS REPORT FOR ALL PARTNER ORGANISATIONS

1. Purpose

The purpose of this paper is to provide the Boards of partner organisations with an update on progress against all aspects of the programme since the last report in February 2013.

2. Structure of the programme going forward

At their meeting on 13th February 2013 the Programme Board agreed that the next phase of the Healthier Together work would be taken forward locally by the CCGs in the north, middle and south of the South East Midlands.

CCGs have confirmed their plans for how this next phase of work will be coordinated locally;

In Northamptonshire Nene and Corby CCGs will work closely together and with the acute hospitals to develop proposals for consultation in summer 2013. The programme of work will be coordinated through a Northamptonshire Programme Management Office (PMO) which will also oversee the development of closer working between the two acute hospitals.

Bedfordshire and Milton Keynes CCGs plan to take a more incremental approach to the planning of service changes in order to prioritise those services where there is the most pressing clinical need. The programme of work will be coordinated through two separate PMOs one based in each CCG, with joint working between the two where this is required. This work will run alongside the organisational change process for Bedford Hospital.

In Luton the next phase of work will be taken forward as part of the 'Healthier Luton' strategy, a key element of which is the redevelopment of the Luton and Dunstable Hospital site. The work programme will be coordinated by the 'Healthier Luton' PMO.

These local arrangements reflect local priorities and circumstances and will ensure that the proposals which are developed meet local needs. Timescales for consultation and implementation of service change will be tailored to meet the needs of the local population.

The five CCGs will continue to work together with Specialist Commissioners to determine how more specialist services, which require only one or two sites across the whole of the South East Midlands, should be configured.

All of the work that has already been undertaken will be transitioned to these new arrangements by 31st March 2013.

3. Update on Commissioner Work Plan

Work continues on the development of the out of hospital care strategies. First drafts have been received from Bedfordshire, Milton Keynes and Luton CCGs. Additional work is still required to strengthen the quantification of the strategies in terms of activity and financial changes and the implementation timetable. External support will continue to be provided to ensure that the strategies can be finalised by the end of March 2013.

4. Clinical work plan

On 8th March 2013 the Clinical Senate formally signed off the work of the six Clinical Working Groups. They also approved the overarching Clinical Senate report. This report brings together the key findings and recommendations from each of the six Clinical Working Groups and outlines the process undertaken by the Clinical Senate to review these and develop draft strategic models for the South East Midlands.

Having considered all of the work undertaken and the differing views expressed, the Clinical Senate recommends a strategic direction of:

- A minimum of three hospital sites across the South East Midlands where the focus is more on urgent and emergency care

- Up to two remaining sites developing a focus on planned care**.**

In making this recommendation, the Clinical Senate was clear that these changes will rely on the successful implementation of CCG out of hospital care strategies moving more care into the community.

The Clinical Senate believes that these recommendations would enhance the safety, quality, clinical outcomes, sustainability and patient experience for the population of the South East Midlands and ensure the future clinical viability of all five Trusts.

Under these recommendations patients would still receive the majority of their care locally, indeed much care will move closer to their home, and so for the vast majority of people there will be no change.

The Clinical Senate report also identifies a number of specific services that whichever strategic clinical model is adopted should only be provided on one or two sites across the SEM. The report also identifies a number of issues that will need to be addressed as all of the work is taken forward.

The Clinical Senate report was accepted by the Programme Board at its meeting on 13th March 2013 and has now been published. The report is attached at annex A.

5. Communications and Engagement

A comprehensive report of the engagement activities undertaken in the current phase of the Healthier Together programme was received by the Programme Board on 13th March 2013 and is attached as annex B. This report will form part of the information bank that will support CCGs as they take the process forward locally.

6. Recommendations

The Board is asked to note the contents of this report and the importance of the Clinical Senate report. The Board is also asked to note the handover to the local arrangements for taking this work forward and ensuring that local proposals are developed for future service arrangements that will enhance the quality and sustainability of local services.

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Healthier Together
South East Midlands
Better care in the right place

Clinical Senate Report

Final Version for Publication

1. Introduction

Healthier Together's aim is to meet the health challenges of the 21st century and improve health services in the South East Midlands (SEM) to deliver improved patient outcomes in a safe, sustainable and affordable way. Led by GPs and hospital clinicians, the programme is a collaboration of twelve NHS partners across Bedfordshire, Luton, Milton Keynes and Northamptonshire.

Healthier Together partners have a shared understanding that the current pattern of hospital provision is not sustainable. With a growing and ageing population, expected to rise from 1.6m to 1.8m by 2022, and finances becoming more constrained, commissioners and the five hospitals have agreed to work together with key stakeholders to improve quality of care, clinical outcomes for patients, efficiency and effectiveness.

2. Summary of case for change for services in the South East Midlands

There is a strong case for change for services in SEM. This case is similar to those facing many other English health care systems and is based on the following key factors:

- The health care demands of a growing population (from 1.6 million now to 1.8 million in 2022) and an ageing population (over 65s to increase by one third over the same period)
- The increasing complexity of healthcare needs as the population ages
- The current and inevitable future financial constraints brought about by the global economic recession
- Increasing standards for service specifications and technological reliance, creating inefficiencies within smaller units
- Shortages of qualified, experienced clinicians in key clinical specialties including A&E, paediatrics and maternity services
- Increasing difficulty in meeting national best practice standards in particular around senior consultant cover
- Increasing evidence of the variability of care and, in specialist areas, of the volume – outcome relationship.

Analysis of current patient pathways shows significant variation for some conditions across SEM. There is good national and international evidence that reducing variation improves outcomes and increases patient satisfaction.

Service reconfiguration is therefore required to secure the clinical and financial viability of the five main hospitals serving SEM namely Bedford Hospital, Kettering General Hospital, Luton & Dunstable Hospital, Milton Keynes Hospital and Northampton General Hospital.

3. Scope, structure and work of the programme

The Healthier Together programme includes all clinical services currently delivered on an acute hospital site. Mental health and dental services are outside the scope of the programme.

The cornerstone of the programme is the Clinical Senate. The Clinical Senate's remit was to develop clinically viable models for the population, based on the continued presence of five hospitals each continuing to deliver A&E and maternity care. Reporting in to the Clinical Senate are six Clinical Working Groups (CWGs) made up of almost 200 clinicians from all specialties and partner organisations. The six CWGs are:

- Maternity
- Children
- Planned Care
- Cancer
- Emergency Care
- Long Term Conditions.

The Clinical Senate is chaired by an acute Trust Medical Director and is made up of clinical representatives from all stakeholder organisations, the chairs of the six CWGs and patient and public representatives. The Clinical Senate met regularly, to ensure all members of the programme were kept abreast of developing ideas and to consider key interdependencies for each speciality and service.

The Long Term Conditions CWG was chaired by a practising local GP and the other five CWGs by hospital consultants from within SEM. Each CWG met at least five times in 2012. In addition a series of joint meetings were held and, where needed, sub groups set up.

The CWGs took account of national and international clinical evidence and best practice and local volume and outcome data in developing potential models of care to recommend to the Clinical Senate. Each report was then checked externally to ensure all the latest evidence had been taken into account.

The task of the Clinical Senate was then to make recommendations on strategic clinical *models* for five acute sites to serve a population of 1.6 – 1.8 million people, irrespective of current service provision.

Thereafter it was the task of the Clinical Implementation Group (CIG) to identify how those strategic clinical models could be delivered within the existing five hospitals to create *options* for clinical reconfiguration.

4. CWG case for change and proposals

The case for change and proposals from each CWG are summarised in the sections below.

4.1 Maternity

Case for change

The National Service Framework (NSF) for Children, Young People and Maternity Services 2004 required Trusts to ensure the availability of midwife-led care including midwife led units in the community or on a hospital site. SEM has not to date fully delivered this requirement.

Obstetrics and gynaecology services are facing many challenges such as an increase in older mothers with higher complication rates, increasingly complex cases, increased fertility treatment resulting in more multiple births, maternal obesity, rising intervention in labour and an increasing social and ethnic diversity within SEM. The ratio of live births to women is higher than the England average particularly in Corby, Luton and Milton Keynes. This is an important factor when considering any proposed changes and geographical location of future obstetric units.

The Royal College of Obstetricians and Gynaecologists has recommended that maternity units should have onsite labour ward cover by a specialist consultant for a designated number of hours each week depending on the number of births. At present not all units in SEM meet those standards. The ultimate aim will be to provide consultant presence in the labour ward 24 hours every day.

Midwife led care should be the norm rather than the exception. Concerns over intervention and caesarean section rates have been highlighted by commissioners.

There is an inequity of critical care services. Luton and Dunstable Hospital, the largest obstetric unit in SEM, does not currently have a High Dependency Obstetric Unit although this facility is available in the four smaller obstetric units.

Proposals

The proposed model is supported by national guidance on clinical standards and workforce issues and allows for the provision of care in the community by midwives and obstetricians including home visits, early pregnancy assessment units, antenatal clinics and late pregnancy assessment units. The model also increases choice by introducing the concept of stand-alone and adjacent midwifery units.

The proposed model is as follows:

- The option of home births for low risk women
- Outpatient and day case (<23 hour) gynaecological services on all five sites supported by obstetricians and gynaecologists based in the obstetric units. The proposed model assumes that inpatient gynaecological services would be co-located with a consultant obstetric unit
- Three obstetric consultant-led units developing specialist services and increased consultant presence supported by acute and inpatient gynaecological services
- Three adjacent midwifery-led units and two stand alone midwifery-led units to increase choice and reduce medical interventions for low risk women. Each midwife led unit would share an overarching management and governance process with an obstetric unit.

Critical interdependencies for obstetric units include neonatal intensive care facilities, imaging, pathology services and critical care.

The proposed model would be supported by one level 3 neonatal unit (providing higher level intensive care in keeping with neonatal network requirements) and two level 2 neonatal units for SEM, following consultation with neonatology leads and existing neonatal networks.

Benefits

The proposed model will deliver the following benefits:

- Normalisation of antenatal, birth and postnatal care through separate midwifery-led care, promoting home births and births in midwifery led units
- Promotion of care close to home – development of early pregnancy assessment units, antenatal clinics, antenatal assessment units
- Improvements in patient choice
- Equity of obstetric services across SEM
- Immediate provision of 98 hours obstetric consultant labour ward presence in the three obstetric units, moving towards 24/7 presence
- Consolidation of emergency and elective gynaecological practice linked with service provision and a consultant-led service
- Provision of equity in obstetric critical care services
- Potential for future separation of obstetric and gynaecology on call rotas in response to specialty trends indicative of a potential future shift (but not achievable under current budgetary limitations)

- Development of neonatal services in cooperation with, and the support of, the neonatal networks
- Centralised inpatient facilities for perinatal mental health services where none currently exist within SEM
- Development of specialist services – twins, chorion villus sampling and obstetric haematology, cardiac, endocrine and mental health care, leading to improved outcomes.

Freestanding midwifery led units are associated with significantly reduced incidences of maternal morbidity, birth interventions including caesarean section, and increased likelihood of spontaneous vaginal birth and no increase in perinatal mortality.

4.2 Children

Case for change

For children's services there are four key drivers of change:

- Safe care at home
- Medical advances
- Service quality
- Workforce challenges.

Safe care at home. Many children who previously required care in hospital can now be assessed and treated by specialist clinicians in and outside hospital and then safely and appropriately cared for at home. As care shifts into the community, fewer inpatient beds are required and smaller units become less viable. In addition, up to 25 per cent of patients presenting in A&E are children. Many of these attendances would be avoidable if better pathways could be established.

Medical advances. There will always be a small number of children who have sudden, unexpected severe illness. There are also more children with complex conditions who now survive and require long term access to expert paediatric care with short periods of treatment in hospital. Critical and less common inpatient paediatric care would be more sustainable by consolidating expertise and resources across fewer hospital sites.

Service quality. Quality and safety standards published by the Royal College of Paediatrics and Child Health (RCPCH) include a requirement that all inpatient children are seen early by a senior clinician and recommendations for increased consultant presence in the evenings and at weekends. Units within SEM currently struggle to achieve these standards consistently. There is also a need for all A&Es and Urgent Care Centres to reach recommended Urgent Care Standards for the care of children including; appropriate separate areas, children's trained / skilled staff available at all times, the ability to initiate resuscitation for a sick child with appropriate resuscitation skills / anaesthetic support and robust safeguarding systems and processes.

