This meeting may be filmed.*

Central Bedfordshire Health and Wellbeing Board

Agenda

Meeting Title:	Central Bedfordshire Health and Wellbeing Board
Date:	Thursday, 2 October 2014
Time:	1.00 p.m.
Location:	Council Chamber, Priory House, Monks Walk, Shefford

1. **Apologies for Absence**

   Apologies for absence and notification of substitute members

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

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

3. **Minutes**

   To approve as a correct record the Minutes of the last meeting held on 5 June 2014 and note actions taken since that meeting.

4. **Members' Interests**

   To receive from Members any declarations of interest.

HEALTH AND WELLBEING STRATEGY

Item	Subject	Page Nos.	Lead
5.	**Executive Summary of the Joint Strategic Needs Assessment** To receive the annual update of the executive summary of the Joint Strategic Needs Assessment.		
6.	**Joint Health and Wellbeing Strategy Refresh** To approve the proposed priorities and outcomes for the Joint Health and Wellbeing Strategy.	11 - 16	

7. **Better Care Fund**

To consider the transfer of 2014/15 funds and to receive the terms of reference for the Commissioning Board.

8. **Review of Health Services in Bedfordshire and Milton Keynes - Update**

To receive a report on the review of Health Services in Bedfordshire and Milton Keynes.

9. **Central Bedfordshire Winterbourne View Programme - Work Area Update** 17 - 34

To receive a progress report on the delivery of Winterbourne View Joint Action Plan.

OTHER BUSINESS

Item	Subject	Page Nos.	Lead
10.	**Annual Director of Public Health Report** To receive the Director of Public Health's annual report and the implications for Central Bedfordshire.	35 - 76	
11.	**Central Bedfordshire Safeguarding Children Board: Annual Report 'The effectiveness of partner's work to safeguard and promote the welfare of children in Central Bedfordshire' from 31 March 2013 to 31 March 2014** To receive the annual report of the Local Safeguarding Children's Board.	77 - 118	
12.	**Protocols for Managing the Relationship between the Health and Wellbeing Board and the Local Safeguarding Children Board** To receive a report on the proposed protocols governing the relationship between the Local Safeguarding Children's Board and the Health and Wellbeing Board.	119 - 132	
13.	**Healthwatch Central Bedfordshire** To receive an update from Healthwatch Central Bedfordshire.	133 - 140	
14.	**Pharmaceutical Needs Assessment** To receive the executive summary of the	141 - 144	

Pharmaceutical Needs Assessment prior to public consultation.

15. **Public Participation**

To receive any questions, statements, or deputations from members of the public in accordance with the procedures as set out in Part A4 of the Council's Constitution.

16. **Board Development and Work Plan 2014-2015** 145 - 152

To consider and approve the work plan.

A forward 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.

To: Members of the Central Bedfordshire Health and Wellbeing Board

Dr J Baxter	Director, Bedfordshire Clinical Commissioning Group
Mr R Carr	Chief Executive, Central Bedfordshire Council
Mr C Ford	Director of Finance, NHS Commissioning Board Area for Hertfordshire & South Midlands
Mrs S Harrison	Director of Children's Services, Central Bedfordshire Council
Dr P Hassan	Accountable Officer, Bedfordshire Clinical Commissioning Group
Cllr Mrs C Hegley	Executive Member for Social Care, Health and Housing, 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
Mr R Smith	Interim Chairman, Healthwatch Central Bedfordshire
Cllr Mrs P E Turner MBE	Executive Member for Partnerships, Central Bedfordshire Council
Cllr M A G Versallion	Executive Member for Children's Services, Central Bedfordshire Council

please ask for	Sandra Hobbs
direct line	0300 300 5257
date published	18 September 2014

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CENTRAL BEDFORDSHIRE COUNCIL

At a meeting of the **HEALTH AND WELLBEING BOARD** held in Council Chamber, Priory House, Chicksands, Shefford on Thursday, 5 June 2014

PRESENT

Cllr Mrs P E Turner MBE (Chairman)
Cllr Dr P Hassan (Vice-Chairman)

Mr R Carr	Chief Executive
Ms R Featherstone	Chair - Healthwatch Central Bedfordshire
Mr C Ford	Director of Finance, NHS Commissioning Area Team for Herts & South Midlands
Mrs E Grant	Deputy Chief Executive/Director of Children's Services
Cllr 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
Cllr M A G Versallion	Executive Member for Children's Services

Apologies for Absence: Dr J Baxter
Mr J Rooke

Members in Attendance: Cllrs Mrs R J Drinkwater
J G Jamieson

Officers in Attendance:		
Mrs P Coker	–	Head of Service, Partnerships - Social Care, Health & Housing
Mrs S Hobbs	–	Committee Services Officer
Ms M Kvello	–	Public Health Registrar
Mrs C Shohet	–	Assistant Director for Public Health, Central Bedfordshire Council

HWB/14/1. **Election of Vice-Chairman for the year 2014/15**

The Board were invited to make nominations for Vice-Chairman of the Health and Wellbeing Board.

Dr Paul Hassan was nominated and seconded.

RESOLVED

that Dr Paul Hassan be elected Vice-Chairman of the Health and Wellbeing Board for 2014/15.

HWB/14/2. **Chairman's Announcements and Communications**

The Chairman advised the Board that the advert for Healthwatch Central Bedfordshire would be played under item 11 'Healthwatch Central Bedfordshire'.

HWB/14/3. **Minutes**

RESOLVED

that the minutes of the meeting of the Central Bedfordshire Health and Wellbeing Board held on 3 April 2014 be confirmed and signed by the Chairman as a correct record.

HWB/14/4. **Members' Interests**

None were declared.

HWB/14/5. **Refresh of the Joint Health and Wellbeing Strategy**

The Board considered a report that outlined the case for a refresh of the Joint Health and Wellbeing Strategy (JHWS). The proposal was for the revised JHWS to be more focussed, concentrating on those issues where the Health and Wellbeing Board could make the biggest impact on health and wellbeing in Central Bedfordshire.

The proposed four key priorities were:

- Ensuring good mental health and wellbeing at every age.
- Giving every child the best start in life.
- Improving outcomes for Frail Older People.
- Enabling people to stay healthy longer.

RESOLVED

that the Joint Health and Wellbeing Strategy be revised following the eighteen months implementation of the current Strategy and as a result of the Joint Strategic Needs Assessment re-fresh.

HWB/14/6. **Review of Health Services in Bedfordshire and Milton Keynes - Update**

The Board considered a report that provided an update on the review of health services in Bedfordshire and Milton Keynes. The review aimed to generate options for delivering sustainable, high quality (hospital and out of hospital) services for the people of Bedfordshire and Milton Keynes. It was anticipated that a final options report for consultation would be available in July 2014.

An out of hospital strategy was also being drafted largely based on the agreed plans from the Better Care Funds from each local authority. The Strategy would take account of suitability of hub and spoke models of care across Bedfordshire.

NOTED

the current progress being made by the review of health services in Bedfordshire and Milton Keynes.

HWB/14/7. **Better Care Fund**

The Board considered a report on the implementation of the Better Care Fund Plan which had subsequently been through the regional assurance process, following submission on 4 April 2014. Feedback from the submission had been received and a number of areas required further work.

A Joint Commissioning Board (JCB) would be established, comprising officers within the Council, Clinical Commissioning Group and locality leads who would lead the commissioning of integrated care and oversee financial and performance management. The JCB would also ensure that the pooled fund was targeted appropriately at services which would deliver the outcomes set out in the plan, including expected efficiencies and integration of services.

Clarification of the labelling of graphs within the performance framework was required.

RESOLVED

1. **that the progress with the Better Care Fund Plan be noted;**

2. **that the setting up of the Better Care Fund Commissioning Board be approved and the terms of reference be submitted to the next Health and Wellbeing Board; and**

3. **that the Better Care Fund Performance Framework be approved and quarterly updates on performance against the metrics identified be compiled.**

HWB/14/8. **Bedfordshire Clinical Commissioning Group 5-Year Vision**

The Board considered a report that set out the draft Bedfordshire Health and Social Care System Plan 2014-2019. The five-year system strategic plan was required to be submitted to NHS England on 20 June 2014. This Plan was aspirational as the outcome of the review of health services in Bedfordshire and Milton Keynes would have a significant impact that would need to be taken into account.

The ambition for years three to five were focused upon supporting the overarching aims of the review and developing system-wide pathways of care around the priorities within the following:

- supporting mental health and wellbeing throughout life;
- helping adults and older people maintain a healthy life as long as possible; and
- helping children and young people start a healthy lifetime.

There needed to be a clear distinction between the needs of and plans for Central Bedfordshire and Bedford. The Board commented that clarification was required on capital planning given the investment required for local infrastructure and workforce planning and the interest in co-commissioning GP services had been registered. There would be an opportunity to refresh the Plan in the Autumn following the strategic review of the health services.

RESOLVED

that the draft Bedfordshire Health and Social Care System Plan 2014-2019, in advance of submission to NHS England on 20 June 2014, be approved.

HWB/14/9. **Provisions for SEN and Disability in Children and Families Act**

The Board received a presentation on changes affecting children with Special Educational Needs (SEN) and disability as a result of the Children and Families Act 2014. The Act extended the SEN system from birth to 25, giving children, young people and their parents greater control and choice in decisions and ensuring needs are properly met, including:

- implementing a new way of working with parents and children in designing and developing services;
- replacing old statements of SEN with a new birth to 25 education, health and care plan;
- providing statutory protections comparable to those currently associated with statement to up to 25 years of age in further education;
- local authorities would publish a local offer showing the support available to disabled children and young people and those with SEN, and their families from 0-25 years;
- parents of young people with Education, Health and Care Plans would have the right to a personal budget for their support; and
- cooperation between all the services that support children and their families would be required to improve the service experience for families.

There would also be a duty on health bodies to bring children to the Council's attention if they were of the opinion that the child had special educational needs or a disability. Joint commissioning arrangements must be made between the Council and its partners about the education, health and care provision to be secured. Schools had been provided with guidance to help them understand their role within the new arrangements.

NOTED

the presentation.

HWB/14/10. **Healthwatch Central Bedfordshire**

The Board considered a report that provided an update on the activities of Healthwatch Central Bedfordshire (HWCB). The Board also had the opportunity to watch the new video that advertised the role and work of HWCB.

The Board noted that HWCB volunteer resource was growing and there were over 30 volunteers who were all undertaking safeguarding training. Their first Board meeting was held in public on 18 March 2014.

HWCB had raised concerns with SEPT that complaints had been received with the lack of access to their crisis line with it either being engaged or not being answered. SEPT had advised HWCB that they were investigating having a second line installed.

The Director of Social Care, Health and Housing agreed to meet with HWCB to explore how best their work could be supported.

NOTED

the update on recent activities of Healthwatch Central Bedfordshire.

HWB/14/11. **Public Participation**

The following question was received in accordance with the Public Participation Scheme.

1. Alison Fisher, Chief Executive of MIND

Ms Fisher asked if consideration had been given to a representative from the third sector being included on the Board and enquired about the number of third sector representatives on Healthwatch Central Bedfordshire.

The Chairman thanked Ms Fisher for her question and explained that the membership had been considered very carefully when the Board was acting under shadow arrangements.

The Chairman of Healthwatch Central Bedfordshire explained that there was in the region of 18 members currently from the third sector involved in her organisation.

HWB/14/12. **Board Development and Work Plan 2014 -2015**

The Board considered a report from the Chief Executive, Central Bedfordshire Council that set out a suggested work programme for 2014-2015. The following items would be added:-

- Review of Health Services in Bedfordshire and Milton Keynes; and
- Better Care Fund - to consider the transfer of 2014/15 funds and to receive the terms of reference for the Commissioning Board.

RESOLVED

that the work programme for the Health and Wellbeing Board be approved.

(Note: The meeting commenced at 2.00 p.m. and concluded at 3.45 p.m.)

Chairman …….

Dated ……..

Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Joint Health and Wellbeing Strategy Refresh
Meeting Date:	2 October 2014
Responsible Officer(s)	Muriel Scott, Director of Public Health
Presented by:	Muriel Scott, Director of Public Health

Action Required:

1. Approval of proposed priorities and outcomes for the Joint Health and Wellbeing Strategy.

2. Agreement on next steps for strategy development.

Executive Summary	
1.	The initial draft of the priorities and outcomes was presented at the Health and Wellbeing Board on the 5 June 2014. This paper presents the priorities and outcomes for the Joint Health and Wellbeing Strategy (JHWS) refresh following an extensive process of engagement with stakeholder groups. This revised JHWS draft is presented in Appendix 1.
2.	The proposed next steps to further develop the strategy are to: • analyse the data and intelligence on a small area level to understand how the need in relation to the JHWS priorities varies locally. This should include listening to the voices of stakeholders, providers and clinicians; • evaluate what is currently taking place and its effectiveness; • understand the levers for change and what steps are required to deliver the desired outcomes; and • agree who needs to take the required action, how success will be measured and ensure that the governance arrangements are in place

Background	
3.	The initial draft JHWS refresh was taken to stakeholder groups and the priorities were agreed. There was broad agreement with the objectives although they were noted to be “process” not “outcome” based. It was felt that whilst they addressed the correct issues, it was proposed that these should be re-worded. It was noted that the strategy would need to undergo a further process of development to ensure that it could be implemented effectively and have maximum impact at a local level.

Detailed Recommendation	
4.	The recommendation to the board is to approve the reworked objectives which are now outcome-based and to approve further work to develop this strategy.
5.	The proposed process is to: • analyse the data and intelligence on a small area level to understand how the need in relation to the JHWS priorities varies locally. This should include listening to the voices of stakeholders, providers and clinicians; • evaluate what is currently taking place and its effectiveness; • understand the levers for change and what steps are required to deliver the desired outcomes; and • agree who needs to take the required action, how success will be measured and ensure that the governance arrangements are in place.

Issues	
Strategy Implications	
6.	This proposal is aligned to the overarching aim of the Health and Wellbeing Board to improve health and wellbeing and reduce health inequalities in Central Bedfordshire.
Governance & Delivery	
7.	The process to finalise the JHWS will include options regarding proposed governance of the strategy.
Management Responsibility	
8.	Muriel Scott, Director of Public Health, and Celia Shohet, Assistant of Public Health will coordinate the process detailed in this paper to further develop the strategy.

Public Sector Equality Duty (PSED)	
9.	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.
10.	If there are any risk issues relating PSED an Equality Impact Assessment will be undertaken once the strategy has been finalised

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

Source Documents	**Location (including url where possible)**
Central Bedfordshire Joint Strategic Needs Assessment	http://www.centralbedfordshire.gov.uk/healthand-social-care/jsna/default.aspx
Central Bedfordshire Joint Health and Wellbeing Strategy	http://www.centralbedfordshire.gov.uk/Images/110213CBCHWBStrategyFinal_tcm6-40628.pdf

Appendix 1: Revised Joint Health and Wellbeing Strategy

Presented by Muriel Scott

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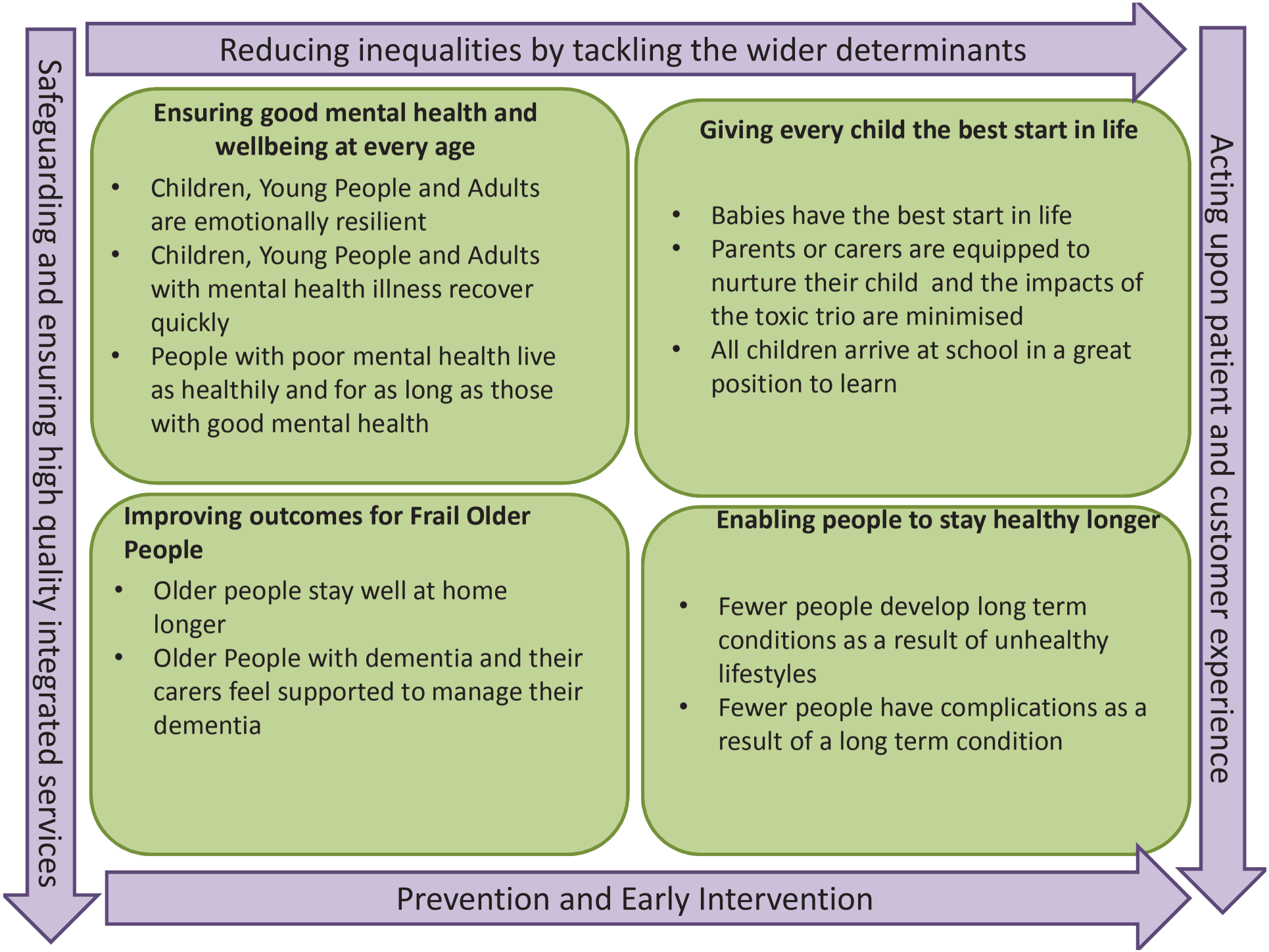
Reducing inequalities by tackling the wider determinants
Safeguarding and ensuring high quality integrated services
Acting upon patient and customer experience
Ensuring good mental health and wellbeing at every age
Children, Young People and Adults are emotionally resilient
Children, Young People and Adults with mental health illness recover quickly
People with poor mental health live as healthily and for as long as those with good mental health
Giving every child the best start in life
Babies have the best start in life
Parents or carers are equipped to nurture their child and the impacts of the toxic trio are minimised
All children arrive at school in a great position to learn
Improving outcomes for Frail Older People
Older people stay well at home longer
Older People with dementia and their carers feel supported to manage their dementia
Enabling people to stay healthy longer
Fewer people develop long term conditions as a result of unhealthy lifestyles
Fewer people have complications as a result of a long term condition
Prevention and Early Intervention

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	Yes
Title of Report	Central Bedfordshire Winterbourne View Programme – Work Area Update
Meeting Date:	2 October 2014
Responsible Officer(s)	Julie Ogley – Director Social Care, Health & Housing
Presented by:	Elizabeth Saunders – Assistant Director Strategic Commissioning

Action Required:

1. Note the Update Information Provided.

Executive Summary	
1.	This report provides an update on the progress and key work streams which are being undertaken by health and social care partners in Central Bedfordshire in response to the severe concern highlighted by the Panorama undercover programme at the Winterbourne View Private hospital in May 2011 for people with a learning disability and the subsequent Department of Health enquiry.
2.	Information for this report has also been provided by Bedfordshire Clinical Commissioning Group (BCCG), Mental Health and Wellbeing Strategy and System Redesign Service.

Background	
3.	The Department of Health (DoH) carried out an in-depth review following the Panorama programme that was broadcasted in May 2011 detailing the scandal and level of abuse that people residing at Winterbourne View were subjected to. Winterbourne View was a hospital for people with learning disabilities, autism and / or behaviour that challenged.
4.	Staff at Winterbourne View had committed criminal acts and six were imprisoned as a result. However the Serious Case Review showed a wider catalogue of failings at all levels.

5.	These wider issues within the care system are: • there are too many people with learning disabilities and autism staying too long in hospital settings or residential care homes. Some people may require hospital care but hospitals are not where people should be living; • there was a failure to assess the quality of care or outcomes being delivered for the very high cost of places at Winterbourne View and other hospitals; and • people are being placed out of their local area and miles away from their family and friends. This puts people at a higher risk of abuse and local provision should be sourced to enable people to live within their local community.
6.	The DoH published the 'Transforming care: A national response to Winterbourne View Hospital – Final Report' and 'Winterbourne View Review – Concordat: Programme of action' in December 2012. These documents focus on the improvements that are required to be developed and implemented by the Clinical Commissioning Groups and Local Authorities.
7.	The concordat and improvement plans focus on the following themes: • the right care in the right place; • strengthening accountability and corporate responsibility for the quality of care; • tightening the regulation and inspection of providers; • improving quality and safety; and • monitoring and reporting on progress.

Detailed Recommendation	
8.	Bedfordshire Clinical Commissioning Group leads on the joint work regarding Winterbourne View in partnership with Central Bedfordshire Council (CBC) and Bedford Borough Council's (BBC). A Pan Bedfordshire Steering Group is held monthly and the members of this group lead on developing and implementing the Joint Improvement Plan. Nikki Kynoch Head of Service for Learning Disability and Mental Health Services and Paul Groom Head of Contracts, are the lead officers representing CBC.
9.	This plan incorporates the key milestones that are set nationally by the DoH, which both the Clinical Commissioning Groups and Local Authorities are expected to deliver against. The Programme of Action sets out to transform services so that people no longer live within inappropriate settings but are cared for in line with best practice, based on their individual needs and that their wishes and those of their families are listened to and are at the heart of planning and delivering their care.

10.	A separate Central Bedfordshire Locality Steering Group has also been established, to ensure there is sufficient focus on translating the Bedfordshire wide actions into specific measures for CBC.
11.	Bedfordshire Clinical Commissioning Group is required to hold a local Winterbourne View Register. The Register is broken into 4 Phases, where individuals who meet the Winterbourne View criteria have reviews of their needs and any hospital detained status completed against set target dates – 1. Phase 1 – Patients placed in hospital settings (June 2014) 2. Phase 2 – Residents placed in out of area residential or educational settings 3. Phase 3 – Transitions / individuals aged 14 years and over 4. Phase 4 – Ordinary Residence (OR) both in and out of county.
12.	In September 2014 specific target dates for completing the reviews are going to be proposed for Phase 2 to 4.
Central Bedfordshire – Phase 1 update (3 x individuals)	
13.	The most recent key milestone was the 1 June 2014, where there was a requirement that everyone listed within Phase 1 of the Local Winterbourne View Register who had been assessed as being inappropriately placed, must have plans for their transition to a community-based setting by the deadline.
14.	BCCG together with CBC has successfully moved four individuals from inappropriate hospital placements into community based settings in 2013/14. There are currently a further three gentleman from Central Bedfordshire who are residing within a hospital setting in Peterborough who have been assessed as being inappropriately placed and need to be stepped down to a community based placement within Central Bedfordshire. These gentlemen have very complex autistic related needs and behaviour that challenges services and therefore require a specific qualified provider to manage their needs, care and support in the community.
15.	There is currently a lack of local support provision that is specialist enough to support these gentlemen in the community and through this transition of change.
16.	Following the joint reviews that were carried out by BCCG and CBC, which involved the individuals', and their families', it was determined that a procurement process may be necessary to procure local specialist services that would be able to offer bespoke and specialist individual packages of care for the three gentlemen referred to above.

17.	An accelerated procurement process through BCCG was initially being pursued however due to capacity issues within the Health system Procurement Support Service, Attain, a waiver to the procurement Process was agreed by the BCCG and approved identified provider market testing instigated.
18.	A provider has been selected from this market testing list based on their ability to support people with similar needs and challenges within a community setting.
19.	The provider has carried out assessments with each of the three gentlemen and these were received on the 11 July 2014, which showed they were able to meet the identified needs and a transition plan is currently being developed; with a timescale to have the service operational by December 2014.
20.	The schedule of reviews for the individuals, who meet the criteria for Phase 2, has already been drawn up.
21.	As part of this work it is important to keep a track on any out of area inpatient admissions from Central Bedfordshire. The BCCG are collecting this information and will report on this at the September Pan Bedfordshire Steering Group and this information will be reported on at the Health and Wellbeing Board on the 2 October 2014. (This report is to follow.)
Review of Winterbourne View – Local Government Association/Joint Investment Programme Stock Take	
22.	A Winterbourne Stock Take progress report was required of all Local Authorities and the CBC report was submitted on the 5 July 2013. Ian Anderson from ADASS reviewed the key area highlighted in the Stock Take in May 2014 focusing on the effectiveness of the health and social care systems approach to delivering the key objectives of the Bedfordshire Improvement Plan. This Review particularity highlighted the strong partnership working across CBC and BCCG in delivering a challenging agenda.
23.	The in-depth Initial Review Report from Ian Anderson is shown as an Appendix to this report (Appendix 1).
Quality of Current Service Provision	
24.	There is a gap in local specialist provision for people with learning disabilities and autism who present with behaviour that challenges services. Predicated on the complexities that individuals present with, specialist quality providers are required to support people through individualised bespoke packages of care whilst managing and maintaining an individual's needs.

25.	Currently, people who present with complex needs are generally placed out of area by BCCG due to the lack of local specialist provision.
26.	There is therefore a need to establish specialist local provision and this is being taken forward by a BCCG led light touch Assured Quality Provider, (AQP) procurement process that will assure commissioners that the providers identified by this method will have the appropriate specialisms to support those who present with the most complex needs and deliver a high quality and safe service through a person centred approach.
27.	The Health System procurement service Attain, have suggested that the most appropriate approach for an AQP would be to issue a PIN (Prior Indicative Notice) to outline the commissioning intentions. The PIN will provide an insight as to how many providers may be interested in engaging in the process and Attain would then facilitate sessions for providers to come and meet with Commissioners in relation to understanding the commissioning intentions and the criteria of the procurement to enable stimulation of the market
28.	In addition CBC has participated in a review of the ADASS East of England Contract Service Specification for Residential and Supported Living Services for people with a learning disability, to check that the specification meets the requirements identified through the Winterbourne View work. The specification has now been revised, to pull out the need for medical health checks to be carried out on a regular basis so as to identify any physical illnesses, much earlier and also requires providers to have in place a range of supports for people who may display challenging behaviour other than solely relying on medication. This revised Specification is being put in place with all Central Bedfordshire contracted learning disability providers on the 1 September 2014.
Improving and Integrating Services	
29.	The review and re-design of the Specialist Learning Disability Services within Bedfordshire which is currently forming part of the Mental Health & Learning Disability Procurement Process has taken into consideration the Winterbourne View Review work stream around integration of services and particularly the role of the Intensive Support Team (IST). This team is designed to provide community based support to enable people with behaviours which can challenge to be maintained in their local community and avoid inpatient admission. It is essential that the IST maintains and further develops its specialism to support people in crisis within their own homes and reduce the number of people being admitted to hospitals and the service specification as part of the Mental Health Procurement Process has been revised to build the capacity of the team to deliver this vital function.

Work with Children's Services	
30.	Through the CBC Steering Group which Children Service Colleagues are members of, the Winterbourne View requirements and outcomes are being linked into all the work streams which report into the Support and Aspirations Programme Board. This Board will report on progress being made through to the Health and Wellbeing Board.

Conclusion and Next Steps	
31.	The Pan Bedfordshire Joint improvement Plan is due for its next refresh at the Steering Group Meeting in September, and the key actions for this will be reported on at the Health and Wellbeing Board on the 2 October 2014.
32.	It is recommended that a further progress report is also provided to the Healthier Communities and Older People Partnership Board before the December deadline for meeting the needs of the three gentlemen being transitioned from their current inpatient unit, so that specific progress on this work can be given.

Issues	
Strategy Implications	
33.	This report is aligned to the overarching aim of the Health & Wellbeing Board to improve health outcomes and experience of health and care services for people in Central Bedfordshire.
Governance & Delivery	
34.	This report provides an update on the progress and key work streams which are being undertaken by health and social care partners in Central.
Management Responsibility	
35.	For Central Bedfordshire Council: Julie Ogley, Director Social Care, Health & Housing will be accountable for delivery and Elizabeth Saunders; Assistant Director Strategic Commissioning will be responsible for day to day delivery. For BCCG: Gail Newmarch, Interim Director of Strategy and Redesign will be accountable for delivery and Michelle Bradley, Head of Mental Health Services will be responsible for day to day delivery.

Public Sector Equality Duty (PSED)	
36.	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

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**
Nil			

Source Documents	**Location (including url where possible)**
Appendix A – Joint Improvement Plan Stock Take Review Report	Appendix 1 - Overview & Scrutiny - Central Beds Final Report.docx

Presented by Julie Ogley

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Appendix 1.

WINTERBOURNE VIEW JOINT IMPROVEMENT PROGRAMME (WVJIP)

INDEPTH REVIEW (IDR) – INITIAL MEETING FEEDBACK REPORT

UPDATE ON PROGRESS AND IDENTIFIED ISSUES FOR FURTHER SUPPORT

Area: **Central Bedfordshire Council/Bedfordshire CCG**

Specialist Improvement Adviser: **Ian Anderson**

Date of meeting: **2 June 2014**

Area attendees (name and position):

Julie Ogley, Director of Social Care, Health & Housing, Central Bedfordshire Council

Paul Groom, Head of Service for Contracts, Central Bedfordshire Council

Nikki Kynoch, Head of Service for Adults with a Learning Disability, Central Bedfordshire Council

Anne Murray, Director of Nursing & Quality, Bedfordshire CCG

Karlene Allen, Quality Manager, Community and Mental Health, Bedfordshire CCG

Kaysie Conroy, Mental Health Project Lead, Bedfordshire CCG

Gwen Ncube, Lead Assessor Nurse, Bedfordshire CCG

Prior to the fieldwork day on 2 June I had telephone conversations with Anne Murray and Kaysie Conroy from the CCG and with Paul Groom and Elizabeth Saunders (Assistant Director) from Central Bedfordshire Council.

On the day I met with Julie Ogley, Paul Groom and Nikki Kynoch together, observed the monthly Steering group meeting and met separately with Anne Murray, Karlene Allen and Kaysie Conroy.

Understanding the numbers – people in inpatient care commissioned by the area

- In 2013 it was confirmed that there were 7 individuals to be considered in Phase 1 of the programme
- As of 2 June 2014, 2 have moved to new services in Central Bedfordshire and 1 to a new service in Bedford.
- One individual was recognised as having mental health issues and that he was inappropriately placed in a learning disability facility. He has

subsequently moved to a mental health resource that is more relevant to his needs.

- There are therefore 3 individuals who are still to move but plans are in place to establish a new joint service for the 3 of them in the Central Bedfordshire area.
- The last year has not seen any new individuals going out of area into inpatient services although people continue to access local in-patient services as required.
- The 3 individuals who are still be re-provided for pose particular challenges to services and in one case in particular, the parents are very anxious about the proposed changes as they see their son as having enjoyed a period of stability and security in the current placement and are concerned that a new service may not meet his needs as well as they see the current one doing.
- It has been decided to pursue a bespoke supported living service for the three individuals with each having separate accommodation but one common provider. The accommodation will either be provided from Central Bedfordshire's own stock or an RSL.
- It was recognised that the usual approach to procurement would be both slower than required and was not guaranteed to deliver a proven provider with the skills and experience required for these 3 individuals. Consequently a waiver of procurement was agreed for the three individuals so that a specific provider could be approached. Meanwhile a procurement process for local specialist service provision for phase 2 of the Winterbourne Programme for people out of area in residential care continues.
- Discussions are currently taking place with a particular provider (Salisbury Autistic Care) and their assessment of how they would meet the needs of the 3 individuals is due by 27 June 2014. Should this prove acceptable, the re-provision process will commence in September and, depending on which is the best approach for each individual, should be completed by December 2014.
- Central Bedfordshire Council has led on re-assessing all 7 individuals, taking a person centred approach to produce new comprehensive, yet brief and easily read summary documents for each person. The model of these assessment summaries and plans could be considered to be exemplars of good practice.
- This approach is now being extended to all individuals in out of area placements under the "Pathway to My Place" programme which aims to bring people back to a more local but appropriate setting unless there are overriding reasons why they should not i.e. they have strong roots elsewhere in the country.
- There is a very strong partnership in evidence with the Bedfordshire CCG essentially "holding the ring" through the Winterbourne View Steering Group which brings together both Central Bedfordshire Council and Bedford Borough

Council into a very effective partnership that operates with a high degree of trust and openness between the 3 organisations but also a recognition that the two council areas have their own identities and ways of doing things. The Steering Group meets monthly and having had the privilege to sit in on one of their meeting I was impressed by the evident commitment, knowledge and purposefulness of all present.