Workforce challenges. SEM does not have enough specialist clinicians to continue to meet the RCPCH standards across five hospitals in the long term, nor are there sufficient trainees to provide the necessary numbers to recruit. Demands on paediatric services are increasing as a result of increasing case complexity. There is a need for earlier senior review and decision making, more consultant delivered care and consultant on site presence in the evenings and at weekends.

Proposals

Two broad models were proposed:

- Three 24/7 sites with A&E, outpatients and inpatient beds, with three alternatives for the other two sites:
    - A&E and outpatients on the other two sites
    - A&E, outpatients and a short stay paediatric assessment unit on one other site and A&E and outpatients only on one other site
    - A&E, outpatients and a short stay paediatric assessment unit on the other two sites
- Four 24/7 sites with A&E, outpatients and inpatient beds, with A&E and outpatients on the other site.

The three 24/7 site proposal offers the biggest opportunity for quality improvements and addresses workforce challenges and is therefore the likely best option. However, the four 24/7 site proposal may provide a useful 'stepped' approach to implementation of full reconfiguration.

Collaboration and clear clinical protocols between sites is necessary to run short stay paediatric assessment units safely, with support from receiving 24/7 paediatric inpatient units. The short stay paediatric assessment unit model could be medical or nurse led and less than 24/7. To reduce reliance on inpatient care community services must be provided 7/7, with extended evening hours to cover periods of peak demand and rapid reaction teams to avert avoidable admissions and readmissions. Clear 'treat and transfer' policies will need to be designed to minimise the number of transfers of children.

When benchmarked against all criteria, models with three 24/7 units best met the requirements. Retaining short stay paediatric assessment units (SSPAU) on sites without inpatient beds would preserve access to paediatric expertise (beyond outpatient services) at each location, but models would need to be carefully developed to address safety, sustainability, safeguarding and medical workforce issues of SSPAUs.

Currently there are three level 2 neonatal units and one level 3 unit within SEM. The proposals envisage obstetric units as proposed will be supported by a level 2 or level 3 neonatal unit.

High volume, planned surgery for children (e.g. ENT) and emergency orthopaedics needs to be easily accessible. There are opportunities to consider whether more specialist children's surgery (but non- tertiary) could be provided on one or two sites.

Access to emergency surgical assessment for children and appropriate emergency children's surgery on site is essential for 24/7 inpatient paediatric units.

A theme throughout the Children's CWG discussions was the interdependency between urgent care / A&E provision and paediatric care and crucially the need for recognised standards with demonstrable competency in initial assessment and treatment to be met at any location offering emergency assessment for children, with or without a 24/7 paediatric facility.

Children's cancer services are currently provided via managed networks with tertiary providers. It is anticipated that existing arrangements will continue. The location and level of children's local cancer care will continue to be determined by POSCU accreditation.

Benefits

The concentration of inpatient care on three sites, whilst retaining outpatient and assessment services on the two other sites, would allow the redeployment of skilled workforce from inpatient services to support more care in the community, in line with the national strategic direction.

The redeployment of consultant medical staff across three inpatient sites would increase frontline consultant presence whilst also still providing outpatient services and access to an opinion close to home on the other two sites. This would improve outcomes, training and patient experience.

Rotational working is recommended between and across hospital sites and community services as an opportunity to ensure that skills and knowledge are maintained and developed across the workforce. This should improve the experience of patients and their families.

There are opportunities to provide some sub specialist services currently not easily accessible in SEM on one or two sites only e.g. Child Sexual Abuse Referral Centre (SARC) and paediatric orthopaedics. Any redesign of services must demonstrably strengthen the quality of safeguarding, requiring effective clinical communication with robust IT systems to access and share information.

4.3 Planned Care

Case for change

In some areas of SEM, primary outcomes such as mortality and complications are higher than expected. Concentrating some specialist services on fewer than five sites will improve overall outcomes. There is an increasing body of evidence to support improved outcomes for patients in specialist centres cared for by specialists. For example:

- Centralisation of gynaecological cancer shows an improvement in survival rates in the region of 10%, particularly for ovarian cancer
- In vascular surgery, there are clearly improved outcomes from aortic surgery in busy vascular centres, with a strong relationship between volume and outcome for each institution
- In urology, there are improved outcomes from major cancer surgery in centres performing a larger number of cases.

Some services have recently been centralised in line with guidance from the Royal Colleges, NICE and Cancer Service Reviews but variability in access to specialist care shows that there is scope for further centralisation within SEM.

It is currently difficult to provide 24/7 cover in a number of specialties in SEM including interventional radiology and specialist gastro-intestinal surgical cover for patients undergoing major colorectal surgery. The increasingly stringent requirements for a consultant delivered service, with recommendations about the minimum number of surgeons needed in order to deliver a sustainable on call rota, make this increasingly difficult. Concentrating some specialist services on fewer than five sites will ensure sustainable staffing. It could also enable SEM to develop services for which patients currently have to travel outside SEM.

Each of the five hospitals in SEM provides elective surgical services alongside emergency care. Increasingly there is evidence to support the separation of emergency and elective work streams. In 2007 the Royal College of Surgeons of England demonstrated that if well planned, resourced and managed, this way of working can achieve a more predictable workflow, provide excellent training opportunities, increased senior supervision of complex/emergency cases, and improved quality of care delivered to patients.

Overall, day surgery rates are variable across SEM. Day surgery should be performed in dedicated units on as many sites as possible, to retain services close to home, including in elective centres, day units, 23 hour units or short stay units.

Proposals

Across SEM core elective surgery would continue to be delivered on all five sites (except ophthalmology where fewer sites could be considered). Day case and short stay surgery would be provided in dedicated short stay units, which offer the greatest flexibility in terms of case mix.

Complex surgery would be delivered on fewer sites as follows:

- One site for complex orthopaedic surgery
- One or two sites for complex breast, head and neck, gynaecology, plastics, colorectal and ophthalmology surgery
- Two sites for complex vascular surgery.

Outpatient and general diagnostic services would continue to be provided on all five sites or in the community where appropriate. Responsibility for some follow ups would be devolved to primary or community providers, with enhanced protocols, to minimise the disruption to patients.

Benefits

The main benefit is to improve the quality and efficiency of planned care services and to improve outcomes and patient satisfaction.

Through collaborative working there is an opportunity to concentrate resource, manpower, expertise and equipment. With seamless pathways between the community and the hospital, there is an opportunity to create a network of services that will serve the demands of an increasing and ageing population, make best use of available resources and retain and develop services within the region. A seamless standard pathway for patients will also reduce variation and improve outcomes.

Another benefit is the opportunity to develop clinical expertise by delivering services differently, for example by centralising specialist services. This could also lead to increased access to high quality training for our consultants of the future.

4.4 Cancer

Case for change

The incidence of most cancers increases with age. Due to an ageing population, the national incidence of cancer is projected to increase by 55% for men and 37% for women by 2030.

Cancer services are amongst the best established network services in the UK, with a system of cancer centres, cancer units and multi-disciplinary management. However, patients from SEM are currently managed within four surrounding networks and reducing variation within SEM should lead to improved diagnoses, better local initial (often surgical) treatment and hence better outcomes for patients.

Improving outcomes guidance on minimum caseload or catchment population exists for head and neck, urological, gynaecological and haematological cancers. Currently, the configuration of specialist cancer services within SEM struggles to meet this guidance. It is unlikely that specialist commissioners will continue to commission services that do not meet the minimum population requirements. This means that, unless we work together, there is a risk that SEM will lose more of the specialist cancer services.

Some services within SEM may not be able to sustain compliance with peer review, as their low volume of activity makes it difficult to justify investment in all the areas of expertise involved in managing the patient pathway. Also, cancer waiting time performance across the five Trusts is variable and very difficult to maintain.

There is a national shortage of oncology consultants, chemotherapy nurses and radiotherapy staff (physicists and radiographers) and hospitals within SEM find it difficult to appoint to these posts. The size and number of hospitals in SEM make it less attractive for the recruitment of specialised staff who may prefer a post in a larger centre with more opportunities for research, technical innovation and career development.

There are a number of small services within SEM, which are based on two or three consultants and one or two Clinical Nurse Specialists. This makes services fragile and potentially unsustainable during periods of holiday or sickness which may result in delayed treatments and poor patient experience.

Some patients have to travel long distances outside SEM to access services not currently available within SEM. For example, it is estimated that about 40 – 50 patients a year travel out of SEM for complex breast reconstruction surgery. Patient feedback has also highlighted concerns about current travel times for radiotherapy, particularly in the south, where patients from Luton and South Bedfordshire have to travel to Mount Vernon for their radiotherapy treatment.

Proposals

A separate model of care has been developed for each tumour site. A summary of the themes of the potential models is as follows:

- Consolidation of some elective surgical specialties to improve outcomes
- Development of some specialist diagnostics
- Uniform co-ordination of screening services
- Provision of satellite radiotherapy to offer patients this service closer to home
- Ensuring reconfigured services continue to link with existing Cancer Networks
- Consideration of joint working for specialist cancer services across SEM to create volume and share expertise between sites

- Elective surgery of low complexity cancer could be on a non acute site but specialised high complexity cancer work eg head and neck should be on an acute site
- All hospitals with an A& E require an acute oncology service on site to meet cancer peer review.

The requirements of each tumour site, including co-dependencies will be different, but the CWG initially looked at the medical and surgical aspects of care for seven specific groups:

- Breast – complex breast surgery on one or two sites to improve local access
- Urology – specialist cancer surgery on one site
- Gynaecology – specialist cancer surgery on one or two sites
- Head and neck – specialist cancer surgery on one or two sites
- Lung – local thoracic opinion on one or two sites
- Haematology – inpatients on one or two sites. Care of acutely unwell haematology and oncology patients should be on an acute site. Specialised commissioning standards require a population of 4 million to undertake stem cell transplants but support a model of shared care with some elements of care undertaken locally
- Colorectal – specialist cancer surgery on two or three sites.

Overall there was a view that it would be better if all the very specialist cancer surgery were done in one or two centres. Further work would be required to look at the detail of this, which would also depend in part on the final configuration of inpatient elective services.

Specialist cancer consultants should work across SEM, for example by taking responsibility for one area with shared rotas to cover on-call. Specialist nurses and rehabilitation specialists would support this work.

Pathways for non-surgical oncology will depend on the final configuration of other services and pathways for each tumour site will need to be developed. Consultant oncologists will continue to be an integral part of the MDT directing patients' treatment by working with radiotherapy and chemotherapy services.

Benefits

With seamless pathways between primary and secondary care, between the community and the hospitals, there is an opportunity to strengthen the local networking of services so they better serve the demands of an increasing and ageing population. This also provides an opportunity to improve efficiency through shared cancer management functions.

The biggest opportunity is to combine specialist surgical services where appropriate for rarer tumours across SEM, leading to a sustainable local service. There is also an opportunity to develop our own specialist services, for example local PET, breast cancer reconstruction and specialist lung cancer diagnostics.

A joined up approach to commissioning radiotherapy across the area would enhance existing radiotherapy services and improve access for patients. Improved access could also be delivered through new models of chemotherapy delivery closer to home and local screening hubs with travelling facilities.

4.5 Emergency Care

Case for change

There are significant pressures on hospitals to cope with A&E attendances and emergency admissions. Nationally there has been a 46% rise in emergency admissions in England between 2004 and 2009. With an increasing and ageing population, rates will continue to rise across all age groups, but more so in older patients.

There is variation in the rate of emergency admission and readmission across SEM. Positively reducing this variation will improve outcomes.

There is significant variation in systems and services in place to reduce inappropriate admission and facilitate timely discharge from hospital. A number of admissions avoidance and demand management strategies have been implemented across SEM. Despite this, overall emergency admission rates and complexity of patients' conditions continue to rise.

The risk of death for emergency admissions is 10% higher in patients admitted at the weekend compared with patients admitted on a weekday. Research also suggests an association between reduced numbers of senior staff at weekends and increased mortality. Evidence shows that the earlier consultants are involved in making decisions in the care of patients, the better the outcomes for the patient.

Current A&E staffing levels do not meet national guidance, which recommends a minimum of ten consultants for a medium-sized A&E department. There is likely to be a national shortage of trained A&E consultants for the next 5-10 years. The staffing of emergency general surgical rotas has also become challenging as surgical training has become more specialised.

Proposals

The CWG's preferred model was the retention of full A&E services on all five hospital sites. A list of specialties required to support an A&E department was also defined. However, further consideration needs to be given to whether all these services need to be on site or can be accessed easily from another site using clear, agreed protocols.

The CWG also recognised the concerns over the long-term viability of retaining five acute surgical rotas. Concentrating A&E and general surgeons onto fewer sites could improve sustainability, but there would still be a need to recruit further A&E consultants to provide consultant presence.

The CWG therefore proposed an alternative model of four fully supported A&E sites with the fifth site being a 'warm' site managing and transferring some patients under clear protocols. Consolidating emergency surgery onto four sites would improve the viability of the acute surgical rota.

Strong commissioning of emergency and network services is also required. National evidence suggests that 10-30% of cases that attend A&E could be classed as primary care. To meet future acute healthcare needs, community and social services need to extend operational hours to incorporate nights and weekends. There is also a requirement for greater standardisation of service provision, skills and expertise to avoid varying responses.

In addition to A&E services, the CWG considered the number of sites for specialty service provision and proposed the following:

- Two sites for urology, acute stroke, ophthalmology, ENT, maxillofacial, complex gastroenterology and complex respiratory cases
- One or two sites for neurology
- One site for complex cardiology and specialist inpatient endocrinology.

Benefits

The main benefits of the proposals are:

- Improved patient pathways involving specialist hospitals, District General Hospitals and primary care providers. There is evidence that outcomes for patients can be improved if reconfiguration is combined with new clinical pathways
- The opportunity to improve healthcare through consolidation of specialist services
- Reduced variation in services through the standardisation of clinical pathways and improved integration between health and social care
- The opportunity to improve consultant cover, particularly at weekends, to improve quality and safety of care
- Less reliance on hospitals for acute care, treating patients within their home environment for longer.

4.6 Long Term Conditions

Case for change

People with long term conditions are significant users of NHS services. Patients with long term conditions currently account for 50% of all GP appointments, 64% of outpatient attendances and 70% of inpatient bed days. Around 70% of the total health and care spend in England is attributed to caring for people with long term conditions.

There is an increasing prevalence of long term conditions in England, in particular people having two or more conditions. The predicted rise in population will only increase this. We also know that early diagnosis and proactive management can affect outcomes for people with long term conditions.

The proactive management of people with long term conditions, including the promotion of self-care by patients, is a key priority for the NHS and is supported by clinical quality (NICE) guidance. Better long term condition management can also make a real difference to narrowing the health inequalities gap.

In SEM there are a number of local initiatives and services in place that fit within a generic framework for people with long term conditions. However, there is significant variation in both provision and outcomes.

Proposals

The first part of the proposals is to adopt the national generic, integrated framework for long term conditions, which is based on implementing three key service components:

- Risk profiling
- Patient self-management
- Shared decision making.

The CWG also proposes a model for complex long term conditions which describes what should be provided at every GP practice and the support available from acute and community services, including social care.

In this model, groups of practices would work together to share expertise and resources in community multi-disciplinary teams covering a population of 50,000 to 100,000. Each community multi-disciplinary team would sit within an integrated care system and be supported by access to specialist services: consultant led community clinics, specialist telephone advice for GPs or input during an acute episode of care. Acute and community based health and social care services would support early discharge and community care.

In addition, seamless pathways of care should be adopted for diabetes, chronic obstructive airways disease and heart failure with much of this pathway being provided in the community. Common aspects of care that could be managed in the community are: support for chronic conditions, improving access to psychological therapies (IAPT), mental health support, patient education and end of life care where appropriate. In acute care, the specialties of care of the elderly, imaging, pathology and ITU/HDU are

identified as close or critical interdependencies for all three diseases.With medical advancement there are growing numbers of adolescents living with long term conditions and disability. Planning future services across SEM must include planning for their transition from paediatric to adult services.

Benefits

Implementation of the generic framework will have a positive impact not only on people's lives but on reducing health and social care costs. It will ensure equity of provision, improve efficiency and provide better value for money.

Risk profiling will help the local health service plan and focus on prevention for many patient groups. At an individual level, risk profiling will ensure that patients and key workers know what to do to manage an exacerbation. This will help avoid unnecessary admission to hospital.

Increasing the number of patients cared for in the community and avoiding unnecessary hospital admissions will free capacity for specialist consultants to focus on newly diagnosed, unstable or acutely ill patients and to provide outreach specialist support for primary care.

Using an integrated model of care for people with complex long term conditions will provide better continuity of care and ensure access to specialist advice when required.

5. Clinical Senate review

The Clinical Senate has reviewed the emerging and final proposals from each CWG and considered the implications for an overarching strategic clinical model for SEM. The Clinical Senate undertook a 'challenge and confirm' process with each of the CWGs to review their evidence base and proposals. The proposals were then discussed and debated.

In considering the CWG proposals the Clinical Senate took three clear starting points:

- The vast majority of outpatient services would remain either on the current hospital sites or, where appropriate, would be moved into community facilities even closer to the patient's home
- There should be uniform access to the majority of diagnostic services across SEM, perhaps ensuring a more central location for those more specialised diagnostic services that will not be required in every area of SEM
- With an increasing and ageing population, changes in acute medical provision will only be feasible when out of hospital care has been significantly strengthened. The implementation of the long term conditions CWG proposals will be critical in reducing reliance on hospital care. In addition, the Clinical Commissioning Groups covering SEM are developing out of hospital strategies to support this.

In considering the individual CWG proposals, the following observations were made:

- It was recognised that reconfiguration of A&E services may not be deliverable without significant change in the provision of out of hospital care services, particularly if significant changes in the provision of acute medical care are to take place
- It was considered very unlikely that the health economy would be able to recruit sufficient emergency department consultants and junior staff to fully meet national recommendations and CWG requirements for all five A&E departments. It was therefore considered that continuing with five A&E departments operating as per existing arrangements will become increasingly unsustainable
- The Clinical Senate coined the term "networked A&E" to describe a 24/7 A&E which works closely with those A&E departments on the more acute sites, sees and manages the majority of patients locally, but has clear protocols in place to manage and transfer patients between sites if necessary. It is envisaged that staff would rotate between departments to maintain and improve skills. The details of the clinical pathway are still to be determined, but this is line with the national direction of travel and reflected in recent changes in London
- It was recognised that resolving the issue of how to provide emergency surgical support to A&E and emergency medicine would be critical
- The interdependence of the maternity and children CWGs proposals was recognised and supported
- The maternity recommendations give a strategic direction which needs to be developed in the context of more detailed local implementation planning, to ensure deliverability
- The maternity proposals envisaging three larger obstetric units supported by a level 2 or level 3 neonatal unit fit with the proposals from the Children's CWG providing that they are co-located with 24/7 inpatient units
- The emphasis on increased provision of children's services in the community was welcomed and the implications for hospital services supported
- The desirability of the separation of the planned and emergency patient pathways in order to deliver improved efficiency and a better outcome and experience for the patient was recognised. It was agreed that this will require clinical staff, and particularly consultants, to work in teams across more than one site
- It was felt that all sites should continue to undertake day surgery, but dedicated elective inpatient units should be developed where necessary for specific specialist services. Whether or not these are co-located with emergency services will depend on the size and nature of the specialty

- The importance of continuing to work closely with the existing cancer networks was stressed. However, it was also recognised that there were opportunities to work more closely together to ensure sustainable and seamless high quality services in SEM that deliver improved outcomes and a better patient experience. To achieve this, mechanisms may need to be developed for patients to have some aspects of their pathway delivered by different cancer networks
- The centralisation of more specialist services was supported
- Improved, proactive and anticipatory care for patients with long term conditions, including cancer, particularly towards the end of life is key to reducing unnecessary hospital admissions and improving patient experience
- The greater the number of variations in service delivery, the greater the risk that the ambulance service might take a patient to a less appropriate facility.

The Clinical Senate is clear that there is no single overarching strategic clinical model that would incorporate all of the CWG proposals. It therefore developed seven strategic clinical models (see Appendix), each of which incorporate differing aspects of the CWG proposals:

- Model 1 represents the status quo. It was agreed that the status quo was not a sustainable position and that this should only be used as a baseline against which to test the other options
- Model 2 retains five sites delivering a combination of emergency and elective care but centralised specialist care. This reflects the views of the emergency care CWG but not the views of the planned care, maternity and children CWGs
- Model 3 has four sites focusing more on emergency care and one site focusing more on elective care, together with the centralisation of more specialist care. This site also has a 'networked' A&E which would provide emergency and urgent care for the majority of patients and manage and transfer small numbers of more specialist patients. This reflects the alternate views of the emergency care CWG but not the views of the planned care, maternity and children CWGs
- Models 4 – 7 have three sites focusing more on emergency care and two sites focusing more on elective care, together with the centralisation of more specialist care. The two sites focusing more on elective care would also provide emergency and urgent care through a 'networked' A&E. These reflect the views of the planned care, maternity and children CWGs but not the views of the emergency care CWG who were of the opinion that such a change should only be delivered when out of hospital care strategies have delivered significant reductions in secondary care emergency activity.

Models 4 – 7 differ in the extent to which general acute medicine is provided on the sites focusing more on elective care and on whether or not obstetric and inpatient paediatric services are provided on the sites focusing more on emergency care or the sites focusing more on elective care.

It was agreed that the views of the cancer CWG could work with any of the models other than Model 1, but that they best supported Models 4 – 7. The views of the long term conditions CWG could work with any of the models other than Model 1 and the successful implementation of their proposals would be critical for Models 4 – 7.

There was considerable discussion and debate over the proposals from the emergency care CWG and those from the planned care CWG. The two key concerns from the emergency care CWG with regards to Models 4 – 7 were the inexorable rise in A&E and emergency activity (particularly in acute medicine) combined with a lack of confidence in out of hospital care strategies delivering significant reductions in activity and the importance of retaining emergency surgery presence 24/7 on any site providing A&E and emergency medicine services. The key concern from the planned care CWG with regards to Models 2 – 3 was the difficulty and inadvisability in retaining complex and emergency surgery on more than three sites.

As a result of these discussions, three conclusions emerged:

- It was important that there was evidence that CCG out of hospital strategies were reducing significantly demand on A&E and emergency medicine services before any changes were made to A&E and emergency medicine services
- Model 3 could be seen as a potential transitional stage to one of Models 4 – 7
- It was suggested that a satisfactory model of access to surgical opinion 24/7 and significant surgical presence could be developed to support A&E and emergency medicine, in the context of single integrated surgical teams working across two hospital sites.

On this basis, the Clinical Senate supports the strategic direction of a minimum of three hospital sites where the focus is more on urgent and emergency care with up to two remaining sites developing a focus on planned care.

Local delivery of these changes will rely on the successful implementation of CCG out of hospital care strategies moving more care into the community. The Clinical Senate believes that these recommendations would enhance the safety, quality, clinical outcomes, sustainability and patient experience for the population of the South East Midlands.

6. Specialist Services

Whichever strategic clinical model is adopted, it is clear from the work of the CWGs that there are a number of specific services that should only be provided on one or two sites across SEM. This will enable them to deliver improved outcomes through increased volumes and better value for money from the required facilities and resources. A summary of these services is shown below and it should be noted that some of these services are already provided from the number of sites indicated.

1 site	1 or 2 sites	2 sites
Complex cardiology (Primary PCI)	Complex plastic surgery	Acute stroke
Complex orthopaedics	Complex ophthalmology	Vascular surgery
Spinal surgery	Neurology	Specialist feto-maternal medicine
Bariatric surgery	Complex colorectal	
Level 3 neonatal unit	Complex gynaecology*	
Complex urological cancer	Complex head and neck*	
Anal cancer	Complex breast surgery*	
	Complex Haematology*	
	Lung cancer assessment	

** Including cancer*

A number of these services relate to specialist cancer services and, as stated above, careful consideration will need to be given to ensure we work with existing cancer networks to deliver robust safe pathways for patients. Accessibility to related diagnostics, treatment facilities and inpatient services will be key to the delivery of these specialist units.

Other interdependencies within the list include breast reconstruction and plastic surgery. It should be noted, however, that the development of a separate burns unit in SEM is not envisaged.