- The work of the Steering Group is defined through the "Winterbourne View Joint Action Plan" which not only addresses issues that flow directly from the Winterbourne view programme but also those that flow from the Francis Report as well as anticipating the implementation of the Care Act.
- NHS England have a standing invite to attend the Steering Group and while they have not made every meeting this has been compensated for by the Mental Health Project Lead from Bedfordshire CCG meeting with a representative from NHS England on a six weekly basis to ensure that strong links are maintained.
- The linkages between adult and children's services are strong. The Director of Children's Services chairs the council-wide "Support and Aspiration Board" with Adult Services leading the transitions programme within this.
- So far, Adult Services have identified all young people aged 14+ (and some as young as 12) and are starting to engage with parents/carers as appropriate to begin discussions on how adult services may respond to the young person's needs in the future. In addition adult services are involved in the planning of any young person aged 16-18 for whom a placement outside of Central Bedfordshire is being considered.
- The CCG is currently leading on the re-procurement of mental health and learning disability services for their area. The process is currently at the competitive dialogue stage and as part of this the opportunity has been taken to strengthen the specification for both rapid response and effective home treatment services for adults with learning disabilities and similarly to strengthen CAMHS provision for children and young people.
- In conclusion it is my view that while the original deadline to move all 7 individuals by June 2014 has not been met, there has been very significant progress. There is an appropriate balancing of pace aligned with a determination to ensure that individuals are provided for in a way that delivers future stability and security while enhancing their life opportunities.
- Partnership working is clearly very strong and is not just focussed on one or two key individuals. I saw this evidenced from director through to middle manager levels in both organisations. Despite the fact that the CCG is still a very young organisation, there is a maturity of approach that has carried across from the previous PCT arrangements, which is not to say that parties never disagree but that when they do they can have the debate and still continue working together effectively.

- If there is a risk to the approach being taken here it may come from pressures to reduce management costs in either or both of the council and CCG. These are not evident yet but I became aware that a number of individual managers were attending a lot of meetings to keep connected with related programmes of work where only a relatively small amount of the time spent in the meeting may have been directly relevant to the Winterbourne View programme. The upside of this though is that these managers are very well connected with colleagues, have a strong understanding of what is going on elsewhere in the system and have opportunities both to shape that work and to reflect it in the Winterbourne View programme itself. There may however be some value in the council and CCG mapping the various groups in operation, their reporting and accountability arrangements and who attends to see if any rationalisation is possible either in the number of groups or attendees.

Positive practice

- *The approach taken to formulating new assessments for all individuals in the initial cohort and the extension of this approach more broadly.*
- *The pragmatic but innovative approach being taken to procuring a supported living service for 3 specific individuals.*
- *The Joint Improvement Plan is an excellent example of an integrated approach to managing a complete agenda across a whole system.*
- *The joint working between Adult and Childrens Services enabling all young people aged 14+ (and some as young as 12) to be identified along with starting to engage with parents/carers to begin discussions on how adult services may respond to the young person's needs in the future is also impressive.*
- *The overall level of trust and openness that has developed across the system reflects both the commitment at all levels and the considerable time that has been committed to making relationships work.*

Challenges

- *If there is a risk to the approach being taken here it may come from pressures to reduce management costs in either or both of the council and CCG. These are not evident yet but a number of individual managers attend a lot of meetings to keep connected with related programmes of work and their ability to do so is critical to the continued success of this area of activity*

Specialised Commissioning

- As elsewhere in the country, the early engagement with NHS England was not as smooth as would have been hoped. With NHS England unable initially to provide reliable information on individuals at CCG/council level there was at

first a lack of clarity about who the system were responsible for. This was however sorted out relatively quickly and proactive work by the Mental Health Project Lead in particular has ensured that there is a good ongoing working relationship with the Specialist Commissioning team.

- Local managers believe that there are no individuals currently funded by NHS England who will become their responsibility beyond those already engaged with. NHS England have a standing invite to the Steering Group and have regular meetings with the Mental Health Project Lead.
- The only current issue with NHS England is the reluctance of the Specialist Commissioners to share in writing their reviews of individuals although, somewhat oddly, they are prepared to discuss these same reviews with CCG/council colleagues.

Positive practice

- *The level of engagement with NHS England*

Challenges

- *Securing copies of written reviews from NHS England*

Understanding the money

- There is currently no formal arrangement in place for joint financial working and there are no immediate plans to enter into the same. The maturity of the partnership between the council and CCG means that the system is aware of all the individuals that either or both parties have a responsibility for and issues of funding are addressed and resolved on a case by case basis. As far as the council and CCG are concerned there is no problem that moving to a pooled budget would resolve and, with the relatively limited capacity that these two organisations have, the priorities are to deliver against the needs of their learning disabled adults, which they are doing well, and to develop more integrated approaches in relation to older people.
- The council has provided resources to meet the demographic growth in relation to learning disabled adults.
- The CCG is having to make savings across its budgets and therefore is looking to deliver good value for money through this area of activity. I am assured however that their highest priority is ensuring quality of care and service for these vulnerable individuals.
- I have not seen any evidence to suggest that the absence of a pooled fund is in any way adversely affecting the system's work in relation to the Winterbourne View agenda.
- I have discussed the absence of a pooled budget arrangement with both the council and CCG and they have jointly expressed an interest in being

supported in undertaking a piece of work to evaluate how they currently manage the money and identify ways in which this could be improved.

Positive practice

- *Both the council and CCG have made financial commitments to ensure that progress is made for individuals and there has been a laudable flexibility across partners to solve any problems that have emerged.*

Challenges

- *The approaches taken to managing the money are relatively informal (albeit effective) but may be strengthened by more detailed financial planning and more formal recording of commitments without necessarily going as far as a pooled budget arrangement.*

Commissioning

- The Steering Group is clearly the place where the CCG and council come together to shape their priorities, work out how they are to deliver them and through the joint action plan hold each other to account. It would be possible to put a form of words around this and for the two parties (three if Bedford Borough Council are included) to formally sign this off. This would not however add a great value to the way the system is working and there is no "problem" that it would solve as far as I can see.
- The Steering Group makes clear who is responsible for which actions and I formed a strong impression that these were allocated appropriately to people who had the right skill sets to deliver them and were committed to doing so.
- The council has produced a market position statement that clearly reflects the needs of adults with a learning disability and/or autistic spectrum disorder that challenge services.
- There is a developing understanding of future needs that will be generated by young people currently in transition and these are being fed into the Joint Action Plan.
- There has already been an enhancement to community based services to strengthen home treatment services and this will be further enhanced once the contract is let for the new mental health and learning disability health and social care provider.
- A register of individuals has been established and that also captures young people in transition, adults in out of area placements and adults placed within Bedford Borough by other systems. The challenge for the council and CCG in expanding this register is to strike a balance between developing something that is meaningful and adds value and the level of resource that can be allocated to it. The Mental Health Lead, who will be leading on this work, has

expressed a desire for assistance in identifying other systems that have already addressed this issue and would be prepared to share their learning.

Positive practice

- *There is a comprehensive and well integrated approach to commissioning effectively overseen and managed through the Steering Group*

Challenges

- *An impressive start has been made to establishing a register of individuals but there is a need to strike a balance between detail and time required to maintain it so examples of how other systems have approached this would be welcomed.*

Working in a co-produced way

- The Joint Action Plan is a standing item on the Learning Disability Partnership Board agenda and there has been a workshop session for LDPB members on this.
- The LDPB is co-chaired by a person with a learning disability.
- At an individual level it is clear that there is significant work to engage with individuals and their families/carers. This is evidenced by the approach taken to both completing and recording the individual case assessments and the awareness of managers of how parents were feeling about the proposed moves of their son/daughter and the fact that enhancing family contact was a re-current theme in the work that has been undertaken for all 7 people in this first cohort.
- With a slightly different focus, the council are working with independent sector providers to enhance safer recruitment using ADASS resources and requiring the providers to produce case studies of where they used the approaches to drill down on specific issues. This enables the council to triangulate evidence of training against both complaints and safeguarding concerns.
- There is also a desire to develop approaches that capture the user's experience of services more routinely and it was reassuring to hear managers from both the council and the CCG regularly challenging each other with "so what?" questions to ensure that there was a constant focus on outcomes rather than just focus.

Positive practice

- *The progress reporting of the Joint Action Plan into the LDPB and the work undertaken to help members understand it is a good example of bringing complex activity to a governance arrangement that involves disabled people and their carers.*

- *The work on safer recruitment with independent sector providers is also innovative.*

Challenges

- *None identified*

Political accountability and ownership

- The Director described her Executive Member as being very committed to this agenda and the council has provided demographic growth funding at a time when financial resources are severely constrained.
- The CCG has this firmly on their radar at a governance level and there is a lead GP to help drive and support the programme. The programme reports into the Patient Safety Sub-committee, a formal sub-committee of the Board.
- The Joint Action Plan is also an agenda item for the Health and Wellbeing Board.

Positive practice

- *Both the council and CCG were able to describe positive engagement with their political leadership/governance arrangements.*

Challenges

- *None identified*

Sector led improvement and notable practice

- The approach taken to joint planning for adults with a learning disability or autistic spectrum disorders is a good example of a system connecting a range of issues together to provide a comprehensive and connected oversight of priorities and the Joint Improvement Plan captures this and progress being made in an easily useable format.
- The work that has been undertaken to review the 7 individuals and produce concise, focussed and relevant person centred case studies is also of a very high standard.
- Finally, the council's work with independent sector providers to enhance safer recruitment using ADASS resources and requiring the providers to produce case studies of where they used the approaches to drill down on specific issues thereby enabling the council to triangulate evidence of training against both complaints and safeguarding concerns is also an example of notable practice.

Ian Anderson

Specialist Improvement Advisor

Appendix 1.

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Annual Director of Public Health Report
Meeting Date:	2 October 2014
Responsible Officer(s)	Muriel Scott, Director of Public Health
Presented by:	Mei-Li Komashie, Public Health Registrar

Action Required:

1. To note the issues surrounding mental health and wellbeing in Central Bedfordshire and to consider the recommendations and suggested actions to improve mental health and wellbeing.

Executive Summary	
1.	Good mental health and resilience are fundamental to our physical health, relationships, education, training, work and to achieving our potential. Poor mental health is also common; at least one in six people will experience a mental health problem in any one year and mental health illness is the leading cause of long term absence from work. The Annual Report of the Director of Public Health focuses on mental health and wellbeing and identifies where action should be taken in Central Bedfordshire.

Background	
2.	The Director of Public Health produces an annual report which is a statutory duty. This paper presents the Annual Director of Public Health Report 2014. This report increases awareness about the consequences of poor mental health and illustrates the widespread negative impact on individuals, families, society and the economy. This report details the local need, the services available and makes recommendations to improve mental health and wellbeing.

Detailed Recommendation	
3.	The recommendations are: *To increase mental health and wellbeing in children and young people by:* • Ensuring excellent maternal mental health. • Helping children become more resilient. • Increasing identification of children who are at risk of poor mental health earlier and ensuring that they have access to appropriate services. *To increase mental health and wellbeing in adults and older people by:* • Improving the physical health of those with mental health illness by ensuring good access to healthy lifestyle support. • Supporting employers to participate in Workplace Health initiatives and to signpost to relevant resources. • Increasing understanding of mental health and wellbeing and reducing the stigma of mental ill health.
4.	The recommendations chosen will have a significant impact on improving mental health and wellbeing of the population, focus on early intervention and prevention and are achievable through maximising the use of resources already within the system.

Issues	
Strategy Implications	
5.	This report is in line with the current Joint Health and Wellbeing Priorities of "Improving child and adolescent mental health" and "Maximising adult mental health". This report is also in line with the proposed Joint Health and Wellbeing Strategy refresh priority of "Ensuring Good Mental Health and Wellbeing at every age".
6.	The proposals are also aligned to: BCCG Bedfordshire Plan for Patients 2014-2016 BCCG Mental Health Strategic Objectives 2013-2016

Governance & Delivery	
7.	Implementation of the recommendations will assured through: • Performance review meetings with providers antenatal and postnatal care to ensure targets around maternal mood assessment are being met and monitoring the follow up of women who have been identified by these assessments. • Contract monitoring of Child and Adolescent Mental Health Services to ensure that appropriate support is given to train Tier 1 providers of mental health services and to deliver Tier 2 CAMHS in a timely and effective manner. • Performance review and contact negotiation for services involved with parents or carers with mental health illness, substance misuse or domestic violence issues to ensure a whole family approach. • Ensuring that non-mental health service professionals who come in contact with children and young people who are at higher risk of mental ill health are trained to recognise early signs of illness and are supported by Tier 2 mental health services. • Mental Health awareness will be increased through the publication of the report and the inclusion of mental health in BCCG Plan for Patients and the Joint Health and Wellbeing Strategy.
Management Responsibility	
8.	The progress will be monitored as described in the processes in Paragraph 7 and will be reported in the Annual Director of Public Health Report 2015.
Public Sector Equality Duty (PSED)	
9.	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)**
Central Bedfordshire Joint Strategic Needs Assessment	http://www.centralbedfordshire.gov.uk/healthand-social-care/jsna/default.aspx

_____

Presented by Mei-Li Komashie

Central Bedfordshire Council
www.centralbedfordshire.gov.uk

Central Bedfordshire

Annual director of public health report 2014

Mental Health and Wellbeing in Central Bedfordshire

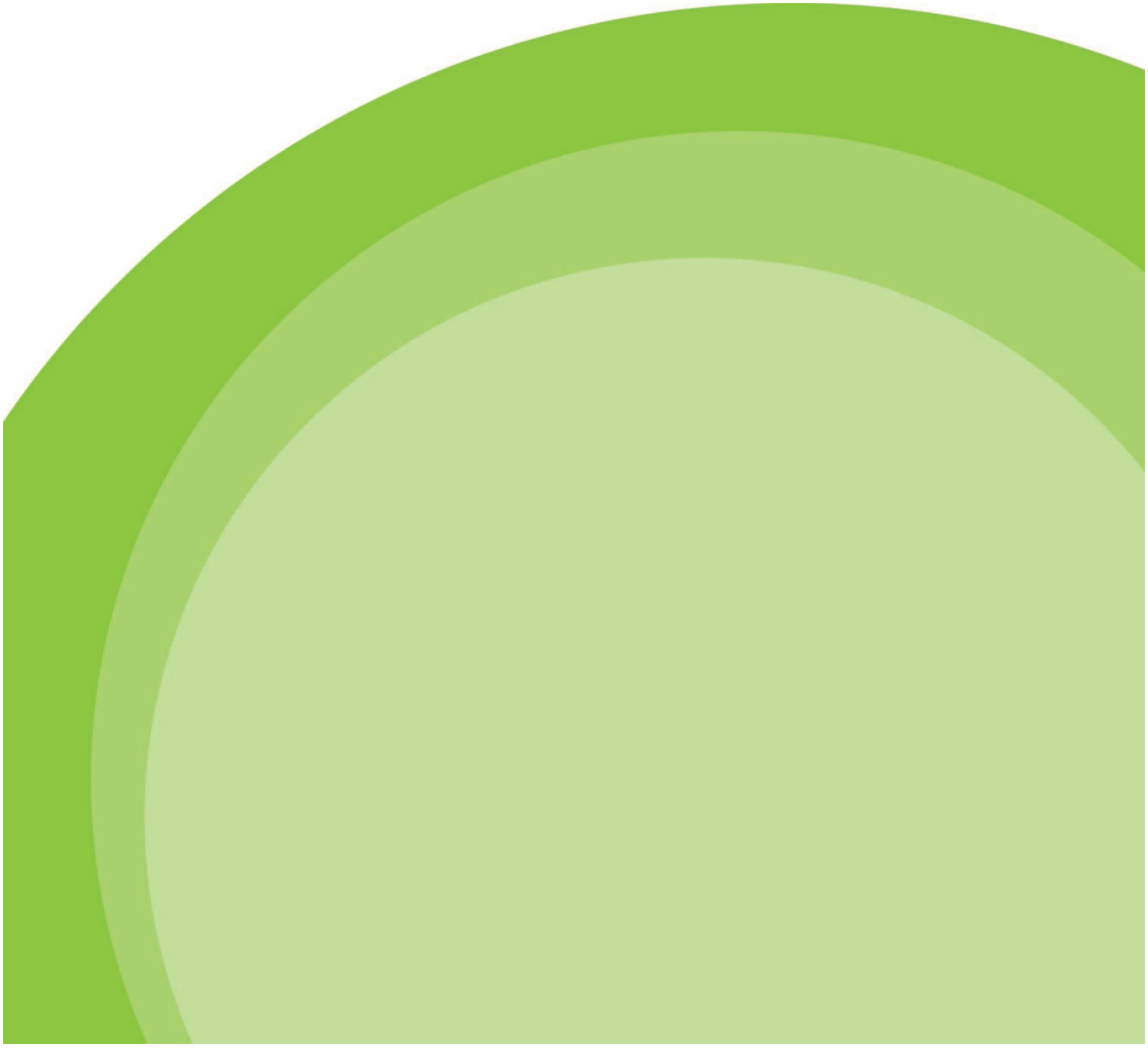


Table of Contents

Acknowledgements: Mei-Li Komashie, Randip Khangura, Edmund Tiddeman, Anthony Scanlon, Bharathy Kumaravel, Celia Shohet and Sarah Stevens.

Foreword from the Director of Public Health

The annual Director of Public Health report is an independent document focused on the health of the people of Central Bedfordshire.

This year I am pleased to present my report on mental health and wellbeing. This is an area that is often overlooked whilst physical health is given prominence. Last year the important issues of premature mortality and the "big killers" of cancer, cardiovascular, lung and liver disease were highlighted in "Longer Lives" from Public Health England. The report showed higher rates of premature mortality in Central Bedfordshire compared with similar areas. Whilst the causes of premature mortality are physical health conditions, mental health and wellbeing is as equally important and the inter-relationship between physical and mental health is significant. People with long term conditions are more likely to have poor mental health and people with mental health illness die often earlier than those without mental illness.

We hope that this report increases awareness about the consequences of poor mental health and illustrates the widespread impact it can have on individuals, families, society and the economy. This report aims to summarise the current burden of disease in the population, highlight the evidence of what works, and provide an overview of some of the services that are available. There are areas that are working well but we also highlight areas that could be improved. By promoting good mental health and intervening early across the life course we can help prevent mental illness from developing and reduce its effects when it does. Effective action requires all stakeholders and partner organisations to work together.

The Joint Strategic Needs Assessment for Central Bedfordshire includes mental health and wellbeing chapters providing more depth into these areas. This is publically available on Council's website at www.centralbedfordshire.gov.uk/jsna

The recommendations made in the report are achievable, have evidence of effectiveness, will have the greatest impact on the population as a whole and that have been highlighted by those working in mental health services or affected by mental health disorders.

This report also provides an update since the last Public Health Report which focused on Health Inequalities. We will report on the progress made on these recommendations in the Annual Public Health report of 2015 to demonstrate where and how progress has been made.

My vision for the local area is one where mental health and wellbeing is addressed routinely and proactively in all stages of life; from pre-birth antenatal checks, in schools, workplaces, health and care environments, and in the later stages of life.

Muriel Scott

Director

Executive Summary

Call to Action

Mental health and wellbeing is important; good mental health and resilience are fundamental to our physical health, relationships, education, training, work and to achieving our potential. Poor mental health is also common; at least one in six people will experience a mental health problem in any one year[1] and mental health illness is the leading cause of long term absence from work[2]. It affects any age group; 10% of 15-16 year olds experience mental health illness. In 50% of people with a lifelong mental illness their symptoms started before the age of 14 and in 75% symptoms started before their mid-twenties[3]. Older people are at increased risk of depression due to factors such as retirement, social isolation, bereavement, physical illness or disability and social isolation[4].

By promoting good mental health and intervening early across the life course we can help prevent mental illness from developing and reduce its effects when it does.

[1] The Office for National Statistics Psychiatric Morbidity report, 2001
[2] Centre for Business Innovation. www.cbi.org.uk/media/.../cbi-pfizer_**absence**___workplace_health_2013.pdf
[3] Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014
[4] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/O/older-people/ accessed on 16/4/2014

Children and Young People

National data[5] estimates the rates of mental health problems in males between the ages of 5-10 years is almost twice that of females (10.4% vs 5.9%) and the rate in females increases to narrow this gap by the ages of 11-15 years (12.8% for males and 9.65% for females). There are an estimated 1,100 males and 595 females aged 5-10 years with a mental health problem in Central Bedfordshire[6] and 1,260 males and 905 females aged 11-15.

In Central Bedfordshire it is imperative that we improve mental health and wellbeing for all children due to the long lasting negative impact of mental health illness. We believe that this requires action in three key areas; ensuring the best start in life; strengthening emotional resilience and wellbeing; and detecting and treating illness early.

Key recommendations to address mental health in children and young people:

1. Ensure excellent maternal mental health:
    a. Identify women early who have poor mental health through antenatal and postnatal maternal mood assessments
    b. Ensure that the ante and postnatal pathways for maternal mental health are followed and women have access to high quality and timely support for mental health illness

2. Help children to become more resilient:
    a. Health and early years practitioners should develop and agree pathways and referral routes that define how practitioners will work together, as a multidisciplinary team, across different services (NICE guideline PH40)
    b. Ensure practitioners have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing (NICE guideline PH20)
    c. Provide a curriculum that promotes positive behaviour and successful relationships and helps reduce disruptive behaviour and bullying (NICE guideline PH20 *Mental health and behavior in schools: Department for Education. June 2014*)

3. Increase the early identification of children who are at risk of poor mental health earlier and ensure that they have access to appropriate services

[5] National Statistics Online, Mental Health: Mental Disorder More Common In Boys, at www.statistics.gov.uk, (2004)
[6] Calculated from applying national prevalence to Central Bedfordshire population (Exeter database 2014)

Adults and Older People

The adult population of 20-64 year olds in Central Bedfordshire totalled 159,600 and those aged 65 and over numbered 44,600 (Exeter database 2013/14 Q2). Approximately 26,200 residents are predicted to have a common mental health disorder (anxiety, depression, obsessional compulsive disorder) and 11,700 to have two or more mental health disorders.

People with mental health disorder have poorer physical health and often are subject to discrimination and stigma. Males with mental illness die on average 16 years earlier and women with mental illnesses die 12 years earlier than those without mental illness.

Cardiovascular disease and cancer account for 75% of this reduction in life expectancy[7]. Despite mental health problems affecting one in four people at some point in their lives, people with mental health conditions are least likely out of all people with a long term condition or disability to be included in mainstream society[8].

The recommendations made below would reduce inequalities, have the potential for widespread impact and are achievable. The current inequality in physical health and resultant premature mortality needs to be addressed urgently and there are services in place that we could use more effectively. Promoting mental health and wellbeing in the workplace would impact a large number of people and could prevent illness and sickness absence. Stigma has negative impacts on the person in terms of mental wellbeing, increases social isolation, and reduces the likelihood that people will seek help early.

Key recommendations to address mental health in adults and older people:

1. Improve the physical health of those with mental health illness by ensuring good access to healthy lifestyle support
2. Support employers to participate in Workplace Health initiatives and to signpost to relevant resources
3. Increase understanding of mental health and wellbeing and reduce stigma of mental ill health

[7] The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. BMJ 2013; 346 doi: http://dx.doi.org/10.1136/bmj.f2539 (Published 21 May 2013)

[8] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/S/stigma-discrimination/ (Accessed 15/05/2014)

Call to Action

> Mental health is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community
>
> WHO

Good mental health and resilience are fundamental to our physical health, relationships, education, training, work and to achieving our potential.

If we achieve our aims for improving mental health and wellbeing in Central Bedfordshire:

1. **More people will have good mental health**
2. **More people with mental health problems will recover**
3. **More people with mental health problems will have good physical health**
4. **More people will have a positive experience of care and support**
5. **Fewer people will suffer avoidable harm**
6. **Fewer people will experience stigma and discrimination**

Mental Health illness affects many people across all ages and in 75% of people with a lifelong mental illness their symptoms started before their mid-twenties[9]. At least one in six people will experience a mental health problem in any one year[10]. Some people might have a single episode of mental illness and people of all ages are affected; 10% of 15-16 year olds experience mental health illness and mental health illness is the leading cause of long term absence from work[11]. Older people are at increased risk of depression due to factors such as retirement, social isolation, bereavement, physical illness or disability and social isolation[12].

Mental health illness results in a broad range of impacts[10].

Impacts of Mental disorder in **childhood and adolescence**:

7. Poorer health and lower levels of educational attainment
8. Higher risk of self-harm and suicide
9. Several-fold higher levels of health risk behaviour such as smoking, alcohol consumption and drug misuse
10. Higher rates of antisocial and offending behaviour and violence

[9] Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014
[10] The Office for National Statistics Psychiatric Morbidity report, 2001
[11] Health at work – an independent review of sickness absence. Dame Carol Black and David Frost CBE. 2011. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181060/health-at-work.pdf (Accessed on 17/6/2014)
[12] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/O/older-people/ accessed on 16/4/2014

Impacts of Mental disorder during **adulthood**:

11. Higher unemployment
12. Higher rate of debt problems
13. Higher risk of homelessness
14. Higher smoking prevalence
15. Increased risk of physical health problems especially heart disease and cancer
16. Reduced life expectancy of 16 years for men and 12 years for women

The ultimate aim of work on mental health prevention is a community in which people take appropriate action to prevent mental health issues in themselves and in their families, but if they do develop an issue, they obtain timely professional help, receive and adhere to evidence-based treatments, feel supported by those in their immediate social network and hopefully recover sooner.

Improving the general public's mental health and wellbeing is one of the most important issues in Public Health.

Actions that can be taken to influence wellbeing include:

- **Connect** to those around you and build positive relationships with family, friends, colleagues and neighbours
- **Be active**. Find the activity that you enjoy, and make it a part of your life.
- **Keep learning**. Learning new skills can give you a sense of achievement and a new confidence.
- **Give to others**. Even the smallest act can count whether it's a smile, a thank you or a kind word. Larger acts, such as volunteering at your local community centre, can improve your mental wellbeing and help you build new social networks.
- **Take notice**. Be more aware of the present moment, including your feelings and thoughts, your body and the world around you. Some people call this awareness "mindfulness", and it can positively change the way you feel about life and how you approach challenges.

NHS Choices. Five Steps to Mental Wellbeing

For children, these activities have been found to be helpful[13]:

1. Seeing friends
2. Teaching yourself new things and
3. Noticing and enjoying your surroundings

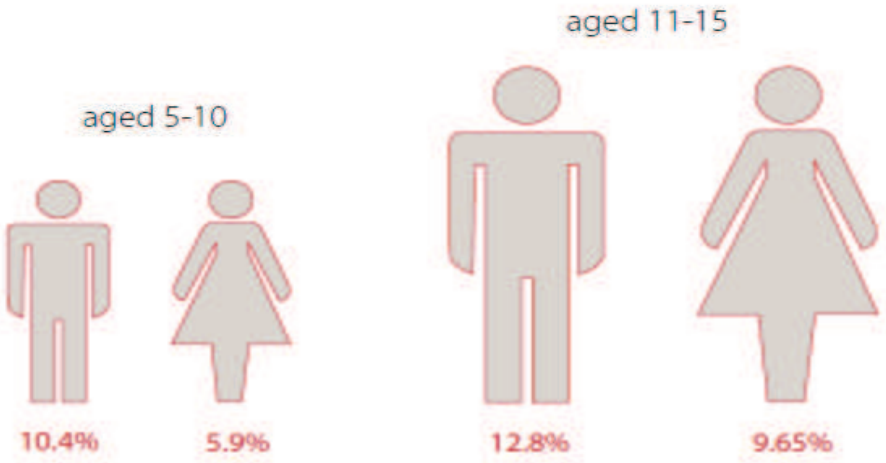
[13] The Good Childhood Report. The Children's Society. 2013.

1. Children and Young People

Of those with a lifetime mental health illness; 50% will experience their first symptoms before the age of 14 years and around 75% by their mid-twenties[14].

Figure 2 shows the difference in rate of mental health illness in different ages and gender groups. National data[15] estimate the rates of mental health problems in males between the ages of 5-10 years as being almost twice that of females (10.4% vs 5.9%) and the rate increases in females to narrow this gap by the ages of 11-15 years (12.8% for males and 9.65% for females). There are an estimated 1,100 males and 595 females aged 5-10 years; 1,260 males and 905 females aged 11-15 with a mental health problem in Central Bedfordshire.

Figure 2: National rates and local numbers of children and young people with mental health problems.



Est. No. of CYP affected in CBC	**1,100**	**595**	**1,260**	**905**

Source: Fundamental Facts. Mental Health Foundation 2007.

Mental Health disorders in children and young people are divided into the following categories: conduct disorders, emotional disorders (anxiety disorder including OCD and phobias, depressive disorders); hyperkinetic disorders (including Attention Deficit Hyperactivity Disorder); developmental disorders (Autistic Spectrum Disorder); eating disorders; substance misuse; psychotic disorders and self-harm.

Some mental health disorders are more frequent in males and others in females. Conduct disorders are more common in males than females and emotional disorders are more frequent in females.

The estimated prevalence for conduct disorders in Central Bedfordshire in 2012 was 910 in children aged 5-10 years and 805 children between 11-16 years.

[14] Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014
[15] National Statistics Online, Mental Health: Mental Disorder More Common In Boys, at www.statistics.gov.uk, (2004)

Boys account for approximately 65-70% of those affected[16]. In addition it is estimated there were 445 children (210 males) aged 5-10 years and 945 children (390 males) between 11-16 years with an emotional disorder. There is a marked difference in numbers of males and females with an emotional disorder between the ages of 16-19 years and an expected 545 males will have an emotional disorder whilst this number is 1,105 in females[14].

Please note the data available regarding numbers of children with mental health illness are provided nationally using prevalence obtained through research and applying this to the local population. It is therefore an estimate and not the number of patients identified locally with the specified condition.

Recommendation 1: Ensure excellent maternal mental health

Maternal mental disorders following childbirth are common and often serious. Pregnancy and childbirth are major life events, with potential consequences on maternal mental wellbeing. Women may develop mental illness for the first time during the perinatal period (covering the antenatal period through to 1 year post birth) or may experience an exacerbation of a pre-existing illness. The risk for severe mental illness (postnatal psychosis) is higher in women with pre-existing mental illness[17].

Local picture

Table 1: Rates of perinatal psychiatric disorder per thousand maternities

Rates of perinatal psychiatric disorder per thousand maternities		Estimate of number of women affected in Central Bedfordshire*
Postpartum psychosis 2/1000	2 in 1000	<10
Chronic serious mental illness 2/1000	2 in 1000	<10
Severe depressive illness 30/1000	30 in 1000	100
Mild-moderate depressive illness and anxiety states 100-150/1000	100-150 in 1000	330-500
Post traumatic stress disorder 30/1000	30 in 1000	100
Adjustment disorders and distress 150-300/1000	150-300 in 1000	330-500

Source: Guidance for commissioners of perinatal mental health services. JCPMH. http://www.jcpmh.info/wp-content/uploads/jcpmh-perinatal-guide.pdf. Accessed 16/06/2014
*Based on a birth rate of 3300 in Central Bedfordshire

Early years mental health promotion services are available in Central Bedfordshire as part of the 0-5 years Healthy Child Programme - led by the Health Visiting Service. This service is delivered at 3 levels - Universal, Universal Plus and Universal Partnership Plus, depending on need.

[16] Source: CHIMAT: CAMHS Needs Assessment. http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34 (Accessed 10/2/2014)
[17] Royal College of Psychiatrists. http://www.rcpsych.ac.uk/expertadvice/problems/postnatalmentalhealth/postpartumpsychosis.aspx. Accessed 16/6/2014

The Universal element is delivered to all women and includes a postnatal maternal mood assessment. Latest data on the maternal mood assessment completion is for Q1 2014/15 and is low at 29% of all mothers at 6-8 weeks post-natally being assessed. However, the number reported may be low as the previous indicator required this assessment to be done at 10 weeks and it may be that adjustment that has affected the result. This figure currently covers all of Bedfordshire but this indicator is expected to be reported by Local Authority in 2014/15.

Maternal health in general, including breastfeeding and smoking, has a longer term impact on child mental health and wellbeing. The breastfeeding rate in Central Bedfordshire at 6-8 weeks was 46.4% in 2012/13 which is slightly lower than the England average of 47.2% (ChiMat 2014 data). The percentage of mothers who are smoking at the time of delivery in Central Bedfordshire is slightly higher than the England average from national comparison data in 2012/13.