In addition to the above services, the development of one or two specialist elective orthopaedic centres serving a wider population should also be considered. Elsewhere, these have been shown to provide high quality and efficient care. The long term need to develop specialist elective surgery centres for other services should be determined by each individual specialty.

The location of these specialist services will either need to be considered alongside the strategic clinical model or, potentially, once the strategic clinical model has been determined. Either way, it will be important that they are considered across the whole of SEM and that decisions on location take into account the potential impact on any wider populations that may be affected by any proposed service changes.

Finally, there are a range of other specialist services which will continue to be provided on more than two sites and which would benefit from a continuation of the networking

opportunities that have been provided by the Clinical Senate and the CWGs. Consideration should be given as to how that might best be achieved.

7. Benefits and Outcomes

The Clinical Senate believes that the above changes will lead to a high quality safer system of health and social care provision for SEM that is clinically sustainable for at least the next ten years. The key benefits of the proposed changes for patients are that:

- Services would be more focussed on the needs of the individual patient so the overall patient experience will increase
- There would be earlier access to specialist opinion for both emergency and elective services
- The move towards 24/7 provision of high quality consultant delivered emergency services, the creation of centres of excellence, improvements to cancer care and improvements to long term condition management would see mortality rates decline as a result of more than 100 lives a year being saved and more than 500 premature deaths a year avoided
- Wherever possible, services would be delivered close to, or in, the patient's home
- The greater separation of elective care from emergency care would result in fewer cancelled operations, the development of more highly skilled and specialised nursing and medical teams, and hence a better, more predictable outcome for patients.

8. Further areas to consider

The Clinical Senate recognises there are a number of further issues that will need to be addressed as this work is taken forward:

- A considerable amount of work is still required to deliver the proposed changes
- Appropriate governance arrangements need to be put in place to ensure that a cohesive view is taken of all services which may need to be delivered on one or two sites only across the South East Midlands
- There will need to be continued strengthening of Long Term Condition management and a focus on the development of out of hospital care strategies with appropriate alternatives to acute hospital admission
- There may be increased travel for clinicians and patients so the implications of proposed service change will need to be considered as part of implementation planning
- SEM is covered by three ambulance trusts. Further modeling is required to assess the impact of possible increased numbers of transfers and longer journey times

- SEM covers a large geographical area. The impact of potential change on public and private transport use and availability, particularly in terms of social-deprivation, will need to be considered
- The development of uniform clear clinical pathways and transfer protocols are essential across SEM
- Improvements to the current hospital infrastructure will be required but, through collaborative working, any building programme should now be planned strategically, to support the delivery of these proposals
- Capital and transitional funding will need to be identified
- A robust IT system is essential to underpin all of these proposals
- The recruitment of consultant and middle grade doctors should continue, to ensure the same high quality service seven days a week
- Easy access to a high quality in hours and out of hours urgent primary care service, including admission avoidance, is essential
- A detailed assessment of the workforce impact and the identification of staffing and training requirements will be needed
- Current patient flows and pathways will need to change, so further discussion and engagement with tertiary providers is required
- Careful consideration must be given to the impact on patients in the areas surrounding SEM who currently access our services
- Strong governance and contractual arrangements will need to be in place so that services can work seamlessly across multiple sites
- Higher quality services should give better educational opportunities for trainees, and further work will be needed with clinical deans and LETBs to ensure equitable access to these
- Public engagement will need to be maintained going forward
- It is recommended that a proactive approach be taken to dissemination of CWG reports and the Clinical Senate report to clinicians and the public.

9. Conclusions

These strategic clinical models are the end result of 12 months of hard focussed work by almost 200 clinicians to recommend models of care for their population that are sustainable and meet 21st century standards and expectations. The Clinical Senate believes the case for change is incontrovertible and maintaining the status quo unsustainable both clinically and financially.

The Clinical Senate supports the strategic direction of a minimum of three hospital sites where the focus is more on urgent and emergency care with up to two remaining sites developing a focus on planned care in order to enhance quality, sustainability and

patient experience. Wherever possible care should remain as close, or even closer, to the patient's home as it currently is. However, a small proportion of patients may be required to travel slightly further in order to access higher quality elective inpatient services, and, depending on the final model adopted, whilst more patients with urgent needs may be treated in their own home or in their local communities others may need to travel slightly further to access emergency inpatient care of a higher quality.

The Clinical Senate also recognises that it will take some time to implement any agreed changes and that key changes in emergency care provision are dependent upon significant change in out of hospital care provision. This will provide the opportunity for transitional stages, which can be used to test and potentially modify any previously agreed assumptions.

There are a number of services still to be reviewed such as critical care, pathology and radiology but the requirements of these services will be determined by the final configuration of the frontline clinical services that they support. It is anticipated that work will continue when the final configuration has been agreed in order to ensure these services undergo a similarly robust review.

Appendix

Strategic Clinical Models

Model 1 (Status Quo)

Site 1	Site 2	Site 3	Site 4	Site 5
A&E	A&E	A&E	A&E	A&E
Trauma Unit	Trauma Unit	Trauma Unit	Trauma Unit	Trauma Unit
Emerg Surgery	Emerg Surgery	Emerg Surgery	Emerg Surgery	Emerg Surgery
Complex & elective surgery	Complex & elective surgery	Complex & elective surgery	Complex & elective surgery	Complex & elective surgery
Acute medicine	Acute medicine	Acute medicine	Acute medicine	Acute medicine
ITU and HDU	ITU and HDU	ITU and HDU	ITU and HDU	ITU and HDU
Inpatient paeds	Inpatient paeds	Inpatient paeds	Inpatient paeds	Inpatient paeds
Obstetrics	Obstetrics	Obstetrics	Obstetrics	Obstetrics
Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement

And .. specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.

Model 2

Site 1	Site 2	Site 3	Site 4	Site 5
Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre
A&E	A&E	A&E	A&E	A&E
Trauma Unit	Trauma Unit	Trauma Unit	Trauma Unit	Trauma Unit
Emerg Surgery	Emerg Surgery	Emerg Surgery	Emerg Surgery	Emerg Surgery
Complex & elective surgery	Complex & elective surgery	Complex & elective surgery	Complex & elective surgery	Complex & elective surgery
Acute medicine	Acute medicine	Acute medicine	Acute medicine	Acute medicine
ITU and HDU	ITU and HDU	ITU and HDU	ITU and HDU	ITU and HDU
Inpatient paeds	Inpatient paeds	Inpatient paeds	SSPAU*	SSPAU*
Obstetrics	Obstetrics	Obstetrics	Midwifery-led unit	Midwifery-led unit
Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement

And centralisation of specialist services – specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.
***SSPAU long term sustainability will need to be determined.**

Supported by strengthened Long Term Condition management and out of hospital care strategy

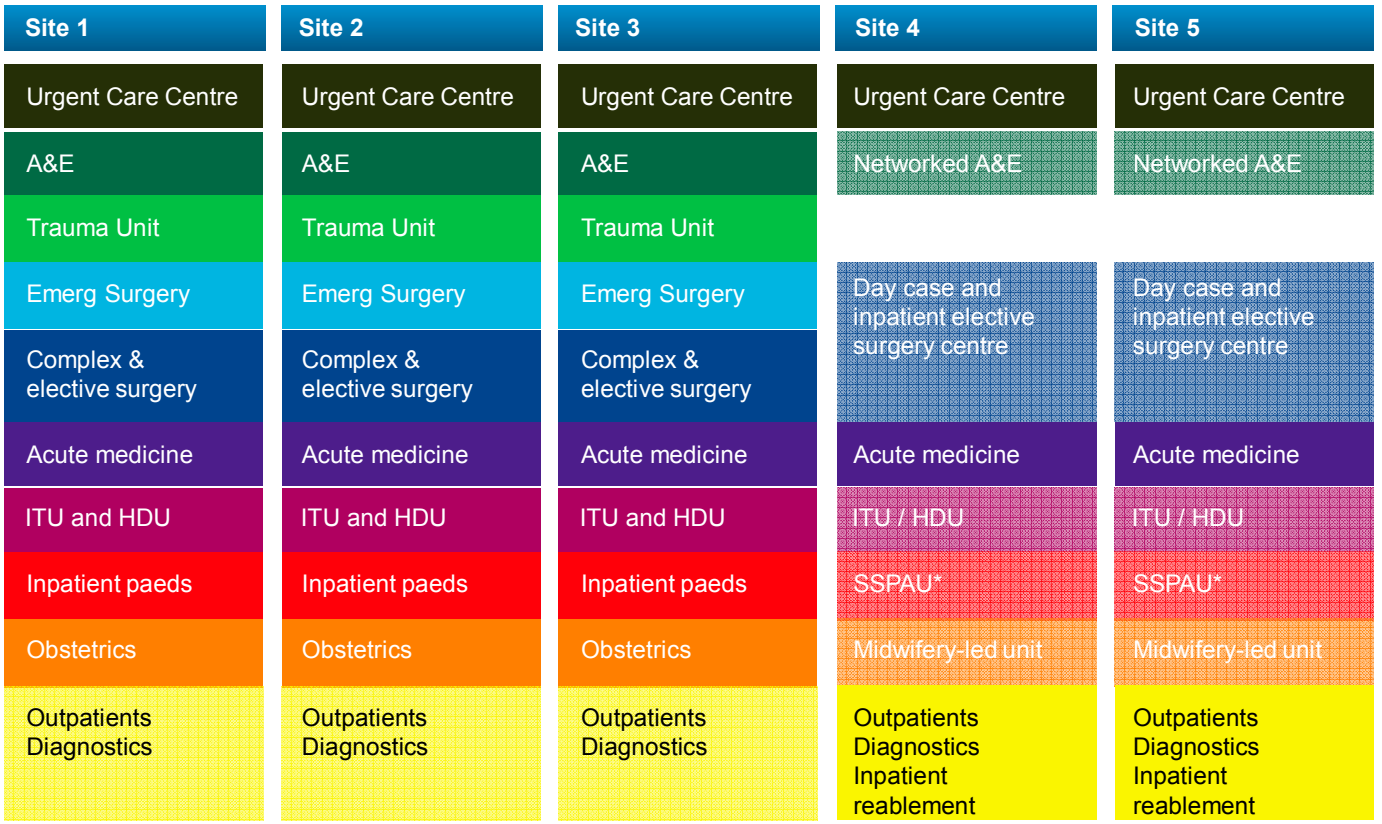
Model 3

Site 1	Site 2	Site 3	Site 4	Site 5
Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre
A&E	A&E	A&E	A&E	Networked A&E
Trauma Unit	Trauma Unit	Trauma Unit	Trauma Unit	
Emerg Surgery	Emerg Surgery	Emerg Surgery	Emerg Surgery	Day case and inpatient elective surgery centre
Complex & elective surgery	Complex & elective surgery	Complex & elective surgery	Complex & elective surgery	
Acute medicine	Acute medicine	Acute medicine	Acute medicine	Acute medicine
ITU and HDU	ITU and HDU	ITU and HDU	ITU and HDU	ITU / HDU
Inpatient paeds	Inpatient paeds	Inpatient paeds	SSPAU*	SSPAU*
Obstetrics	Obstetrics	Obstetrics	Midwifery-led unit	Midwifery-led unit
Outpatients Diagnostics	Outpatients Diagnostics	Outpatients Diagnostics	Outpatients Diagnostics	Outpatients Diagnostics Inpatient reablement

And centralisation of specialist services – specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.
***SSPAU long term sustainability will need to be determined.**

Supported by strengthened Long Term Condition management and out of hospital care strategy

Model 4


Site 1
Site 2
Site 3
Site 4
Site 5
Urgent Care Centre
A&E
Networked A&E
Trauma Unit
Emerg Surgery
Day case and inpatient elective surgery centre
Complex & elective surgery
Acute medicine
ITU and HDU
ITU / HDU
Inpatient paeds
SSPAU*
Obstetrics
Midwifery-led unit
Outpatients Diagnostics
Outpatients Diagnostics Inpatient reablement
And centralisation of specialist services – specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.
*SSPAU long term sustainability will need to be determined.
Supported by strengthened Long Term Condition management and out of hospital care strategy

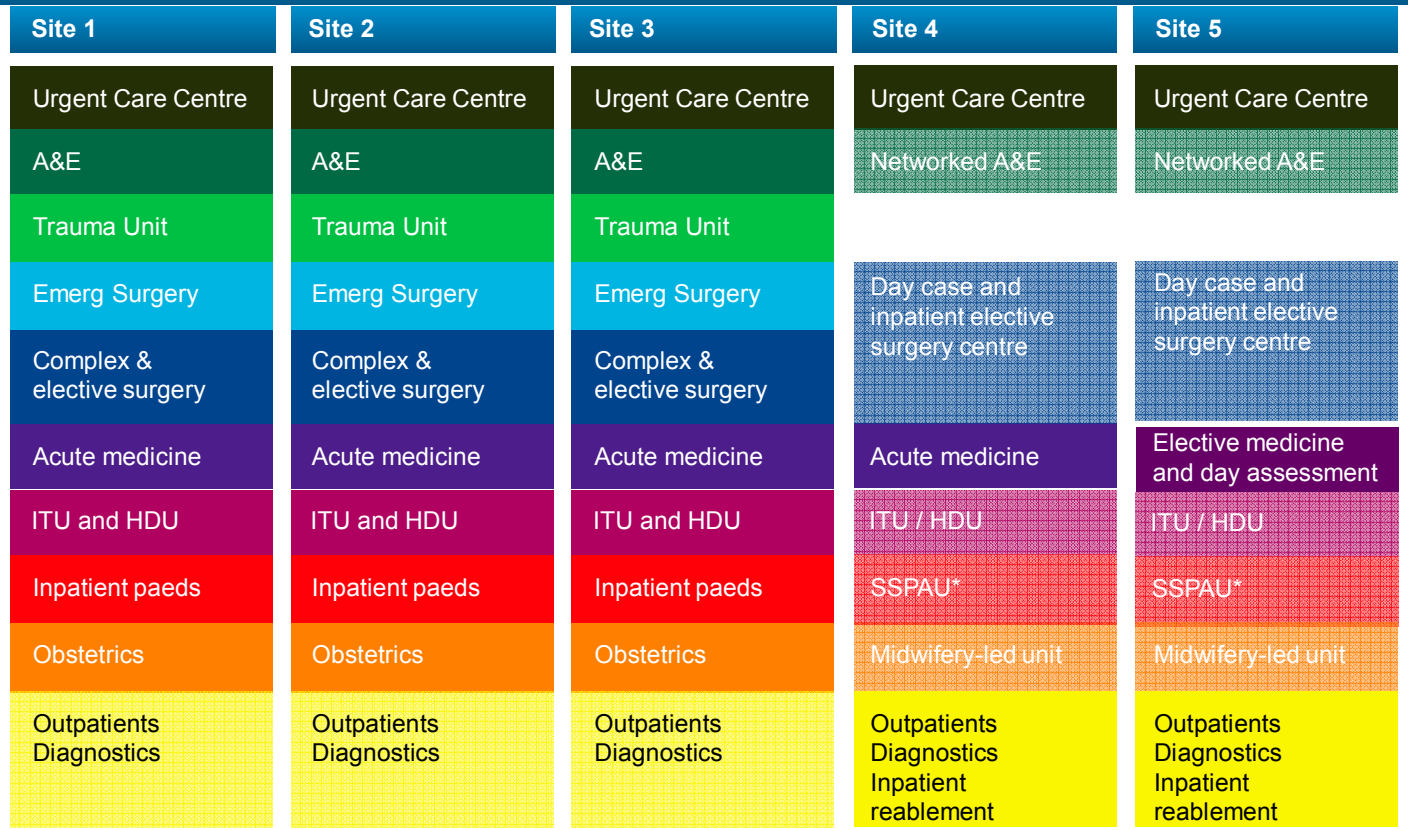
Model 5

Site 1	Site 2	Site 3	Site 4	Site 5
Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre
A&E	A&E	A&E	Networked A&E	Networked A&E
Trauma Unit	Trauma Unit	Trauma Unit		
Emerg Surgery	Emerg Surgery	Emerg Surgery	Day case and inpatient elective surgery centre	Day case and inpatient elective surgery centre
Complex & elective surgery	Complex & elective surgery	Complex & elective surgery		
Acute medicine	Acute medicine	Acute medicine	Acute medicine	Acute medicine
ITU and HDU	ITU and HDU	ITU and HDU	ITU / HDU	ITU / HDU
Inpatient paeds	Inpatient paeds	SSPAU*	Inpatient paeds	SSPAU*
Obstetrics	Obstetrics	Midwifery-led unit	Obstetrics	Midwifery-led unit
Outpatients Diagnostics	Outpatients Diagnostics	Outpatients Diagnostics	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement

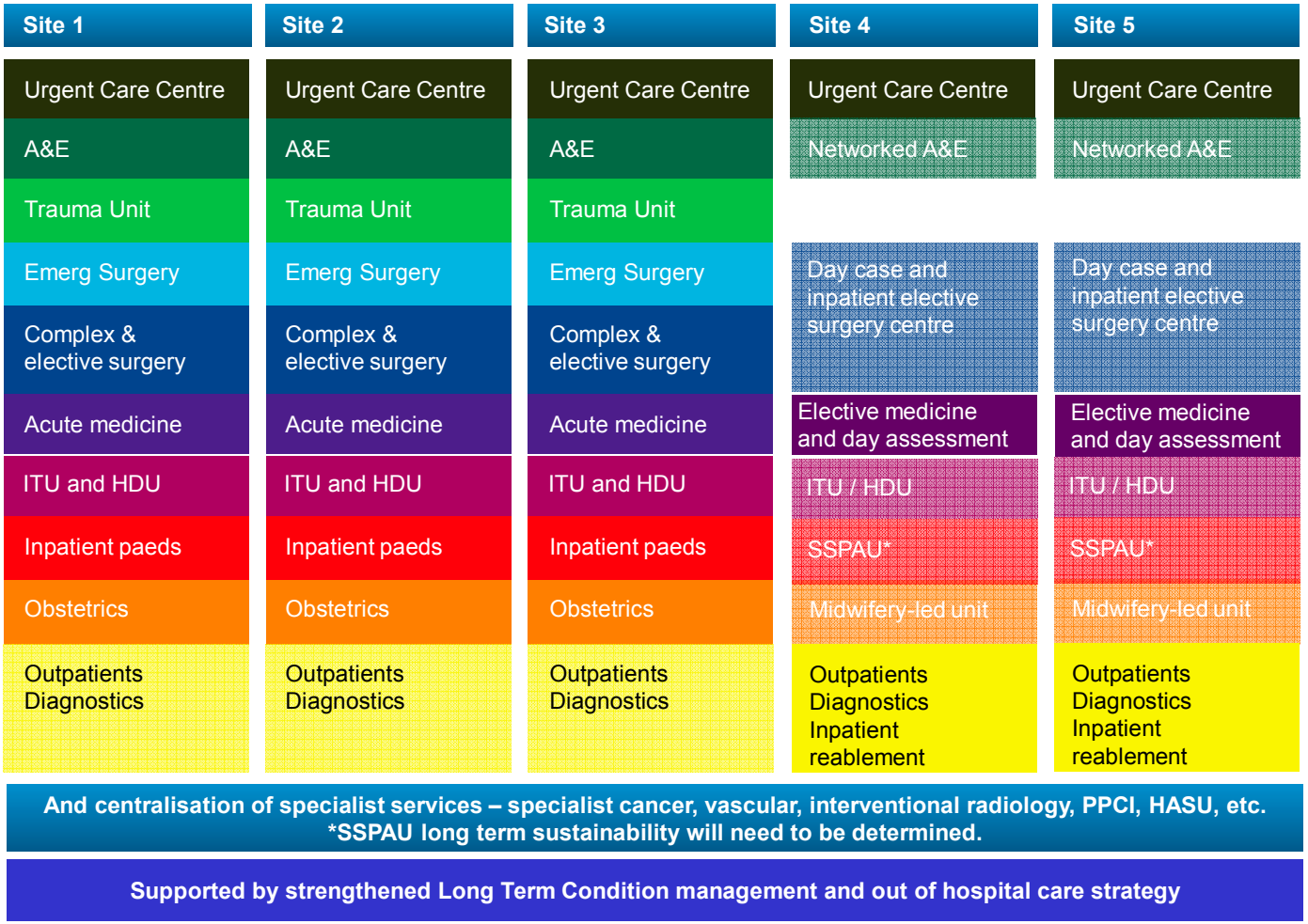
And centralisation of specialist services – specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.
***SSPAU long term sustainability will need to be determined.**

Supported by strengthened Long Term Condition management and out of hospital care strategy

Model 6


Site 1
Site 2
Site 3
Site 4
Site 5
Urgent Care Centre
A&E
Networked A&E
Trauma Unit
Emerg Surgery
Day case and inpatient elective surgery centre
Complex & elective surgery
Acute medicine
Elective medicine and day assessment
ITU and HDU
ITU / HDU
Inpatient paeds
SSPAU*
Obstetrics
Midwifery-led unit
Outpatients Diagnostics
Outpatients Diagnostics Inpatient reablement
And centralisation of specialist services – specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.
*SSPAU long term sustainability will need to be determined.
Supported by strengthened Long Term Condition management and out of hospital care strategy

Model 7


Site 1
Site 2
Site 3
Site 4
Site 5
Urgent Care Centre
A&E
Networked A&E
Trauma Unit
Emerg Surgery
Day case and inpatient elective surgery centre
Complex & elective surgery
Elective medicine and day assessment
Acute medicine
ITU / HDU
ITU and HDU
SSPAU*
Inpatient paeds
Midwifery-led unit
Obstetrics
Outpatients
Diagnostics
Inpatient reablement
And centralisation of specialist services – specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.
*SSPAU long term sustainability will need to be determined.
Supported by strengthened Long Term Condition management and out of hospital care strategy

Healthier Together Summary Engagement Report, March 2013

Introduction

The communications and engagement strategy for the Healthier Together programme has been underpinned by the key principle that nothing can be achieved without authentic patient and public involvement. The aim in delivering the strategy was to ensure 'best practice' and meaningful engagement with staff and all sections of our diverse community, to enable them to influence our work.

The two key objectives of the communications and engagement strategy were:

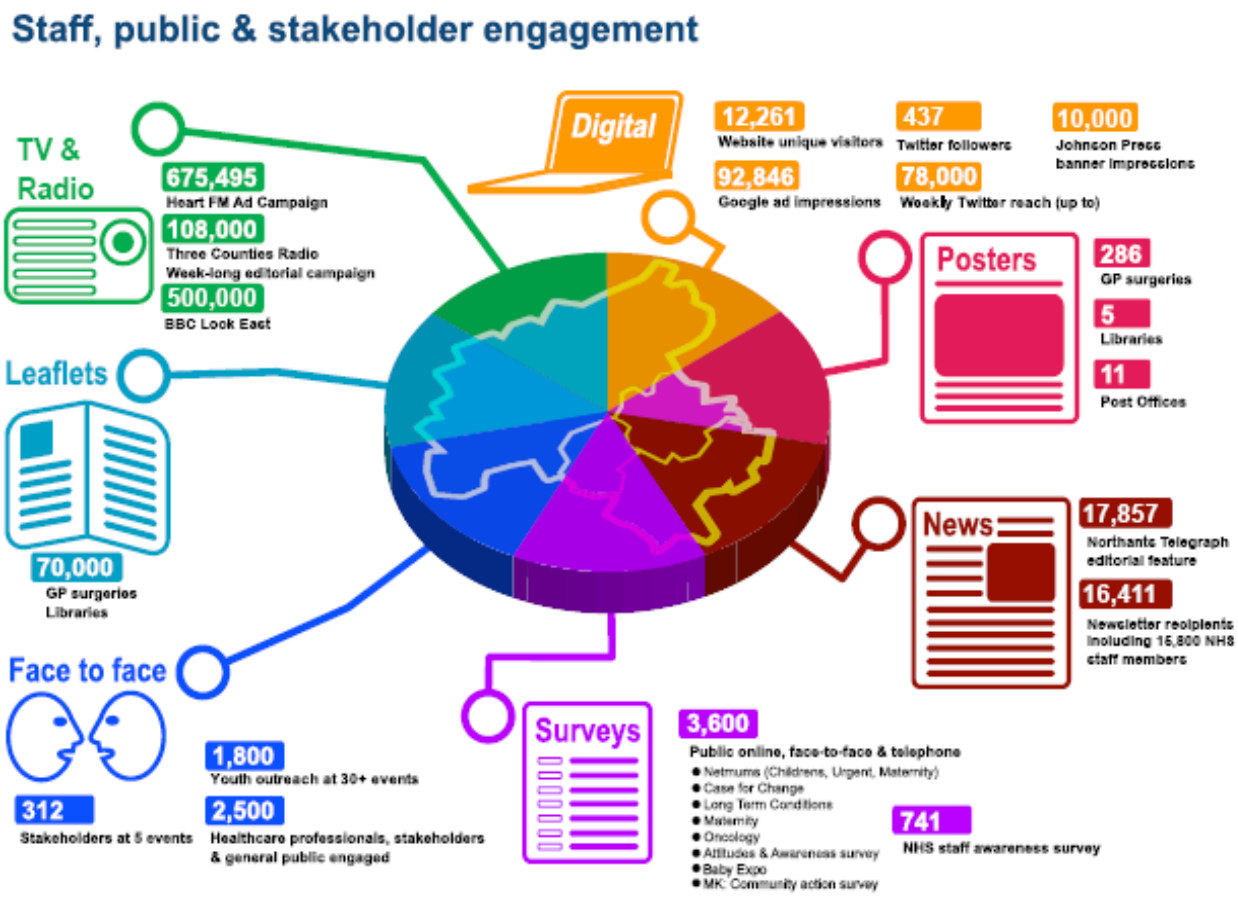
- Ensuring engagement at all levels of the programme
- Raising awareness and understanding of the case for change