Improved early years mental health and wellbeing would be expected to impact upon the pre-school stage. Currently Central Bedfordshire has a lower "school readiness" of its children compared with the England average; 49.1% of children achieved a good level of development within Early Years Foundation Stage Profile in 2012/13 in Central Bedfordshire compared with 51.7% in England as an average (Public Health Outcomes Framework 2014).

What works

Good antenatal care, postnatal care and parental support improve parental mental and physical health and as a result, child mental health and wellbeing. Table 2 describes the interventions which are evidence-based and describes the positive impacts that have been demonstrated.

Table 2: Mental health and wellbeing outcomes for evidence-based interventions in early years

Life Stage	Intervention	Evidenced based outcome
Starting Well	1. Promotion of parental mental and physical health	Reduction in maternal smoking is associated with reduced infant behavioural problems and Attention Deficit Hyperactivity Disorder
	2. Increased breastfeeding	Increased breastfeeding is associated with higher intelligence score later in life, reduced obesity and reduced behavioural problems
	3. Support after birth such as home visiting	Improved maternal and child health
	4. Parenting support	Improved parental mental health Improved child emotional and behavioural adjustment Promotion of pro-social behaviours Reduced antisocial behaviour Reduced aggression and violence in children with conduct disorder

Source: Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014

What we should be doing

We should continue to support women through pregnancy with effective antenatal support and through this promote a healthy lifestyle - such as not smoking, aiming for a healthy weight and increased physical activity. We should also continue to effectively support women to breastfeed their children.

We should strengthen the area of antenatal support, ensuring that all women's mental health and wellbeing is assessed at each of the key points during the antenatal period – i.e.:

- at booking/by 12 weeks (or at first contact if later (Midwife)
- at 16-28 weeks (Midwife)
- 28-32 weeks (Health Visitor)
- 32-36 weeks (Midwife)

Postnatal support should also be strengthened, ensuring that **all** women receive their postnatal maternal mood assessment with a Health Visitor at 6-8 weeks. We must increase the percentage of women receiving this assessment from 29% to the following stepped targets which have been locally agreed between commissioner and provider. These targets have been set to reflect planned increase in, and up-skilling of the health visitor workforce.

Targets for percentage of women receiving their postnatal maternal mood assessment:

- 75% by Q3 2014/15
- 95% by Q4 2014/15

So that all women have access to high quality and timely support for mental health illness, the agreed Bedfordshire Joint Care Pathways for Maternal Mental Health – antenatal and postnatal should be followed and reviewed and revised against the developing *0-5 Healthy Child Programme Integrated Commissioning & Delivery Toolkit* (NHS England, East Anglia Area Team), and updated NICE Guidance (to be published in December 2014).

Recommendation 2: Helping children become more resilient

Children need to build skills early in life to be able to increase their resilience to future life events. This will help to prevent behavioural problems (including drug and alcohol misuse) and mental illness. Resilience results in the ability to be autonomous, problem-solve and manage emotions.

Local picture

All children should receive social, emotional and developmental support from professionals outside specialist mental health services who should deliver this as part of their everyday work. These professionals include teachers, social workers, special educational needs workers, health visitors, school nurses and GPs. This level of intervention is known as "Tier 1" support. This level of support forms the base of mental health support for Children and Young people as seen in the tiered diagram in Figure 3.

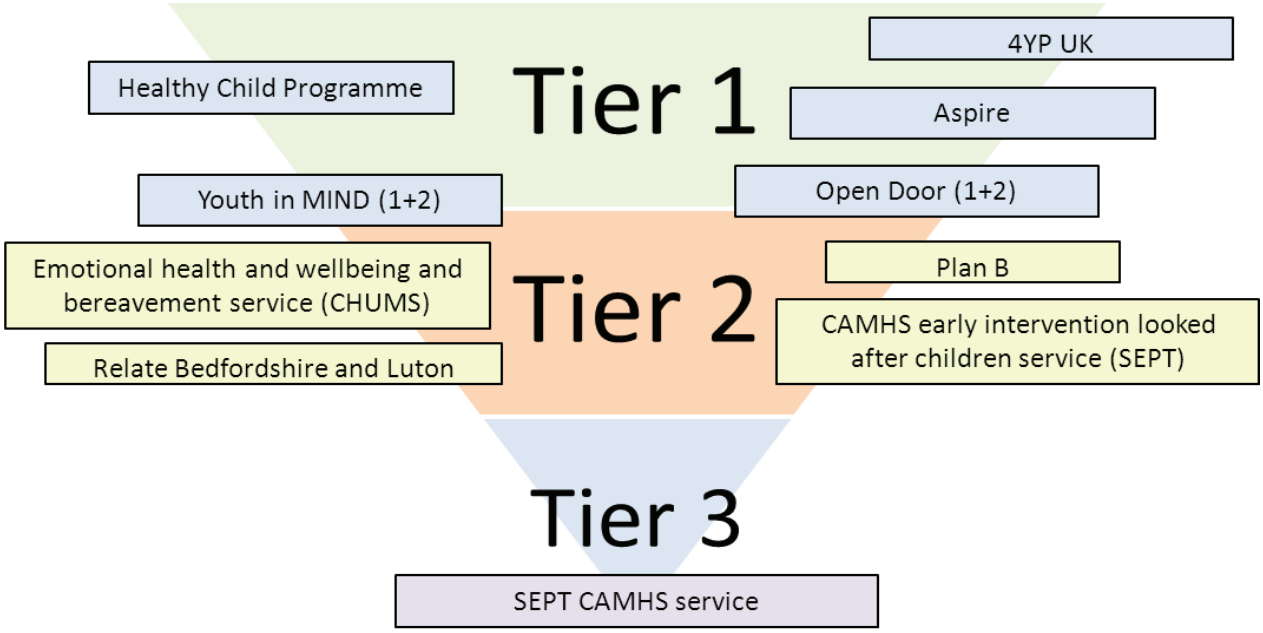


Figure 3: Tier 1-3 Children and Young People Mental Health Services

Features of Tier 1 support such as universal delivery through routine contacts made with children and young people make it difficult to assess. The 2013/14 Tier 1 and 2 review looked at the current provision and through discussions with stakeholders identified that some of these services could be strengthened. Increased support at early stages is important. It can prevent mental health illness from developing or reduce the severity of existing mental health illness by intervening early. This will both improve the mental wellbeing of the population through acting early and also reduce costs associated with the need to treat more severe mental health illness.

Poor mental health and wellbeing in children and young people can lead to negative outcomes such as poor educational attainment and an increased risk of unemployment.

This is likely to be a two-way association and poor mental health can lead to, and be a result of young people being Not in Education Employment or Training (NEET). In Central Bedfordshire there were 390 16-18 year olds who were NEET in 2012 which is 4.6% of this age group. This compares with a national average of 5.8% and whilst this is statistically significantly lower, we still need to provide support to this vulnerable group.

What works

There is a good evidence base for intervention during childhood and adolescence and in particular for school-based interventions as shown in Table 3.

Table 3: Mental health and wellbeing outcomes for evidence-based interventions in childhood

	Intervention	Evidence-based outcome
Developing Well	1. Pre-school and early education programmes as in the Healthy Child Programme	Improved cognitive skills, school readiness, academic achievement, prevention of emotional and conduct disorder
	2. School-based mental health promotion programmes and intervention strategies – promoting positive mental health for all and identifying and targeting those with problems	Improved wellbeing with resultant improvement in academic performance, social and emotional skills, classroom behaviour and reductions in anxiety and depression. Social and emotional learning (school based intervention) showed 10% reduction in classroom misbehaviour, 11% improvement in achievement tests, and 25% improvement in social and emotional skills

Source: Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014

School based interventions have been evaluated and found to produce a net cost saving as shown in Table 4.

Table 4: Calculations of cost savings of interventions. Cost savings presented related to £1 investment

Intervention	Saving per £1 investment
School-based social and emotional learning programmes	£84
Pre-school educational programmes for 3-4 year olds in low-income families	£17
School-based interventions to reduce bullying	£14
School-based violence prevention programmes with net savings six and ten years after the programme began	£829 and £6,446 net savings six and ten years after the programme began

Source: Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014

What we should be doing

It is clear that early years and school-based interventions are both effective and cost-effective. The National Institute for Health and Care Excellence (NICE) has produced guidelines for emotional and social wellbeing for early years and secondary schools (PH40 and PH 20 respectively). The recommendations are also informed by a review of Tier 1 and 2 child and adolescent services for mental health and wellbeing for Central Bedfordshire. Undertaken in 2014, the review compared current service provision against the available evidence and NICE guidelines.

Progress towards full implementation of the Healthy Child Programme (HCP) 0-5 years was identified as a gap in 2010 and is now being addressed through the 2011-2015 Health Visiting Implementation Plan. We should continue to act to increase health visitor workforce and full implementation of the HCP 0-5 years. Health and early years providers, should put systems in place to deliver integrated universal and targeted services that support vulnerable children's social and emotional wellbeing. This should include systems for sharing information and for multidisciplinary training and development. It was also recommended that health and early years, practitioners should develop and agree common pathways and referral routes that define how practitioners will work together, as a multidisciplinary team, across different services

The review also highlighted that Tier 1 and 2 services should be strengthened. Professionals working with children who are responsible for the delivery of Tier 1 services must primarily be aware of this responsibility and have the right skills to deliver this service. We therefore recommend that practitioners working with children and young people have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing. They should also provide an environment that promotes positive behaviours and successful relationships and helps reduce disruptive behaviour and bullying.

Recommendation 3: Increase identification of children who are at risk of poor mental health earlier and ensure that they have access to appropriate services

Risk factors for mental ill health in children and young people can be grouped into child, parental and household risk factors. These include:

- substance misuse and maternal stress during pregnancy,
- poor parental mental health,
- parental unemployment,
- social deprivation,
- low birth weight,
- child abuse and
- being a looked after child.

Local Picture

Domestic Violence, Substance Misuse and Mental Health Illness are three influencing factors in a child's environment. They have been shown to have a potentially amplifying and negative effect. This has been termed the "Toxic Trio"[18]. Pressures on parents from factors within the Toxic Trio can adversely affect parenting capacity and extra support should be considered in these circumstances. It is estimated that 26% of babies in the UK have a parent who is affected by one of the "Toxic Trio"[19].

Between April 2013 – March 2014 there were 2698 incidents of domestic abuse in Central Bedfordshire, an 11% increase on the same time period the previous year. 41% of the domestic abuse incidents in Central Bedfordshire were noted to have a child present at the time of the abuse occurring, this is a 4% decrease on the same time period last year.

Data regarding the Toxic Trio risk factors are collected by the drug and alcohol misuse services in Central Bedfordshire. Table 5 shows the number of clients in contact with the drug and alcohol services in Central Bedfordshire living with children. The total number of clients seen living with children was 193 of whom 5 had all three of the Toxic Trio risk factors.

[18] All Babies Count. NSPCC. Available at: http://www.nspcc.org.uk/Inform/resourcesforprofessionals/underones/all_babies_count_pdf_wdf85569.pdf Accessed on 10/02/2014

[19] The 1001 Critical Days, the importance of the conception to the age 2 period. A cross-party manifesto. Leadsom, A; Field, F; Burstow, P; Lucas, C. Available online at http://www.andrealeadsom.com/downloads/1001cdmanifesto.pdf (Accessed on 30th January 2014). Adapted from the NSPCC's all babies count campaign.

Table 5: Number of clients of drug and alcohol services living with children and Toxic Trio risk factors (snapshot May '14)

Toxic trio Risk factors		Central Bedfordshire
Substance Misuse	Substance Misuse only	140
Two out of three	Substance Misuse and Mental Health Illness	40
	Substance Misuse and Domestic Violence	8
All three	Substance Misuse, Mental Health Illness and Domestic Violence	5
All Clients with Children Total		193

Source: Drug and Alcohol Services provider data

Young offenders are a specific group of young people who are vulnerable to mental health illness and whilst the numbers of first time entrants have reduced annually within Central Bedfordshire, many of those entering the system have mental health needs. In 2013/14 17 of the 65 first time entrants were referred to the CAMHS worker seconded to the Youth Offending Service.

What works

NICE has produced guidance for early intervention for a range of mental health disorders. These have been summarised in Appendix 1. Importantly, both the model of interventions used (e.g. Cognitive Behavioural Therapy, medication, family therapy) and the way the clinician works in collaboration with a family or young person (the therapeutic or working alliance) can have a significant effect on clinical outcomes.

As well as the moral argument for early intervention, there is also a positive return on investment for interventions. Cost effectiveness data has shown that for a £1 intervention for psychosis there is a return of £18 and early interventions for parents of children with conduct disorder there is a return of £8[20].

What we should be doing

Tier 1 services should not only improve resilience and wellbeing but also identify children who need more targeted intervention. Once a mental health issue has been identified that has not been resolved by Tier 1 support there should be a referral made to Tier 2 services. Tier 2 is the first step of the 'specialist Child and Adolescent Mental Health Service'.

We should increase identification and early intervention through raising awareness of existing Tier 1 and 2 child mental health and wellbeing services locally as part of the development of a standard referral pathway. This would be helped by the creation of a directory of services (e.g. on a webpage) for child mental health and wellbeing which is kept up to date.

We recommend a longer time period for Tier 2 mental health services to be delivered to patients, echoing the recommendation made by the recent Tier 1 and 2 review.
Currently most local services offer 4-8 sessions and NICE recommends that 8-12 weeks treatment may be required for certain mental health illnesses such as depression to improve outcomes. This increased intervention at Tier 2 should be monitored to ensure that it improves outcomes and prevents some children and young people needing more intensive treatment.

[20] Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014

Case Study

Why were mental health services approached for support?

Lucy's* mother contacted our service to request support for her daughter who appeared to be suffering from anxiety and panic attacks. The anxiety had impacted on Lucy's day to day activities and she had decided to drop out of college as she was struggling to attend lessons and concentrate on her work. She was therefore spending most of her day at home and had dis-engaged from seeing friends and going out with family. The reduction in activities and anxiety seemed to impact on her mood and she appeared to also be suffering symptoms of depression secondary to the anxiety.

What support and services were provided?

Lucy attended for an initial assessment within CHUMS Emotional Wellbeing Service **(**Tier 2 intervention service) where it was agreed to offer Lucy on-going psychological support based on Cognitive Behaviour Therapy (CBT). CHUMS deliver the CYP-IAPT service (Children and Young People's Improving Access to Psychological Therapies service) which enabled Lucy to access an evidence based long-term intervention of 16 sessions of support. Lucy attended weekly appointments which were targeted to support her work towards her goals of reducing the frequency of panic attacks, going back to school and seeing her friends more regularly. We utilised a CBT approach to enable her to develop strategies to understand panic attacks and to identify helpful coping strategies.

What was the outcome?

At the end of the intervention, Lucy was working weekends as a shop assistant and had started back at college full time. She had significantly reduced the frequency of panic attacks from two per day to not experiencing a panic attack for the last 3 weeks of intervention. She was now going out with friends more regularly and felt that her mood had improved owing to the increase in her daily activities.

What could have made the service even better?

Lucy was able to take benefit of accessing longer term support within a Tier 2 service, which supported her to work on her goals without necessitating a referral to specialist Tier 3 colleagues. Owing to the volume of referrals to our service Lucy had a waiting time between referral and assessment and again between assessment and intervention. It would have enhanced the level of care if this was a more timely process for Lucy and her family.

Case study from clinical psychologist at CHUMS

*Name has been changed to maintain confidentiality

Summary

Among teenagers, rates of depression and anxiety have increased by 70% in the past 25 years[21]

In Central Bedfordshire it is imperative that we improve mental health and wellbeing for all children due to the long lasting negative impact of mental health illness. We believe that this requires action on the following recommendations:-

- a good start in life,
- emotional resilience and wellbeing and
- detecting and treating illness early.

Key recommendations to address mental health in children and young people:

1. Ensure excellent maternal mental health
   a. Identify early women with poor mental health through antenatal and postnatal maternal mood assessments
   b. Ensure that the ante and postnatal pathways for maternal mental health are followed and women have access to high quality and timely support for mental health illness

2. Help children become more resilient
   a) Health and early years practitioners should develop and agree pathways and referral routes that define how practitioners will work together, as a multidisciplinary team, across different services (NICE guideline PH40)
   b) Ensure practitioners have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing (NICE guideline PH20)
   c) Provide a curriculum that promotes positive behaviour and successful relationships and helps reduce disruptive behaviour and bullying (NICE guideline PH20: Mental health and behavior in schools. Department for Education. 2014)

3. Increase the early identification of children who are at risk of poor mental health earlier and ensure that they have access to appropriate services

[21] Fundamental Facts. Key facts and Figures about Mental Health. 2007. Mental Health Foundation. http://www.mentalhealth.org.uk/content/assets/PDF/publications/fundamental_facts_2007.pdf?view=Standard Accessed 16/06/2014

2. Adults and Older People

At any one time, approximately one in six of us experience a mental health problem and mental health problems are estimated to cost the English economy around £105 billion[22].