The Secretary of State identified four key tests for service change, designed to build confidence within the service, with patients and communities. The tests were set out in the revised Operating Framework for 2010-11 and require existing and future reconfiguration proposals to demonstrate:

- support from GP commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

The Healthier Together communications and engagement strategy was designed to ensure the programme could evidence that it had met these four tests.

A wide range of communications and engagement methods have been used to give people different opportunities to find out more about, and become involved in, the Healthier Together programme. In total, since February 2012, there have been more than 120 public and stakeholder meetings, 16 road shows and 5 deliberative events. The programme has had direct involvement with approximately 12,000 people and the reach of some of our communications led to many more thousands of local people being aware of our messages as the following diagram illustrates:



This paper summarises how engagement was embedded in the programme structure, the issues that were engaged on, the activities undertaken, findings from an independent assessment, a summary of feedback received and how this influenced the work of the six clinical working groups.

Programme structure

Meaningful patient, public and clinical engagement was embedded at all stages and levels of the programme in order to meet statutory requirements and best practice standards.

A Patient and Public Advisory Group (PPAG) with an independent Chair was established to provide advice and assurance that best practice was being followed. The Chair of the PPAG also sat on the Programme Board, Clinical Senate and Commissioners Group. PPAG membership reflected a good geographical balance and included Chairs of LINks, third sector representatives, acute trust governors and patient representatives. More than 200 local hospital clinicians and GPs were directly involved in the programme with many hundreds more involved via local briefings, staff surveys and regular updates.

The PPAG provided the programme with ongoing scrutiny and challenge and an assurance that the patient voice was central to all aspects of the programme's work. Some of the key tasks undertaken by the PPAG included:

- Input and recommendations on the evaluation criteria
- Scrutiny of the communications and engagement strategy
- Comment and guidance on the work of the Clinical Working Groups (CWGs) – each CWG had a PPAG member and undertook their own targeted engagement
- Ensuring communications and literature produced was accessible

- Advising on how stakeholder and public feedback was recorded, presented and used to inform the work

- Advising on travel and transport issues – this was a key area for the PPAG which was regularly reviewed; PPAG members also sat on the Travel and Transport group, helping to develop a travel analysis tool for the SEM area and raising areas of patient concern

Engagement on the Case for Change

Specific engagement on the Case for Change was taken forward with a range of stakeholders, patients, members of the public and NHS staff as part of a multi-layered communications and engagement campaign. The aim was to raise awareness and understanding of the need to change and target audiences included patients, members of the public, NHS staff, hospital clinicians, GPs and stakeholders. Harder to reach groups, such as Black and Minority Ethnic (BME) groups, children and young people, disability and learning disabilities groups, older people forums, faith organisations and carers groups were also engaged directly or through local groups/organisations..

The engagement on the Case for Change took place primarily between February and June 2012 and activities included: a telephone survey of 1,600 local people, deliberative events in each area with a representative sample of the local population, public meetings in each area, an extensive website and new media campaign, road shows, staff events and two stakeholder deliberative events .

The four public deliberative events took place in February and March 2012 in Milton Keynes, Wellingborough, Bedford and Luton. A representative sample of each local area was recruited to attend, ensuring appropriate representation in terms of age, gender and ethnic profile. The events were used to explore:

- Awareness and views of the case for change
- Views on the vision for the future
- Views on the draft evaluation criteria

By the end of each event attendees evidenced a very high awareness of the challenges facing the local healthcare system and strong support for the Case for Change. There was also consistent support for the programme's vision.

Attendees gave careful consideration to draft evaluation criteria discussing the appropriateness or otherwise of the criteria and ranking them in terms of importance. Their feedback was used to develop the final criteria which were later agreed by the Programme Board.

Feedback on the Case for Change

Feedback on the Case for Change clearly showed wide spread acceptance of the need for change to take place and an understanding of the reasons for this. There were a number of themes that were consistently raised:

Travel and transport

- Cost
- Availability of public transport
- Rural/isolated communities

The potential increase in cost of travel for patients, their family and carers was a concern, along with concerns that patients could be further away from home, particularly expectant mothers, children and those reliant on family members for care. Public transport was a significant concern, including the availability, cost and ability for patients and visitors to use public transport services. It was felt that these issues were especially acute for those living in rural areas.

Specialist Centres

There was general support for the development of specialist centres, and an understanding of the benefits this would have on patient outcomes and the quality of care. Concerns raised related to travel and transport issues, and accessibility. A common requirement was for patients to be relocated for rehabilitation at a facility closer to home once the initial treatment or procedure had taken place.

Evaluation criteria

Stakeholders and members of the public were involved in developing, agreeing and ranking the key evaluation criteria to use when assessing draft clinical models. The original criteria discussed were:

- Quality/Safety
- Access
- Sustainability
- Affordability
- Achievability

Feedback from the PPAG and stakeholder/public deliberative events led to the definitions of the criteria being rewritten and the final criteria changing. 'Access' was replaced by two criteria: 'Travel Access' and 'Equity of Access'. This was because it was felt that 'Access' was not explicit enough. In addition it was felt that aftercare and the safety of any journey a patient might have to make, such as travelling further to a specialist centre of excellence, should be an explicit component of the definition of quality/safety. In addition 'Achievability' was changed to 'Deliverability' as it was felt that any proposal had to have the support of GPs and other clinicians in order for it to be implemented effectively.
The final criteria ranked in order of importance were agreed as follows:

- Quality and Safety
- Affordability
- Deliverability
- Sustainability
- Equity of Access
- Travel Access

Engagement on emerging draft clinical models of care

Following the support demonstrated by stakeholders and the public for the Case for Change, the Healthier Together programme engaged on draft clinical models of care, which were developed in response to the work of the CWGs at the end of July 2012. The draft clinical models were not site specific and discussions reflected this.

Initial engagement on the draft clinical models of care was with stakeholders and NHS staff in the five hospitals. This engagement was then widened to include members of the public through online surveys, public meetings, newsletters, new media, road shows and attendance at community group meetings and events.

At a stakeholder deliberative event in July there was broad support for the direction of travel signalled by the draft clinical models. In addition, nine out of ten delegates agreed that Healthier Together had made the Case for Change. Delegates included Clinical Commissioning Group chief executives, chairs of Health &Wellbeing Boards, members of the Joint Health Overview and Scrutiny Committee, LINKs representatives, local councillors, NHS trust chairs, directors and governors.

In addition a public road show took place in early Autumn during which over 800 local people from across the South East Midlands answered specific questions about the themes underpinning the draft clinical models. Overall 683 respondents (almost 80%) who took part in the roadshow told us that they thought that a healthcare system that provides as many services as possible locally and more serious emergency care and specialist care at centres where this led to better results was either good or acceptable. A breakdown of response rates for each geographical area was as follows:

- 177 respondents (85%) from Kettering felt this was either good or acceptable
- 73 respondents (68%) from Corby felt this was either good or acceptable
- 185 respondents (79%) from in Northampton felt this was either good or acceptable
- 87 respondents (88%) from Milton Keynes felt this was either good or acceptable
- 84 respondents (54%) from Luton & Dunstable felt this was either good or acceptable
- 67 respondents (79%) from Bedford felt this was either good or acceptable

Targeted engagement

Targeted engagement with specific community and harder to reach groups included working with children and young people, older people, Long Term Condition groups, BME communities, carers and expectant parents. The Clinical Working Groups also carried out targeted engagement with patients and local people, with patient and public surveys on cancer services, maternity services, children's services and long term conditions. A long term conditions event was held with over 40 representatives from long term conditions groups and charities.

An online survey was hosted by Netmums, the UK's leading online parenting community to seek feedback on maternity services, children's services and emergency services, as well as seeking participants' views and experiences of acute hospital services. In addition a survey was undertaken at the BabyExpo at thecentre:MK over two days in September where a total of 107 questionnaires were completed.

Regular briefings and updates were provided for MPs within the South East Midlands to ensure awareness and understanding of the case for change and work of Clinical Working Groups. Healthier Together regularly responded to parliamentary enquiries from local MPs and where required arranged additional briefing events. This was particularly prudent around the time of the Corby and East Northamptonshire by-election in November 2012. Questions about Healthier Together were also raised in the House of Commons on more the one occasion, including at Prime Minister's question time.

Healthier Together regularly attended local authority full council and sub-committee meetings and district council meetings within the SEM area to ensure elected members and officers were kept informed and engaged in the programme. In addition to this, a Joint Health Overview and Scrutiny Committee was established to provide a statutory scrutiny function, consisting of three councillors and LINk representatives from each local authority area. Regular briefings, presentations and scrutiny sessions have taken place with this committee.

The voluntary and community sector had a central role in delivering targeted engagement work to harder to reach groups. Partnerships with VCS umbrella organisations were established in each area: NVC Northamptonshire, Community Action: Milton Keynes and Voluntary Action Luton (incorporating work across Bedfordshire). For example harder to reach communities in Milton Keynes were engaged through MK Community Action using community mobilisers (community engagement specialists working in areas of socioeconomic deprivation across Milton Keynes). Over 60% of people engaged responded positively when asked if they would travel further to access better care although concerns about the cost of travel were raised.

Engagement with young people was taken forward via activities with colleges in the area such as Barnfield College in Luton, Tresham College, Moulton College, Milton Keynes College, University of Bedfordshire and the University of Northampton. In addition to engagement with local authority Young Person Parliaments and Councils, a pilot piece of work was been established in Northamptonshire with the Children and Young People's Partnership Board on a peer research project. A small group of young people designed and delivered focus-group type discussions with their peers through school parliament/councils or local youth group. So far, two focus groups have been completed, one with the Children in Care Forum and another with Bishop Stopford School Council. Three further focus groups are planned, one being with members of the Shadow Partnership Board.

Engagement took place with over 40 attendees at carers cafes organised by Carers in Bedfordshire. Attendees gave useful insightful into their experience of accessing healthcare services as both carers.

Media coverage of Healthier Together

The importance that members of the public attach to safe, accessible and reliable NHS services in their locality is reflected in the high news value that all media attach to health issues.

Healthier Together has consistently attracted local and regional media coverage since the programme's launch in February 2012. Coverage was at its most dense during the Corby

parliamentary by-election campaign when the future of Kettering General Hospital became an important issue of debate and contention between, particularly, Labour and Conservative candidates.

A key characteristic of Healthier Together coverage in local print titles has been the desire expressed by local politicians, patients and residents to see the retention of all acute services locally. Media portrayal of potential service reconfiguration has focused on the negative effect of longer patient journeys rather than the positive benefits of improved patient outcomes and the need to secure financial and clinical sustainability.