Mental illness in adults can be classified through common mental disorders (anxiety, depression, obsessional compulsive disorder), personality disorders, psychoses, eating disorders (including anorexia nervosa and bulimia) or disorders related to substance misuse (alcohol and drugs). The number of the population in Central Bedfordshire who are affected by mental health disorders are described in Table 6 with future projections to 2016 (based on the changing population)

Table 6: Five year projections of common mental disorders, personality disorder, psychotic disorders and two or more psychiatric disorders (all persons) in Central Bedfordshire

Mental Health - All People	2012	2013	2014	2015	2016
People aged 18-64 predicted to have a common mental disorder	25,782	25,948	26,232	26,503	26,735
People aged 18-64 predicted to have a borderline personality disorder	721	725	734	741	748
People aged 18-64 predicted to have an antisocial personality disorder	559	563	568	575	579
People aged 18-64 predicted to have psychotic disorder	641	645	652	659	664
People aged 18-64 predicted to have two or more psychiatric disorders	11,522	11,600	11,723	11,846	11,947

Source: www.PANSI.org.uk (Based on National Prevalence of 17.6% of 16-64 year olds; applied to 18-64 year olds)

Through estimations of the changes in population it is predicted that there will be an 11% rise in the prevalence of dementia cases in those aged 65 years and over between 2013 and 2016 in Central Bedfordshire. This is an increase in cases from 2,804 to 3,104 (POPPI data figures). The ratio of recorded to expected prevalence of dementia is used to detect unmet need. Latest comparison figures in the Community Mental Health Profiles 2013 show that this ratio in Central Bedfordshire in 2010/11 was lower than the England average. This means that the proportion of people with dementia who are formally diagnosed is lower than the England average. This means that there may be higher unmet need for dementia in Central Bedfordshire.

[22] No Health Without Mental Health Framework. Department of Health

Recommendation 1: Improve the physical health of those with mental health illness by ensuring good access to healthy lifestyle support

Males with mental illness die on average 16 years earlier and women with mental illness die 12 years earlier than those without mental illness. Cardiovascular disease and cancer account for 75% of this reduction in life expectancy[23]

An estimated 70% of new cases of depression in older people are related to poor physical health[24]

Mental ill health can lead to poor physical health and physical ill health can lead to poor mental health. We know that we can modify our lifestyles to have a large impact on our physical health. Whilst there can be direct reasons why people with mental health illness find it harder to adopt healthy lifestyles such as not smoking, having a healthy weight and taking regular exercise, there needs to be equal and fair access to healthy lifestyle support.

Local Picture

Local services are available to support people stop smoking, lose weight, reduce harmful drinking and to be more physically active. It is not possible to determine precisely what proportion of people accessing most services also have a mental health issue, however we do know that approximately 20% of those entering treatment for drug and alcohol misuse in Central Bedfordshire also have a diagnosed mental health issue.

Cancer screening programmes and the NHS Health Check Programme are important to detect disease early and improve physical health outcomes. Data that links mental health diagnosis with attendance at these programmes is not routinely collected but anecdotal evidence suggests that those with mental health illness are less likely to attend these programmes.

What works

Evidence based interventions that are currently offered locally to improve physical health are:

- providing healthy lifestyles support including stop smoking services and weight management
- cancer screening
- early detection of illness through the NHS health check programme and
- "Making Every Contact Count" (MECC) which takes opportunities during health care contacts with patients to detect risk, deliver brief advice and signpost to relevant services

[23] The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. BMJ 2013; 346 doi: http://dx.doi.org/10.1136/bmj.f2539 (Published 21 May 2013)
[24] The Fundamental Facts. Mental Health Foundation 2007.

What we should be doing

Services to promote physical health are in place locally but we need to ensure that those with mental health illness are able to access these services equally. We recommend that GPs should identify and contact patients with known mental health illness who smoke and offer them referral to Smoking Cessation Services. Health and care professionals should be aware of the higher prevalence of smoking in those with mental health illness and increase the use of MECC to identify smokers and direct them to appropriate services. Data should be recorded of those people with mental health illness who have accessed the available services for physical health promotion so that we can ensure that we are accessing this population and further activity should be taken if these numbers are low.

Recommendation 2: Support employers to participate in Workplace Health initiatives and to signpost to relevant resources

There is a strong relationship between employment and mental health. Work is generally good for physical and mental health and well-being and can be therapeutic for people with common health problems. Unemployment is associated with poorer physical and mental health and well-being. Stress and mental health disorders are one of the biggest causes of long-term absence and, according to a number of business surveys, are on the increase as a reason for absence. It is estimated that each year one in six workers in England and Wales is affected by anxiety, depression and unmanageable stress[25]. Mental health promotion can help to make the workplace environment a positive one[26].

The Sainsbury Centre for Mental Health estimates that mental health illness costs £8.4 billion due to absenteeism and £15.1 billion due to "presenteeism" to UK employers. "Presenteeism" is a term used to describe the loss in productivity caused by illness whilst the employee is still present in the workplace and not on sick leave. This is equivalent to a cost of £335 and £605 per average employee for absenteeism and presenteeism respectively.

Local Picture

It is important to note that there is a significant gap in the employment rate for those in contact with secondary mental health services and the overall employment rate. In Central Bedfordshire there is a difference of 61.7% (percentage point difference) in these two groups; the range in the local authorities in the East of England in 2012/13 was between 56.6-71.5%[27]. This is the difference in percentage of people employed who either have or do not have mental health illness. It is possible that providing a healthy workplace could help to reduce this gap.

The Acas training course for mental health and Mental Health First Aid awareness course is an example of a widely used intervention designed to increase understanding of mental health, increased ability to identify mental health illness and support those with illness.

A recent survey from Business in the Community (BITC) indicated that 82% of local businesses wanted to know more about mental wellbeing in the workplace.

[25] Health at work – an independent review of sickness absence. Dame Carol Black and David Frost CBE. 2011. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181060/health-at-work.pdf (Accessed on 17/6/2014)

[26] Centre for Business Innovation. Healthy Returns? Absence and workplace health survey 2011 www.cbi.org.uk/media/.../cbi-pfizer_**absence**___workplace_health_2013.pdf

[27] PHOF, www.phoutcomes.info accessed 24/4/2014

What works

There are several aspects and benefits of work-based mental health promotion. Work-based mental health promotion intervention leads to increased performance at work, reduced sickness rates and reduced anxiety and depression. The provision of work-based stress management reduces work-related stress/sickness absence. There is evidence to show that support during a period of unemployment leads to both increased likelihood of subsequent employment and reduced distress[25].

We know that there is a great financial impact on society as a result of mental ill health. The Department of Health has shown through cost calculations how small investments in public mental health services which focus on early intervention and prevention can result in cost savings. The impact of £1 investments in the various interventions below show that substantial cost savings can be made and, therefore in an age of austerity, should be prioritised.

For every £1 invested in public mental health interventions could save[28]:

- £10 – work-based mental health promotion (after 1 year)
- £5 – early diagnosis and treatment of depression at work

What we should be doing

Continue partnership working between the local authority, health services and voluntary and community organisations. The aim should be to support employers to provide a healthy workplace through providing health and wellbeing information and support to their staff and signposting to the relevant agencies.

In addition to training, Public Health offer mental health support to workplaces through staff health events, newsletters, Workplace Health brochure and the workplace health webpage on Central Bedfordshire Council's website.

[28] Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on 25/3/2014

Recommendation 3: Increase understanding of mental health and wellbeing and reduce stigma of mental ill health

Nearly nine out of ten people with mental health problems say that stigma and discrimination have a negative effect on their lives[29]

Despite mental health problems affecting one in four people at some point in their lives, people with mental health conditions are the least likely out of all people with a long term condition or disability to be included in mainstream society[29]. Part of this problem is due to the inaccurate view of people with mental health illness being in some way violent or dangerous. In fact, people with mental health illness are more likely to be victims of crime than the perpetrators[29].

A good way to tackle myths surrounding mental illness is through social contact; this, both reduces stigma and the negative cycle of social isolation[29].

Local Picture

Social isolation is not only a consequence but an important risk factor for mental ill health The Adult Social Care Survey has shown that in Central Bedfordshire only 43.5% of adults receiving social care report that they have as much social contact as they would like. This low percentage is also the national average showing that it is a widespread problem. The same survey question was asked of adults carers of whom 41.6%% reported that they had as much social contact as they would like. This group of people are at increased risk of mental health illness due to the increased pressures of caring for someone else.

What works

The majority of evidence-based mental health promotion interventions for adults and older people involve opportunities for social interaction as shown in Table 7.

[29] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/S/stigma-discrimination/ (Accessed 15/05/2014)

Table 7: Evidence based recommendations for mental health promotion in adults and older people

Life Stage	Activity	Evidenced based outcome
Living well	1. Neighbourhood enhancement and regeneration	"walkable" neighbourhood schemes increase rates of physical activity and provide more opportunity for social interaction. Increase perceived safety.
	2. Increased opportunity for physical activity including active leisure and transport	Reduction in depression, improved wellbeing in people with schizophrenia, better cognitive performance in children, better mental health outcomes in older people.
	Activity	Evidenced based outcome
	3. Spiritual awareness, practices and beliefs	Improved mental and physical health as well as improved quality of life and recovery from mental health illness.
	4. Increased social capital; arts, music, creativity, learning, volunteering	Improvement of social skills and reduction in health risk behaviour, improved recovery from mental ill health, meaningful occupation and participation. Individual and community empowerment.
	5. Access to safe, open, green spaces; community spaces and allotments	Improved mental health, reduced stress and aggression, improved social interaction, social inclusion and training.
Ageing Well	6. Interventions to reduce social isolation such as befriending	Improved mental wellbeing. Befriending reduces depression.
	7. Psychosocial interventions	Promote wellbeing and prevent depression.
	8. Volunteering opportunities	Improved wellbeing, self-reported health, and reduced depression.
	9. Learning programmes	Improve wellbeing.
	10. Addressing hearing loss	Improved quality of life.

Source: Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on 25/3/2014

What we should be doing

We make the recommendation of reducing stigma through decreased social isolation and increased understanding of mental health illness to the whole population of Central Bedfordshire, as well as the organisations responsible for health and wellbeing.

We encourage people to reach out to those around them with simple acts of befriending; especially to those that they know to be vulnerable to social isolation such as the elderly and the marginalised. A regular visit to an elderly person's home or a weekly telephone call can be simple but effective ways of providing that support.

There are several ways to increase social contact; one example is through the "Time to Change" campaign. This advocates sending an e-card to a friend with an invitation to a social activity which can be as simple as; spending time together; having a cup of tea; going for a bike ride or playing a video game. For more details on this campaign see http://www.time-to-change.org.uk/

An assessment of the Health Needs of people with Dementia will be carried out later in 2014 to inform the further development of preventative and supportive care for those affected by dementia and their carers.

Case Study

Why were mental health services approached for support?
This client had depression and anxiety and was struggling to cope. There were also issues with mounting debts and ex-employer.

What support and services were provided?
The client received intervention from; community mental health team, counselling at GP, psychological input and medication, psychiatrist, care co-ordinator and group help.
This client also self-referred for advocacy services and Christians Against Poverty (CAP)

What was the outcome?
A compromise agreement was reached with employer. Housing issues were resolved regarding rent and discretionary payment. Debts were cleared with CAP. Client is now in receipt of Disability Living Allowance (DLA) all with advocacy support. Client still has support of care coordinator and groups

What could have made the service even better?
Time to get to know client and listen to her.
More group sessions for longer time and support should be available outside of the group as issues have to wait for another week to be discussed.
The crisis team need to be more client focused rather than time focused.

This client would like to say:
Don't judge me!!
Case study from PoWher
POhWER is a charity and membership organisation. PoWher provides information, advice, support and advocacy to people who experience disability, vulnerability, distress and social exclusion.

Summary

Adults and Older People

The recommendations made here have been highlighted because they will reduce inequalities, have the potential for widespread impact and are achievable. The current inequality in physical health and resultant premature mortality needs to be addressed urgently and there are services in place that we could use more effectively. Promoting mental health and wellbeing in the workplace would impact on a large number of people and could prevent illness which would reduce sickness absence. Stigma both has negative impacts on the person in terms of mental wellbeing and reduces the likelihood that people will seek help early.

Key recommendations to address mental health in adults and older people:

1. Improve the physical health of those with mental health illness by ensuring good access to healthy lifestyle support
2. Support employers to participate in Workplace Health initiatives and to signpost to relevant resources
3. Increase understanding of mental health and wellbeing and reduce stigma of mental ill health

3. Progress against key recommendations in the 2013 DPH report on inequalities

The Director of Public Health's Annual Report on Health Inequalities in Central Bedfordshire (published in January 2013), set out a number of key recommendations for Central Bedfordshire Council, General Practices and Bedfordshire Clinical Commissioning Group (BCCG). Some of the recommendations related to strengthening 'business as usual' so this summary focuses on progress of new local or national initiatives commenced, or those further developed during 2012/13.

It was clear from the Director of Public Health's Report on Health Inequalities that progress can only be made by key organisations working together and considering what combined action they can take. This summary demonstrates that we have achieved progress in this area and we will continue to strengthen partnership working. (See Appendix 2).

There has been a reduction in the life expectancy gap between people living in the most and least deprived areas of Central Bedfordshire for both men and women (2010-12). The life expectancy gap is now 6.6 years for men (8.0 years in 2009-11) and 5.4 years for women (6.3 years in 2009-11).

The conditions in which people are born, grow, live, work and age can all lead to health inequalities. The 2010 Marmot Review, Fair Society, Healthy Lives[30], identified six key objectives to reduce inequalities in health:

1. giving every child the best start in life;
2. enabling all children, young people and adults to maximise their capabilities and have control over their lives;
3. creating fair employment and good work for all;
4. ensuring a healthy standard for all;
5. creating and developing sustainable places and communities;
6. strengthening the role and impact of ill-health prevention.

These objectives define the vision in Central Bedfordshire, outlined in the refreshed priorities of the Joint Health & Wellbeing Strategy:

- giving every child the best start in life;
- ensuring good mental health and wellbeing at every age;
- improving outcomes for frail older people;
- enabling people to stay healthy longer.

Central to the Marmot Review is the recognition that disadvantage starts before birth and accumulates throughout life. Thus, the first priority – giving every child the best start in life – remains of paramount important and focus in Central Bedfordshire[31].

[30]The Marmot Review 2010, Fair Society, Healthy Lives.URL:http://www.instituteofhealthequity.org / Content/FileManager/pdf/fairsocietyhealthylives.pdf
[31]Children and Young People's Plan June 2013 – March 2015.

Appendix 1

NICE Best Practice for mental health disorders in Children and Adolescents

Conduct Disorders		
NICE Parent-training/education programmes in the management of children with conduct disorders TA102 (2006)	Parenting programmes (for children under 12 years old). Evidence based and ideally lasting 8-12 sessions. Some evidence for individual interventions to help with coping skills and problems solving in adolescents.	Tier 1/2

Emotional Disorders		
NICE Depression in children and young people : identification and management in primary, community and secondary care CG28 (2005)	Mild depression can be treated at tier 1 or 2 with psychological interventions for 2-3 months (if not improved after 4 weeks of watchful waiting). Include individual non-directive supportive therapy, group CBT or guided self-help. Referral to specialist services is suggested if not improved. Psychological therapies are also appropriate therapy for anxiety problems.	Tier 1/2/3

Hyperkinetic Disorders		
NICE Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults CG72 (2008)	Watchful waiting up to 10 weeks or offering a referral to a parent-training/education programme considered if suspected ADHD is having an adverse impact on development or family life. For young people with moderate levels of impairment a group parent-training/education programme, either on its own or together with a group treatment programme, CBT and/or social skills training, for the child or young person.	Tier 2/3

Developmental Disorders		
NICE Autism in children and young people CG128 (2011)	Local pathway for recognition, referral and diagnostic assessment of possible autism. 'Autism team' to be set up. Single point of referral to autism team. Behavioural interventions to address a wide range of specific behaviours in children and young people, to reduce symptom frequency and severity, increase development of adaptive skills.	Tier 2/3

Eating Disorders		
NICE Eating disorders CG9 (2004)	People with suspected anorexia nervosa should be referred to specialist care immediately. Those with suspected bulimia can be managed with an evidence-based self-help programme. Adolescents can be appropriately managed with cognitive behavioural therapy but will normally need 16-20 sessions over 4-5 months	Tier 1/2/3

Self - Harm		
NICE Self Harm CG16 (2004)	Referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, it should not be determined solely on the basis of self-harming.	Tier 1/2/3

Appendix 2: Summary Against Key Recommendations (from 2013)

The report recommended:	Progress to date:	Next steps:
a) Give every child a good start in life by ensuring:		
• Early access to antenatal care;	SEPT Community Health Visiting Service is working in close partnership with Midwifery Services in both local hospitals to provide antenatal contact from The Health Visiting Service between 28 and 34 weeks for all pregnant women. This contact includes a discussion with both parents to discuss preparation for parenthood and to deliver key public health messages around smoking; feeding; maternal obesity; dug and alcohol issues; guidance on reducing the risk of Sudden Infant Death Syndrome (SIDS). The Health Visiting Service is currently able to contact approximately 60% of pregnant women. Health Visitors and Midwives have also piloted *'Bump, Birth and Baby Stuff'* Programmes in community based clinics in Children's Centres in Dunstable and Houghton Regis – with very effective outcomes. A Maternal Obesity Programme began in March 2014 to support obese pregnant women in the south of Central Bedfordshire who deliver at the Luton & Dunstable hospital. The programme is delivered in partnership by Slimming World and the Midwifery Service at Luton & Dunstable hospital. Pregnant women are able to access a 12-week programme to support them in their pregnancy and to signpost them to manage their weight post-natally.	Formal Information Sharing Agreements (ISAs) are due to be finalised imminently with both Bedford Hospital and The Luton & Dunstable Hospital to ensure that information regarding 100% pregnant women is shared between Midwifery and Health Visiting Services. Additional *'Bump, Birth and Baby Stuff'* Programmes will now be rolled out in all localities across Central Bedfordshire. The impact and outcomes from the programme will be monitored and reviewed to inform commissioning beyond 2014.
• Reducing smoking in pregnancy and the number of babies living with a smoker;	The Stop Smoking Service has piloted a new, Specialist Stop Smoking in Pregnancy Programme - targeted in areas of high prevalence: Houghton Regis, Dunstable and Leighton Buzzard. The conversion rate from attendance to	The Specialist Stop Smoking Programme will now be rolled out across all of Central Bedfordshire. Other work also includes the continuity of working closely with maternity teams and children's services to ensure brief interventions are being given

	quit has increased significantly in the pilot, with latest figures showing 90% of women quitting after 4 weeks. Figures also show an increase in women signing up to the long term Smoking in Pregnancy Programme. Links are also being made with Outreach Workers in Children's Community Centres to deliver support to stop smoking and referrals to the *'Smokefree Homes and Cars'* programme.	to pregnant smokers and young parents to increase access to the Stop Smoking Service and meet quitters targets.
• Increase in breastfeeding;	Midwives are actively encouraged to discuss/promote breastfeeding with all pregnant women as part of routine antenatal visits, and as part of the 28-34 weeks antenatal visit by Health Visitors. There is continued support for breastfeeding at birth by midwives and Health Visitors, with additional support from Health Visitors to promote beast feeding until the 6-8 week assessment: • 6-day phone call • New Baby Face-to-face Review by 14 days • 4-week phone call UNICEF Baby Friendly Accreditation achieved – which supports breastfeeding and parent/infant relationships. Implementing Baby Friendly standards is a proven way of increasing breastfeeding rates.	Midwifery and Health Visiting Service to maximise antenatal opportunities to promote, encourage and support breast feeding. The Midwifery Service to continue to actively promote "skin to skin" and breastfeeding initiation immediately after birth. Ensure that The Baby Friendly Action Plan is implemented, monitored and evaluated, with a particular emphasis on key actions to: • Increase the numbers of Breastfeeding Buddies and Baby Brasseries • Further develop *'Out and About Breastfeeding'* • Establish and expand the special support service for breastfeeding mothers by the Baby Friendly Team
• Reduction in childhood obesity.	Two Family Weight Management Intervention Programmes – *BeeZee Tots (2-4 years)* and *BeeZee Bodies (7-15 years)* have been commissioned locally to support children and their families in to embrace a healthier lifestyle. These programmes encourage boosting children's self confidence and equipping them with the information and skills to make positive lifestyle choices. Those children who are identified through The National Child Measurement Programme (NCMP) as having high levels of obesity are targeted specifically to engage with these programmes.	Further developments include developing more bespoke programmes within targeted areas for example a *BeeZee Bodies* programmes specifically for girls aged 9-15 to run alongside the current *BeeZee Bodies* programmes. There are also new initiatives and training planned to strengthen pathways for referrals from School Nurses and other health and education professionals into commissioned family weight management programmes and appropriate support services. Public Health will be working with schools within high obesity areas to strengthen their engagement with the School Food

	A local schools based programme to increase physical activity, self-esteem and positive eating choices - 'Making *the Most of Me'* – has also been piloted in Years R and Year 4 in targeted school communities.	Trust and to review and develop their Whole School Food and Physical Activity Policies and Practice to secure maximum positive outcomes. All Lower School communities will be able to access *'Making the Most of Me'* via a rolling programme of training across the academic year. Public Health will also be contributing to development planning which would assist with the improvement of use of green spaces, cycle ways, increasing activity as well as changing eating habits with healthier food outlets – e.g. to ensure that hot food take away establishments are restricted for planning permission within 500 metres near schools.
b) Improve the wider determinants of health such as:		
• Housing;	Worked with Private Sector Housing around improving the quality of peoples homes through the on the Warm Homes Healthy People scheme, for example to provide better heating, more efficient insulation etc., for the target vulnerable populations Awareness of the strategic links between housing and addressing inequalities ('*Designing in Health')* were fed into the draft Housing Development Strategy document to ensure that environments, services, facilities and opportunities are available to prevent inequalities in new developments as well presenting opportunities to reduce inequalities in existing neighbouring communities.	Develop WHHP outline through secondment post with a view to identifying sustainable, on going action plan and resource. To continue to identify and use opportunities to reduce/prevent inequalities linking with housing related to developments, e.g. to inform the Pharmaceutical Needs Assessment
• Employment;	The LSOA have identified the rates of employment and average wages as requiring further work to improve the skills of those of working age. Recommendation of a number of initiatives have been put in place to support those living in the areas of greater deprivation to access work - for example; a Work Club at	Next steps to increase access to skills and employment support, particularly in the south of the area will be to link with Job Centre arrangements also need to be resolved, which although are a combined service in Watling House for the top 10-15% most vulnerable clients, the remainder have to go to Luton for job support. This links with the issue of affordable transport and childcare as a major barrier to work and ensure

	Kingsland; the Library in Dunstable offers ICT access and support in addition to the innovation centre in Dunstable which offers support for those wishing to set up in business and train in sustainable construction skills. Working with Central Bedfordshire College includes delivering a bespoke course to develop skills in hospitality, and attendees are referred by Job Centre Plus, who upon completion offer guaranteed interviews. The College are extending this offer to both Tragus (one of the Centre Parcs franchises) and HoneyTop Foods who are recruiting another 100+ staff each over the next year. Another development linked with social housing and housing association tenants in targeting training and employment opportunities directly to this group led by tenant participation officers.	good ICT access to be able to apply on line and job search. Further development required for work with the Travel Choices Team to make sure people are confident in being able to get to work.
c) Secure high quality alcohol and drug prevention and treatment services for our most vulnerable residents.		
	The contract for drugs and alcohol has been re-procured and a new provider started in September 2012. This included an integrated service and increased emphasis on recovery (being drug or alcohol free) rather than reducing the harm associated with addiction. It has been noticed that the proportion of people successfully completing treatment and not representing within six months is gradually increasing, and the service provision within Central Bedfordshire has increased with the hub at Dunstable having been re-furbished and new satellite services being established. There is an increased provision of community based alcohol services which has also commenced and furthermore, the drug and alcohol prevention and treatment service is also being re-procured - with increased emphasis on prevention - targeted in the areas of higher deprivation.	Recommendations are to increase the numbers accessing and successfully completing treatment. Also to ensure that the services are working closely with social care and meeting the needs of vulnerable groups such as troubled families, looked after children, and people with mental health issues. There is a review currently in progress to identify required alcohol treatment and provision.

	There has also been a rise in numbers of front-line workers that have been trained to deliver interventions and brief advice for alcohol (IBA).	
d) Continue to deliver on public health targets which influence health inequalities such as:		
• Teenage pregnancy rates;	Targeted work continues with vulnerable groups with continuity of improvements to increase access to Contraceptive and Sexual Health (CASH) Services and high quality PSHE/SRE.	To implement a PHSE/SRE Partnership Network to support school communities in ensuring that all young people have access to high quality PHSE/SRE. There will also be the launch of a new, local website and marketing materials which are part of the Sexual Health Communications Strategy. Further work will explore how harmful drinking is linked with teenage pregnancy and how to help young people to build their resilience and coping strategies.
• Obesity;	Workplace Health Events provide opportunities for visual and verbal advice on healthy eating/obesity, including information to those with families. All GP Practices across Central Bedfordshire are now participating in a Weight Management Referral Scheme to ensure that the most vulnerable and most deprived communities are able to access a weight management programme. Weight Watchers and Slimming World have been commissioned to deliver the programme. Work is also being done with Physical Activity/Leisure Services, to ensure food within vending machines at all 6 leisure centres in Central Bedfordshire have a healthy option of at least 25%. Centres must also provide a Well Being Plan, working alongside the Submission Committee appointed the Contractor for 4 of the leisure centres.	Continued support for adults (16+) to access weight management referral and exercise schemes. To continue to monitor the uptake of the programme in the most deprived areas and to ensure that the programme is promoted through GP Practices and through other partners in Health, and in Social Care.

• NHS Health Checks;	Delivery of a Health Check Programme involving all GP practices as providers, supplemented by provision in a number of other community contexts.	To develop a new wave of campaigning for implementation links to a 'Systm One' Health Check template currently being produced for GP Practices to utilise. There is an emphasis on Practices looking at ways of targeting vulnerable communities in their areas. To also enhance promotion with local companies throughout Central Bedfordshire currently being consulted on the benefits of Health Checks.
e) Increase access to the Stop Smoking Service for the populations with the highest smoking prevalence and premature mortality rates by:		
• Additional support to GP practices serving these people and setting and monitoring challenging quitter targets.	Stop Smoking Service continue to review best effective methods of promoting access to the Service. These promotions are done through workplaces with smoke awareness stands, encouraging employers to offer group stop smoking support especially targeting workers in distribution warehouses. Other stop smoking promotions considered are car park tickets, working closely with pharmacies and evening clinics to improve awareness of local services. GP Practices are also involved in assisting with raising the target of quitters. Targets for 2013/14 were set using historical prevalence data and have been monitored quarterly.	Commissioning decisions are to ascertain methods to increase quitter target with suggestions including premium incentives for Practices who achieve targets and specific targets from MSOA areas. Practices who underachieve will receive a possible penalty to encourage them to take on a more proactive responsibility in reaching their quitter targets.
f) Produce tailored information on health inequalities for GP practices in the most deprived areas and make practice-specific recommendations for evidence-based action.		
	The Stop Smoking Service is currently encouraging GP Practices to send Stop Smoking information included with patients mail outs with a financial support in line with patient confidentiality regulations. Other support includes	The development of phase 2 of the Locality Profiles will include other indicators and drivers of inequalities of health and will have an additional focus on children.

	regular visits by L2 Advisers and general training has been redesigned to adapt to meet Practice needs. Data reports are provided for Practices to assist with achieving targets and any decision making resources delivered free. There are also Locality Profiles which have been developed for each of the 4 Localities within Central Bedfordshire and have identified areas where there is a variation in care, which has influenced the locality plans to drive reduction in variations of care. Contracts with community, mental health and acute providers for 2013/14 are all including targets for Making Every Contact Count, and this includes SEPT Community Service areas also including targets for smoking quitters. These are all currently monitored on a monthly basis.	
g) Make Every Contact Count (MECC) by ensuring that relevant frontline council staff have received MECC training.		
	MECC training is currently being promoted through CBC website and forums. Social Care, Health and Housing, Care Forum, Leisure Services and Voluntary and Community Sector have all requested training.	MECC training and Train the Trainer courses will be continually promoted to all council front-line staff. These will be delivered to a range of providers/staff who will often be accessing a number of vulnerable populations, for example Fire & Rescue staff who will be going into homes to do safety checks.

Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Central Bedfordshire Safeguarding Children Board: Annual Report 'The effectiveness of partner's work to safeguard and promote the welfare of children in Central Bedfordshire' from 31 March 2013 to 31 March 2014
Meeting Date:	2 October 2014
Responsible Officer(s)	Richard Carr, Chief Executive; Sue Harrison, Director of Children's Services.
Presented by:	Alan Caton OBE. Independent Chair of Central Bedfordshire Council Local Safeguarding Children Board.

Action Required:

1. To receive Central Bedfordshire Local Safeguarding Board's Annual Report 2013-2104 as required by the Working Together 2013 statutory guidance on interagency working to safeguard and promote the welfare of children.

2. To note and comment on the achievements and areas for development described within the Annual Report 2013 – 14.

Executive Summary	
1.	Working Together 2013 guidance sets areas to be covered in the Annual Report. It should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period.
2.	It should also list the contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training. The Annual Report should be published on the local LSCBs website and is drawn to the attention of the Health and Wellbeing Board, the Police and Crime Commissioner, the local authority Chief Executive and the Leader of the Council. This report is submitted to the Health and Wellbeing Board for information.

Background	
3.	Working Together 2013 states that the Chair of the Local Safeguarding Children Board (LSCB) must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area (this is a statutory requirement under section 14A of the Children Act 2004). The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Wellbeing board.
4.	The Annual Report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period.
5.	The report should also list the contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training. All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective. Members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies.
6.	This report therefore provides Health and Wellbeing Board Members with a view of the LSCBs achievements and challenges during 2013-2014. This report shows how LSCB partners have worked together and individually to keep children safe, deliver our agreed Board priorities and meet our statutory objectives to: • coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and • ensure the effectiveness of what is done by each such person or body for those purposes.
7.	The foreword from the Independent Chair provides a summary of the key achievements and challenges.

Detailed Recommendation	
8.	For Board Members to note receipt of the LSCB's Annual Report 2013-2104 as required by the Working Together 2013 statutory guidance on interagency working to safeguard and promote the welfare of children.
9.	For Board Members to note and comment on the achievements and areas for development described within the LSCB Annual Report 2013 – 14.

Issues	
Strategy Implications	
10.	Health and Wellbeing Board Members may wish to consider the key challenges faced by the Board during the year, in particular the performance issues relating to domestic abuse and the impact that this is likely to have on the following Health and Wellbeing priorities: • Improving the health of looked after children • Safeguarding and quality of care • Improving mental health for children and their parents • Improving mental health and wellbeing of adults.
Governance & Delivery	
11.	The governance of this report sits with the Central Bedfordshire Safeguarding Children Board.
Management Responsibility	
12.	The annual report is the responsibility of the Independent Chair. At the time of the production of the annual report 2013-2014 the Independent Chair was Phil Picton. However, the Independent Chair is now Alan Caton OBE.
Public Sector Equality Duty (PSED)	
13.	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 *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
This is not a proposal so there are no risks that are attached to this report. The LSCB has a risk log to manage risks relating to its key priorities.			

Source Documents	Location (including url where possible)
LSCB Business Unit.	Watling House, Dunstable Will be published online at http://www.centralbedfordshirelscb.org/lscb-website/home-page

Presented by
Alan Caton OBE. LSCB Independent Chair.

Central Bedfordshire Safeguarding Children Board: Annual Report

31 March 2013 to 31 March 2014

The effectiveness of partner's work to safeguard and promote the welfare of children in Central Bedfordshire

Information about this report

The publication of an annual report summarising the work of the Central Bedfordshire Safeguarding Children Board and assessing the state of safeguarding across the partnership is a requirement of the statutory framework within which Safeguarding Boards work.

The annual report should provide rigorous and transparent assessment of performance and effectiveness of local services. It should identify weak areas, causes, remedial action; lessons learned from reviews; and income and expenditure.

The Statutory functions of the LSCB are set out in Section 14 of the Children Act 2004 as:

- to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- to ensure the effectiveness of what is done by each such person or body for those purposes.

Date of publication: 2 September 2014

Contents

1. Foreword from independent chair

The last year has again brought a raft of changes for partners to grapple with, whilst retaining a focus on working together to keep children safe.