Healthier Together has sought to generate balanced coverage through pro-active media releases and one-to-one media briefings whenever possible. Notable examples of this positive approach include a week long feature on Healthier Together by BBC Radio Three Counties and BBC Radio Northampton, an out-of-hospital care initiative broadcast on BBC Look East in January 2013, a background article published by Health Service Journal in November 2012, and consistently balanced and informed coverage in the Northants Telegraph and Northampton Chronicle and Echo.

Independent review of engagement

Participate UK were commissioned to undertake an independent review of the progress of the engagement and communications work stream. An interim report and interim stakeholder survey were produced in August and October 2012 respectively and a final report will be produced at the end of this phase of the Healthier Together programme.

Evidence from the interim report and survey suggests that stakeholders such as Health and Wellbeing Boards, the Joint Overview and Scrutiny Committee, LINks and GPs were satisfied that they were being kept informed of progress and responses to the patient and public engagement.

The interim report concluded that "Healthier Together has taken more than appropriate steps to ensure that people know what is happening and how they can participate. The use of online and social media is particularly encouraging and the Healthier Together website should be applauded as a good practice example." It said that Healthier Together had taken "considerable steps" to reach people through traditional media and that the Healthier Together team was doing a "good job" in responding to requests for meetings and face-to-face events. The full report is available on the Healthier Together website.

Summarising feedback

Key themes emerging from the feedback received from the patient and public engagement undertaken since February 2012 are as follows:

*safety and quality of services are valued as more important than any other aspect of care – including access and transport

*there is increasing recognition that not all specialist services can be provided at local district general hospitals

*moving routine, non-emergency procedures out of hospital into community settings has the overwhelming support of patients and carers

* travel and transport issues are a concern for many people

Theme	Summary of feedback
Case for Change	• Widespread agreement with the need for change and understanding of current pressures • Quality of care is highest on people's agenda and they are willing to travel further for better outcomes • Support for providing care closer to home • NHS staff concerned about impact of service change on local growing population and quality of care – particularly in North Northants
Travel and transport	• Potential rise in costs for patients/carers a concern • Availability, access and cost of public transport could impact on some

	patients ability to access care • Appropriate support needs to be in place – particularly for less-able patients, carers and relatives of children • Concerns over ability of Patient Transport Services to meet additional patient needs
Specialist centres	• General acceptance of the reasons and benefits of specialist centres being established • A range of concerns relating to travel, transport and access • Rehabilitation should be as close to home as possible • Concerns raised over impact on patient outcomes in time-sensitive/emergency situations • Queries regarding the impact of reconfiguration on hospitals surrounding the South East Midlands
Draft clinical models of care	• Broad support for direction of travel from stakeholders • Acceptance that all services can not be offered at all hospitals to the best clinical standards • Concerns raised about having to travel further in an emergency • Some concerns over patient safety relating to any reduction in obstetric led maternity units • This was countered by overwhelming support for the model from new mums at the BabyExpo in Milton Keynes as evidenced by response to questionnaire • Strong support for more services in the community • Concerns from children and young people that if they need to be admitted as inpatients they could be further away from home – concerns about visiting, contact and support from family and friends
Coordinated care for LTC/elderly	• General support for more joined up services – particularly between health and social care services • Multi-disciplinary teams seen as a possible solution • Examples of good practice should be used and built upon • Third Sector/Voluntary and Community Sector organisations need to be involved more in planning and delivery of services/additional support for patients
Care closer to home	• Strong support for better provision of test and diagnostic facilities closer to home • Outpatient clinics and appointments should be available at local GP practice/health centre • Support for more non-emergency routine procedures to be carried out in a community setting rather than hospital
Communications/ patient choice	• More involvement of patient and carers in decisions on treatment and health • More appropriate and understandable patient information is needed • Concerns raised over the provision of care for vulnerable patients in hospital

The themes from the engagement carried out can be used by CCGs to inform and shape any localised draft proposals as work continues on a more localised basis.

Impact of communications and engagement

Feedback from Healthier Together's engagement and communications activity has helped to inform and support the work of the programme's six Clinical Working Groups (CWGs). The following table illustrates how engagement feedback has had specific influence on the recommendations of the CWGs.

Engagement feedback	CWG conclusions
*Clinical excellence Engagement with patients, local people, stakeholders and NHS staff has consistently identified quality and safety as the most important factor in considering service reconfiguration. In February and March 2012, quality and safety was identified as the most important criterion at four public deliberative events. In the Spring/early summer 2012, 70 per cent of participants in a survey of hospital staff and GPs ranked quality and safety as most important. A participant at the stakeholder event held in July to consider draft strategic models commented: "Acknowledging the message around travel will be very difficult because it means much more awkward travel in a complex situation but ask anyone and safety is the main thing up front so I buy it." In the summer of 2012, 60% of respondents to a survey carried out by Community Action in Milton Keynes responded positively to the notion of traveling further for specialist care if patient outcomes were improved. One respondent commented: "I would travel for all services if it meant my children would get better care." In September 2012, 79 per cent of respondents to a questionnaire at the BabyExpo event in Milton Keynes said the most important aspect was receiving the appropriate level of maternity care – even if it meant travelling further.	*Clinical excellence A top priority for CWGs is to ensure that services covering the South East Midlands should meet contemporary national standards of safety and service, such as the Royal College of Obstetricians and Gynaecologists Standards for Medical Care and College of Emergency Surgeons guidelines. No hospital within the SEM currently meets these standards. This commitment is reinforced by the reports of all six clinical working groups which will act as the evidential foundation for the next phase. A set of criteria, shaped by feedback from clinicians, patients and the public, to evaluate reconfiguration proposals has been developed. The criteria, in order of importance, were as follows: • Quality and safety • Affordability • Deliverability • Sustainability • Equity of Access • Travel Access
*Location of services/specialised units Respondents have consistently reported that patient outcome was more important than location of services/specialised units, Participants at public deliberative events in February expressed the view that location of maternity services was less important than good outcomes for families. In addition, they identified the importance of good access to specialist support 24/7 and particularly at weekends. There was recognition that not all specialist services could be provided at all hospitals. A participant at an event in Luton said: "As much as we would like every service at every hospital, we have to accept that is not possible." In a survey of local members of Netmums, the UK's leading online parenting community, carried out in May 2012, respondents were asked to rank	*Location of services/specialised units All Clinical Working Groups have reported their commitment, wherever appropriate, to deliver care as close to home as possible. In the large majority of cases that will be through the five district general hospitals in the South East Midlands or even closer to home by taking services out of hospital and delivering them through community settings. This is highlighted particularly in the reports of the Children's, Long Term Conditions and Planned Care working groups. Specialist centres of excellence should only be established when there is clear clinical evidence that this would result in improved patient outcomes. .

five elements of maternity service in order of importance. Seeing the same midwife was ranked one; having a specialised unit in one place with more expertise and equipment was ranked two.	
*Access to A&E Patient and public members of the Emergency CWG raised concerns about the potential impact of increased journey times. Participants at the July stakeholder's workshop supported in general the principle proposals for a networked system including three main A&E departments. Comments included a belief that the proposed system would be acceptable – "if 80 per cent or patients are still seen where they arrive".	*Access to A&E Under the draft clinical models being considered around 80 per cent of patients would continue to be treated at the same A&E sites. Additional patients could be treated closer to home through the development of new community facilities – for example Corby Urgent Care Centre. Concentration of expertise in fewer locations would strengthen 24/7 consultant coverage against a background of limited human resource and difficulties in recruiting qualified experienced consultants..
*Access to cancer care Patient representatives on the Cancer CWG said "Care should be delivered as locally to the patient as possible without compromising on quality." Cancer patient respondents to a Healthier Together survey carried out in February and March 2012 identified waiting times as the most important aspect for improvement (39 per cent) against treatment closer to home (8per cent). Participants at a stakeholder's workshop in July raised some concerns about the cost of transport to specialist centres further afield – particularly in accessing radiotherapy treatment from east Bedfordshire.	The generic cancer pathway developed by the CWG proposes that a greater amount of follow-up care could be provided in primary care or in the community under the guidance of enhanced protocols. The Cancer CWG report also contains a commitment to improve access to treatments including radiotherapy and chemotherapy through local community facilities. Both these measures are intended to reduce the onus of transport and travel on local cancer patients and their families/carers. The CWG recognises that concentrating resources on centres of excellence can reduce waiting times and improve outputs but also lead to longer journeys.
*Access to planned care 151 people with recent experience of planned care services responded to a Healthier Together survey. They ranked access to experts as more important than services closer to home and services in one place. Patient members of the CWG identified the importance of delivering care as locally as possible "providing this does not impact on quality".	*Access to planned care The Planned Care CWG recognises that patients may have to travel to a centre of excellence for some specialised inpatient services. While recognizing the impact of longer journeys on some patients and their families, the group believes that the benefits of improved outcomes and potentially shorter waiting times outweighed potential disadvantages. As a balance, some services including all outpatients will continue to be available locally – and, potentially even closer to home through delivery at community facilities. The CWG has identified some services currently provided out of the region that could be repatriated within the SEM through the development of specialist centres.
*Access to care for Long Term Conditions	*Access to care for Long Term Conditions

63 per cent of respondents to a CWG-commissioned survey in June 2012 reported that GP practices and local clinics were their preferred location for future care. Some patient feedback suggested that GP practice hours should be extended to 24/7. DoH national consultation on LTC pathways identified that patients did not want to be in hospital unless absolutely necessary.	The CWG endorses the use of the national generic integrated pathway for LTCs. Under this pathway the majority of care would be delivered through primary care or community environments with less reliance on hospital-based care leading to significant bed reductions. The group also identified examples of where the transformation of LTC services from hospital to community based is already in place or being developed in parts of the SEM. The CWG supports the development of self-help community hubs.
*Access to children's services In a survey of local members of Netmums, the UK's leading online parenting community, carried out in May 2012, respondents ranked access to expert/specialist care as their most important priority when using NHS children's services. Participants at a stakeholder workshop in July were concerned about the increased costs of travel if specialist centres were established at only three centres as well as transport issues for children needing to access emergency care. However, participants at the event also expressed approval of the principle of caring for children with long term conditions in the community and not in hospitals.	*Access to specialist services The Children's CWG recognises that, owing to resource constraint, it is not possible to provide specialist services on all five hospital sites. In addition, the group recognises the need to build an enhanced skills base at community level. In its report, the CWG stated that critical and less common paediatric care was likely to be provided in fewer centres where expertise could be concentrated. The CWG has maintained a commitment, wherever appropriate, to deliver children's care in the community rather than in hospital. This would minimise transport demands on both children and their families. In addition, the group has identified the key principle of minimising the transfer of sick children and the need to establish consistent pathways for travel, assessment treatment and transfer.
*Maternity care Participants at four public deliberative events held in February and March expressed the view that location of maternity services was less important than good outcomes for families. In addition, they identified the importance of good access to specialist maternity support 24/7 and at weekends whenever it was needed. Comments from the survey included: "Access to specialist/expert care quickly" "All the services I need are in one place" In a survey of local members of Netmums, the UK's leading online parenting community, carried out in May 2012, respondents were asked to rank five elements of maternity services in order of importance. Having a specialised unit in one place with more expertise and equipment was ranked	*Maternity care The CWG has concurred that a variety of environments was needed to meet guidelines set out by the ROCG's report "High Quality Women's Care: A Proposal For Change". These include the principle that women should receive the right treatment at the right time in the right place from the right person according to the needs of themselves and their babies. The group's report to the Clinical Senate in July 2012 identified four birth environments. They are: at home with care provided by a midwife; in a stand-alone midwife-led unit; in a midwife-led unit operating alongside a consultant obstetrician unit; in an obstretrician-led unit. In its report of initial findings to the Clinical Senate, the Maternity CWG supported a model including three consultant-led units which would concentrate

second (behind seeing the same midwife).	specialist knowledge to deliver complex care.

As this report demonstrates, patient and public engagement has been embedded throughout the Healthier Together programme and has been a key factor in the development of the recommendations of the Clinical Working Groups. The programme can demonstrate that the Clinical Working Groups have taken account of the views and feedback received from a wide variety of sources and this is evidenced by their final reports.

Ongoing engagement will now be taken forward by the individual CCGs. The Programme Board is asked to note the impact of the extensive patient and public engagement that has taken place and its influence on the work of the Clinical Working Groups.

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Healthwatch Central Bedfordshire – Context and Activities
Meeting Date:	9 May 2013
Responsible Officer(s)	Ruth Featherstone, Chair
Presented by:	Ruth Featherstone

Action Required:

1. note the Healthwatch work and progress to date for information and consideration by the Board.

Executive Summary	
1.	**This Report is submitted to the Board for information only** **1. The Report outlines the activities and proposed development of Healthwatch Central Bedfordshire.** **2. The intention is to improve services and make sure that the patient or service user is at the heart of the new health and care system and is never forgotten or relegated.** **3. The activities are set out together with the relationships to be fostered in order to achieve this in the context of Healthwatch Central Bedfordshire.**

Background	
2.	The creation of Healthwatch Central Bedfordshire as part of the network of local Healthwatch organisations
	REPORT
3.	This Report is the first Report of Healthwatch Central Bedfordshire to the Health and Wellbeing Board and seeks to explain the relationship between our local Healthwatch and Healthwatch England and outlines the activities and proposed development of Healthwatch Central Bedfordshire. .

4.	Healthwatch Central Bedfordshire came into existence on 1 April 2013. An independent panel met and a Chair has been appointed. Healthwatch is the new consumer champion for health and social care in England. It is to give people a powerful voice making sure their views and experiences are heard by those who run, plan and regulate health and social care services. The intention is to improve services and to make sure that the patient or service user is at the heart of the new health and care system and is never forgotten or relegated.
	Healthwatch is made up of two parts; the nationally focused Healthwatch England and 152 community focused local Healthwatch. Together they form the Healthwatch network working closely to ensure consumers' views are represented nationally and locally.
	Healthwatch is both proactive and reactive and the defined activities of Healthwatch Central Bedfordshire reflect this as follows:
	1. Gathering views and understanding the experiences of people who use services, carers and the wider community We will achieve this by: • gathering information that is already available and working with other community groups to understand local views and experiences of health and care services • actively seeking the views of those people whose views are seldom heard • sharing information • working in collaboration with the Care Quality Commission • developing good relationships and working with other local Healthwatch organisations through Healthwatch England and independently • developing skills to understand and interpret data and information collating information to be used as evidence to support recommendations to Healthwatch England and the CQC
	2. Making people's views known We will achieve this by: • identifying existing channels to avoid unnecessary duplication • developing effective and varied methods of gathering views from local and national sources particularly where there are gaps • being responsive to what we find out and reporting on developments • publishing findings and making them accessible

	• identifying causes for concern or celebration in our area and feeding back findings on these to the CQC and local commissioners as part of a regular and ongoing dialogue • using people's views to influence decision-making bodies such as local commissioning groups, the Health and Wellbeing Board and through Healthwatch England, the CQC, national regulators and the Secretary of State
	3. Promoting and supporting the involvement of local people in the commissioning of local care services and how they are scrutinized To achieve this Healthwatch Central Bedfordshire will need to assert its independence and build its credibility and knowledge base and demonstrate its success to the local community. Visibility is crucial to ensure that it : • is easy to reach • is inclusive of all groups within its community • respects, involves and works with existing networks • encourages membership of Healthwatch Central Bedfordshire • offers support and training to its staff and volunteers on equality and diversity legislation, safeguarding and information gathering • carries out "enter and view" visits and the purpose is understood and respected • develops meaningful dialogue across the local health and care system • maintains a constructive relationship with the Health and Wellbeing Board by maximising the opportunity presented by having a full representative on the Board • makes a valuable contribution to the Joint Strategic Needs Assessment
	4. Recommending investigation or special review of services through Healthwatch England or directly to the Care Quality Commission To ensure this Healthwatch Central Bedfordshire will: • agree and establish timely two way information flows with Healthwatch England and Healthwatch Central Bedfordshire • use protocols for good information governance • ensure that urgent concerns are escalated • enshrine the NHS Constitution as the benchmark of NHS service-users'

	rights • understand CQC's essential standards of quality and safety • be aware of good practice such as outlined in Think Local Act Personal
	5. Providing advice and information about access to services and support for making informed choices To be effective Healthwatch Central Bedfordshire will: • identify what information already exists and how to access it • identify unmet needs so gaps can be filled • be up to date in accessing latest information and where to direct people • build awareness of Healthwatch Central Bedfordshire • understand the concept of personalisation • develop relationships with commissioners and providers • make sure information is accessible • use social networking to access groups that would otherwise be under represented • have the capacity and systems to direct people to services they require ensure that it provides feedback
	6. Making the views and experiences of people known to Healthwatch England and Local Healthwatch organisations It is crucial for Healthwatch Central Bedfordshire to have a close two way relationship with Healthwatch England to strengthen Healthwatch England's role as national champion. In order to provide a steer to Healthwatch England, Healthwatch Central Bedfordshire will: • have robust protocols for keeping HWE up to date with issues and concerns • ensure that all contacts are meaningful • influence the emphasis of Healthwatch England's work • be accountable to Healthwatch England • identify for Healthwatch England local matters with wider significance • ensure that Healthwatch Central Bedfordshire's contribution to national outcomes are evaluated

	• foster its own independence by enshrining clear rules of engagement , self assessment tools, etc. Healthwatch England provides leadership, support and advice to Healthwatch Central Bedfordshire so we can be strong ambassadors for local people and develop strong partnerships across our community.

Issues	
Strategy Implications	
7.	Healthwatch's work is aligned to the Health and Well Being Strategy in terms of improving outcomes for the most vulnerable and is an advocate for early intervention and prevention in terms of health and well being.
8.	The objectives in the Healthwatch report are in line with the main themes within the JSNA and the BCCG strategy.
Governance & Delivery	
9.	Central Bedfordshire Council is responsible for contracting support arrangements for the independent Healthwatch. Central Bedfordshire is responsible for commissioning Healthwatch under the Health and Social Care Act 2012.
Management Responsibility	
10.	Central Bedfordshire Council is responsible for contracting support arrangements that enables the work of the Healthwatch which is overseen by the Healthwatch Board.
11.	Commissioning Healthwatch Central Bedfordshire is a duty for the Local Authority under the Health and Social Care Act 2012. Management of this process is via a multi-agency Steering Group which also is responsible for leading the development of Healthwatch Central Bedfordshire. Updates on progress on commissioning Healthwatch to the Health and Well Being Board will be through the Director of Social Care, Health and Housing.
Public Sector Equality Duty (PSED)	
12.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

	Are there any risks issues relating Public Sector Equality Duty	No
	No	Yes *Please describe in risk analysis*

Risk Analysis

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

Source Documents	**Location (including url where possible)**

Presented by Ruth Featherstone

Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	**Board Development and Work plan 2013 -2014**
Meeting Date:	21 March 2013
Responsible Officer(s)	Richard Carr
Presented by:	Richard Carr

Action Required: That the shadow Health and Wellbeing Board:

1. considers and approves the work plan attached, subject to any further amendments it may wish to make.

Executive Summary	
1.	To present an updated work programme of items for the Health and Well Being Board for 2013 -2014.

Background	
2.	Health and Wellbeing Boards are a requirement under the Health and Social Care Act 2012. The Board brings together key local commissioners for health, social care and public health. It provides strategic leadership and will promote integration across health and adult social care, children's services, safeguarding and the wider local authority to secure high quality and equitable health and wellbeing outcomes for the population of Central Bedfordshire.
3.	The Work Plan is designed to ensure the Health and Wellbeing Board is able to deliver its the statutory responsibilities and key projects that have been identified as priorities by the Board.

Work Programme	
4.	Attached at Appendix A is the currently drafted work programme for the Board.
5.	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.

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

Issues	
Strategy Implications	
1.	The Health and Wellbeing Board is responsible for the Health and Wellbeing Strategy. The work plan contributes to the delivery of priorities of the strategy,
2.	The Work plan includes key strategies of the Clinical Commissioning Group.
Governance & Delivery	
3.	The work plan takes account the duties set out the Health and Social Care Act 2012 and will be carried forward when the Board assumes statutory powers from April 2013.
Management Responsibility	
4.	The Chief Executive of Central Bedfordshire Council is responsible for work plan and development of the Health and Wellbeing Board.
Public Sector Equality Duty (PSED)	
5.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
	Are there any risks issues relating Public Sector Equality Duty Yes/No
	No Yes *Please describe in risk analysis*

Risk Analysis
A forward work plan ensures that the Health and Wellbeing Board remains focused on key priorities areas and activities to deliver improved outcomes for the people of Central Bedfordshire.

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

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

Source Documents	**Location (including url where possible)**

Presented by Richard Carr

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Appendix A

Work Programme for Shadow Health and Wellbeing Board

Ref	Issue for Decision	Intended Decision	Indicative Meeting Date	Documents which may be considered	Contact Officer (method of comment and closing date)
1.	Safeguarding and Patient Safety	To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy.	18th July 2013		Julie Ogley (Director of Adult Social Care, Health and Housing, CBC) Anne Murray (Director of Quality and Safety, BCCG) Contact Officers: Emily White (Safeguarding Vulnerable Adults Manager, CBC) and Clare Sanders (Deputy Director, BCCG)
2.	Improving mental health for children and their parents	To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy.	18th July 2013		Dr Diane Gray (Director of Strategy and System Redesign, BCCG) Contact Officer: Jane Hainstock (Head of Partnership Commissioning, BCCG)
3.	Community Beds Review	To receive and comment upon the outcomes of the review	18th July 2013		Dr Diane Gray (Director of Strategy and System Redesign, BCCG)

Ref	Issue for Decision	Intended Decision	Indicative Meeting Date	Documents which may be considered	Contact Officer (method of comment and closing date)
4.	Working Together	To consider the implications of review guidance	18th July 2013		Edwina Grant (Director of Children's Services and Deputy Chief Executive, CBC) Contact Officer: Sue Tyler (Acting Assistant Director of Health, Children's Services, CBC)
5.	Improving mental health and wellbeing of adults	To consider a report detailing why Central Bedfordshire is behind benchmark and the actions in place to address this.	18th July 2013		Julie Ogley (Director of Adult Social Care, Health and Housing, CBC) Jane Hainstock (Head of Partnership Commissioning, BCCG)
6.	Reducing Teenage Pregnancy	To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy.	5th September 2013		Muriel Scott (Director of Public Health) Contact Officer: Celia Shohet, AD Public Health
7.	Annual Report Local Safeguarding Childrens Board	To receive and comment on the annual report.	5th September 2013		Edwina Grant (Director of Children's Services and Deputy Chief Executive) Contact Officer: Phil Picton, Independent Chair of the Central Bedfordshire

Ref	Issue for Decision	Intended Decision	Indicative Meeting Date	Documents which may be considered	Contact Officer (method of comment and closing date)
					Safeguarding Children Board
8.	Impact of Welfare Reforms	To receive and comment on the Welfare Reforms	5th September 2013		Julie Ogley (Director of Adult Social Care, Health and Housing, CBC)
9.	Improving the health of Looked After Children	To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy.	24th October 2013		Anne Murray (Director of Quality and Safety, BCCG) Contact Officer: Clare Sanders (Deputy Director, BCCG)
10.	Follow up report – the implications for high dependency children and young people of the special educational needs reform		24th October 2013		Edwina Grant (Director of Children's Services and Deputy Chief Executive, CBC) Contact Officer: Edwina Grant
11.	Reducing Childhood Obesity	To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy.	19th December 2013		Muriel Scott (Director of Public Health) Contact Officer: Celia Shohet, AD Public Health
12.	Update on Progress to reducing inequalities		14 Feb 2014		Muriel Scott (Director of Public Health) Contact officer: Celia Shohet, AD Public Health
13.	Governance and	To consider a report detailing the governance	TBC		Julie Ogley (Director of Adult

Ref	Issue for Decision	Intended Decision	Indicative Meeting Date	Documents which may be considered	Contact Officer (method of comment and closing date)
	delivery of the Improving outcomes for Frail Older People	arrangements and the delivery of this element of the Joint Health and Wellbeing Strategy			Social Care, Health & Housing, CBC) John Rooke, Chief Operating Officer, BCCG
14.	Transition arrangements for High Dependency Children to Adult Social Care		TBC		Julie Ogley (Director of Adult Social Care, Health & Housing, CBC) and Edwina Grant (Director of Children's Services and Deputy Chief Executive, CBC)
15.	Annual Assessment of CCGs	To receive a report on the annual assessment process for the CCG	TBC		John Rooke (Chief Operating Officer, BCCG)

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.

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