The year started with the publication of the long awaited Working Together 2013 at the end of March 2013, coming into force on 15 April 2013. The new document continues the reforms identified as part of Professor Eileen Munro's independent review of children protection which puts the child in focus at all stages. This brought with it a range of new requirements for our LSCB, including:

- expectations around developing a learning and improvement process to include Serious Case Reviews so that they form an integral part of our work to improve services to children
- the requirement to monitor the effectiveness of Early Help
- defining the safeguarding responsibilities of LSCB partners, including NHS Commissioning Board, Clinical Commissioning Groups and Police and Crime Commissioners – these include staff induction and child protection
- promoting the involvement of children and young people in the work of the LSCB and for the local authority to take reasonable steps to ensure that the LSCB includes two lay members representing the local community

Membership of the Board has been extended and at our September meeting we welcomed two new lay members, a governor representative, a further education representative and a representative from one of our Academy schools. Our previous representative from Barnfield College who represented all schools has since resigned and schools are being invited to provide representatives to ensure system of representation is complete.

During the year Bedford Borough decided to withdraw from the remaining joint working arrangements with the Central Bedfordshire Safeguarding Board and at the end of September the Boards formally separated their joint working arrangements. This included disaggregating the business unit providing support to the Board, reviewing the shared multi-agency training functions and disaggregating the joint working arrangements sitting beneath the Board structure. This provided unique challenges for all partners involved, including recruitment of new staff to the newly created business unit, attendance at additional meetings and the review and development of new protocols and strategies. The Training Review reported at the end of December and the only remaining shared function relates to multi-agency safeguarding training; this continues to be hosted by Central Bedfordshire Council.

The period between October and the end of March saw the Board agree and publish a number of key strategies following the disaggregation, this included:

- a revised Thresholds document following a threshold review

- a Learning and Improvement Framework, including a new performance framework
- a Joint Training and Development Strategy with Bedford Borough Safeguarding Children Board, and
- a Child Sexual Exploitation Strategy

This period also saw the Board focus on its priorities of:

- **Evaluating the impact of Early Help – significant progress and improvement.** This involved reviewing audits of early help cases, communicating the learning and promoting refreshed **Thresholds** and the Early Help offer and process to all key stakeholders. The number of early help assessments has since increased and they now come from a wider range of partners, including GPs. The rate of referrals to assessment is on target and thresholds are understood. The authority reviewed its arrangements for the 'front door' and at the end of the year (March 2014) early help services were re-aligned alongside the referral and assessment team to ensure children in need of early interventions are referred swiftly. This is the preparation in Central Bedfordshire towards any future Bedfordshire Multi-agency safeguarding hub (MASH). Partners have also provided assurance that there is greater stability in key parts of the workforce (social workers, health visitors and school nurses) and that recruitment targets are on track to be met or that a stable agency workforce is covering key vacancies.

- **Evaluating the impact of work undertaken by partners in relation to Domestic Abuse– significant weaknesses and challenges identified.** This involved an in-depth review of the prevalence of domestic abuse and the range of services on offer, seeking assurance from Bedfordshire Police in relation to their response to a negative HMIC inspection report and seeking assurances from partners to provide adequate resources for the Independent Domestic Violence Advisory services. This is one of the key areas of challenge for the Board going forward and a number of actions have been agreed in order to improve strategic leadership, resourcing and support to children and families. To help support this work a specialist social worker and domestic violence worker has been commissioned to review this area of work and a report will be published in the Autumn 2014.

- **Ensuring an effective response to the Sexual Abuse of Children and young people through Exploitation (CSE) – good progress and Pan Bedfordshire arrangements in place. Further work required to evaluate the CSE Panel (formerly known as the SERAC panel).** A CSE Strategy was agreed by Board and awareness has been raised about the issues. A number of actions in relation to the identification and

management of child sexual exploitation have also been completed. Ofsted have attended an operational meeting in respect of a group of young people about whom there have been concerns regarding sexual exploitation. Ofsted expressed no concerns about the way in which these risks were being managed and reviewed. Bedfordshire Police now have a dedicated CSE team and the CSE Panel meetings continue monthly to share information and monitor intelligence in relation to children and young people at risk of sexual exploitation. A Pan Borough strategic group is now formed.

- **Implementation of Working Together 2013** – **good progress made and new arrangements defined and in place.** The Board completed a self-assessment as part of its development and arrangements are compliant with the guidance. A Learning and Improvement Framework was agreed and protocols are in place for reviewing cases of concern referred by partners.

In the context of the challenges at Bedford Hospital and the closure of the paediatric services at the end of July 2013, the CCG reviewed all safeguarding arrangements in Bedford Hospital to ensure safeguarding advice and expertise is resourced, appropriate training is provided and a robust transparent quality assurance framework meets the CCG's safeguarding standards.

Looking forward, and taking account of the improvements and challenges identified during the year, the Board has agreed the following priorities for 2014-2015:

- **Ensuring children and families have faster, easier access to early help and safeguarding support through the delivery of a multi-agency support hub (MASH)** – this will involve taking multi-agency working and information sharing around safeguarding to the next level and building on current improvements;
- **Ensuring the effectiveness of safeguarding support for children living with domestic abuse, adult mental health problems and/or substance misuse** – this will involve implementing further actions to improve support for children and families living with domestic abuse and reviewing support for children and families where mental health and substance misuse is an additional risk factor; and
- **Ensuring the effectiveness of the strategy to deal with child sexual exploitation** – this will involve evaluating our SERAC panel and ensuring the Board is sighted on the data and intelligence to assess the effectiveness of the strategy and the support to children at risk;
- **The development of the Board's core functions to ensure it can deliver these priorities** – this will involve reviewing relevant procedures and policies, ensuring we have in place protocols for joint working with other key strategic partnerships, raising awareness about key issues,

learning from national and local case reviews and training and development.

I would like to take this opportunity to thank the members of the Board, particularly the newly appointed lay members who volunteer their time, for continuing to focus on keeping children safe, and for providing challenge and support in equal measure. Additionally I would like to thank all those at the front line who face the daily challenges of keeping children safe. The following pages of our annual report set out in some detail the considerable efforts of everyone.
I hope these highlights give you some idea of our shared effort during the year in rising to the challenges of further change and demand on our resources.

Phil Picton
Independent Chair
Central Bedfordshire Safeguarding Children Board

2. Central Bedfordshire in context

Central Bedfordshire has a population of 260,000 people. This is forecast to increase to around 287,300 people by 2021 with a 13.9% increase forecast in children aged 0-15 between 2011 and 2021 and a 35% increase in the number of people aged 65 and over during the same period.
Overall levels of deprivation in Central Bedfordshire are relatively low. Deprivation is measured at small area level known as lower super output areas (LSOAs). Three LSOAs in Central Bedfordshire are in the most deprived 10-20% in England. These are Dunstable Manshead (Downside - 594), Parkside (602) and Houghton Hall/Tithe Farm (618). Analysis of the LSOAs shows that particular aspects of deprivation in Central Bedfordshire are in the most 10% deprived in England. These are:

- Education, skills and training – a particular issue in eight LSOAs in parts of Dunstable Manshead, Dunstable Northfields, Flitwick, Houghton Hall, Leighton Buzzard North, Parkside, Sandy and Tithe Farm wards.
- Crime and disorder – a particular issue in six LSOAs in parts of Dunstable Central, Dunstable Icknield, Dunstable Northfields, Eaton Bray and Parkside wards.

Unemployment is lower in Central Bedfordshire than in England. 2,655 people were claiming JSA in Central Bedfordshire in March 2014, a rate of 1.6% compared to the England rate of 2.8%. The five wards with highest unemployment rates in Central Bedfordshire are Dunstable Manshead, Tithe Farm, Parkside, Houghton Hall and Dunstable Northfields.
Average house prices in Central Bedfordshire (£175,000) are higher than the national average (£166,600), however 73% of people owned their own home and this is greater than the figure for England as a whole (64%).

Central Bedfordshire residents are less likely to have higher level qualifications compared to the England average, and a lower proportion of Central Bedfordshire pupils achieved 5+ A*-C GCSE including English and Maths compared to the England average. Life expectancy for both men and women is longer in Central Bedfordshire than it is in England as a whole and overall health was slightly better than the England average and children are less likely to be obese.

Central Bedfordshire is less diverse than England as a whole and has a greater proportion of people who are White British. In 2011 89.7% of the population were White British (79.8% for England). The biggest ethnic minority groups in Central Bedfordshire were White Other (not White British, White Irish or Gypsy or Irish traveller) 2.8%, White Irish 1.2%, Indian 1.0% and other 5.3%.

View the online version of key Statistics in Central Bedfordshire here.

3. Safeguarding children in Central Bedfordshire

Safeguarding of children in Central Bedfordshire continues to be good and regular rigorous performance evaluation has provided assurance to the LSCB throughout 2013-2014.

This has been provided through quarterly monitoring of key child protection indicators in the performance framework and through in depth reports highlighting particular issues, such as workforce sufficiency, audits in relation to early help and rates of conversion to child protection plans.

The following table shows safeguarding and early help activity with Central Bedfordshire children and families compared to 2012/1/3 including last known comparative data for the year ending 31st March 2013.

Table 1

	National 12/13	Statistical Neighbour 12/13	Central Beds 12/13	Central Beds 13/14 (provisional)
Number of referrals	**2940**	**2160**	**2260**	**2598**
Number of early help assessments opened	**N/A**	**N/A**	**827**	**1353**
Number of early help assessments opened as a result of step down from social care		**N/A**		**171 (10 months)**
Number of early help assessments closed		**N/A**	**394**	**894**
Number of children in need	**1900**	**1423**	**1631**	**1508**
% of referrals of children in need with an outcome of assessment	**N/A**	**N/A**	**N/A**	**72.5%**
Number of children subject to a child protection plan	**217**	**162**	**266**	**196**

A gradual improvement in performance with identified challenges is described below. On this, our core business, the council's internal performance evaluation arrangements are central to overall performance and a core indication of multi-agency working.

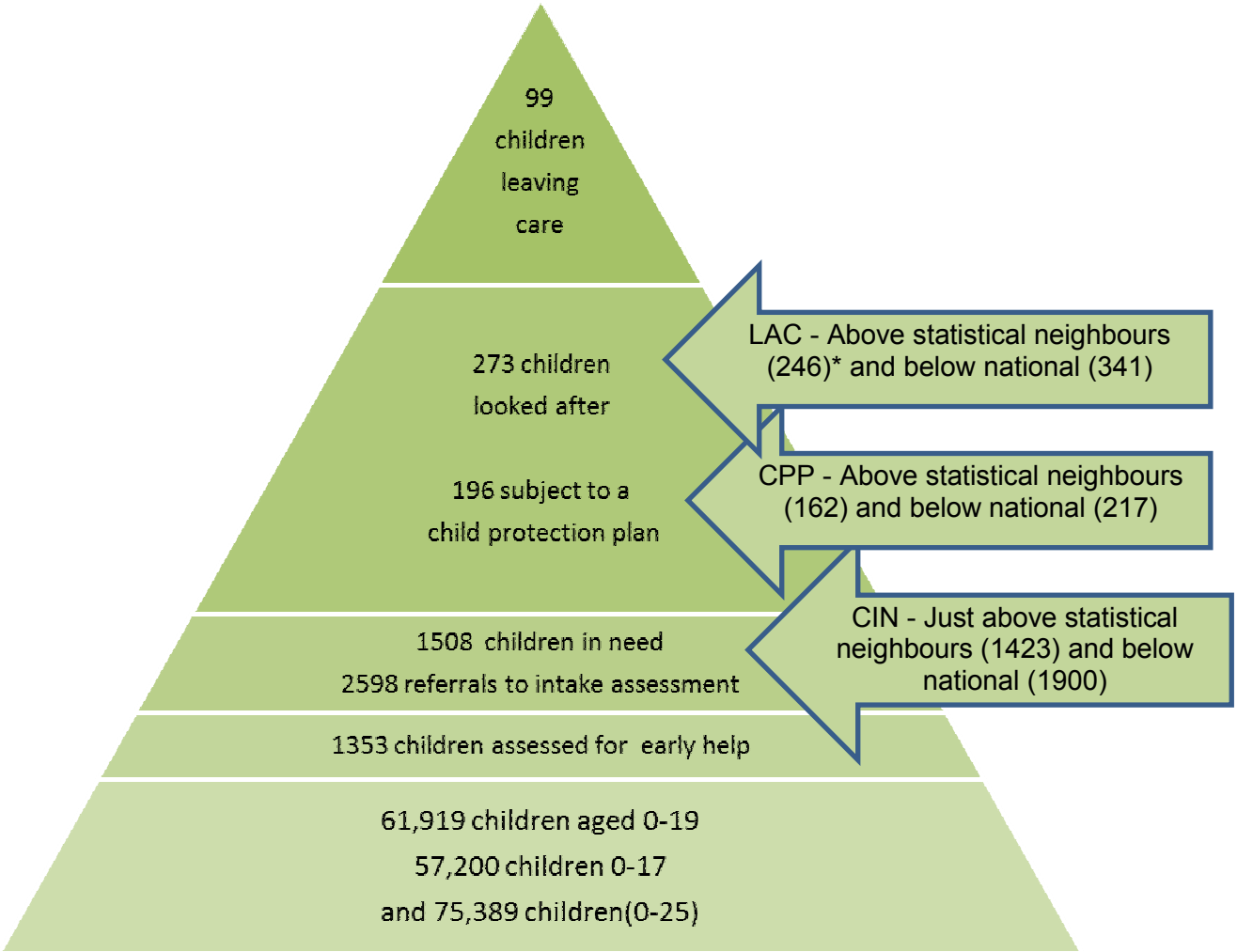
Within social care, a systematic programme of case audit throughout 2013-2014 resulted in practice challenge and review, resulting in a reduction of children with child protection plans and improvements in quality assurance arrangements.

Performance monitoring is a continuing, rigorous and transparent process, with quality control as part of day-to-day practice and supervision. Weekly team and senior management meetings provide appropriate attention to detail. The senior management team is attended by managers from the front

line when appropriate, providing immediate resonance to evaluation and identifying threats to high performance and swift remedial action to ensure long term sustainable improvement. For example, the identification of a high rate of section 47 investigations using statistical neighbour and national comparators resulted in investigation and remedial action which is summarised below. This was reported to the Local Safeguarding Children Board, endorsing social care actions.

An analysis of the child's journey in Central Bedfordshire

This section analyses performance using key indicators in relation to child protection. It examines data at key points in decision making from the point of referral through to child protection plans. It aims to help us understand the flow of cases through early help and referral and assessment within the context of multi-agency working. Below are the numbers of children at various stages in the care system (provisional data for end of March 2014).



* statistical neighbour and national figures have been calculated based on population size to provide population comparisons. These are based on 12/13 outturn figures as 13/14 data is not yet available.

Early help was a priority for the LSCB in 2013-2014 and the numbers of early help assessments opened was 1353 in 2013/14, compared to 827 in 2012/13. This is a local measure and there are no national or statistical neighbour

comparators. The numbers of early help assessments show an increase from last year.

Referral rates are slightly increased in comparison to the year 2012/13. The rate (454 per 10,000) lies between the England average of 520 and statistical neighbor average of 382.9 per 10,000 population.

A threshold document was revised and widely disseminated by the LSCB and training is being re-modelled to support the new 'one front door' which sees the integration of early help and intake and assessment from 1 April 2014. It is anticipated that referral to an Early Help Assessment will increase compared to those proceeding to formal social care assessments. Every family now receives a service or advice and 'no further action' (NFA) is no longer a category on the case management system.

Assessment timescales for social care reflect the changes required following the Munro recommendations. Performance using the old measures has been good and remained stable and initial indicators from the new measurements demonstrate early signs of good performance

The rate of cases converting to a Section 47 enquiry and to child protection conference was identified as being higher than our regional comparators**.** There was a higher conversion rate at each stage of the child protection process from referral to initial child protection conference within Central Bedfordshire compared to others in the region. The rate of progression from referral to Initial Child Protection Conference (ICPC) in 2012/13 was 1 in 11 nationally, 1 in 10 for our statistical neighbours and 1 in 9 for Central Bedfordshire. Whilst there is very little difference between the rates of referral to Central Bedfordshire Children's Social Care compared with our statistical neighbours there was a higher chance of a Section 47 enquiry progressing to a Child Protection Plan.

A review of decision making at key stages in the journey from referral to child protection plan was carried out. Audits were undertaken and overall an analysis of the children on plans indicated that a proportion could have been managed through alternative strategies using Child in Need processes.

Concerted work and careful scrutiny to raise awareness and enable sound decision making resulted in the following impact;

- Between 1st November 2013 and 31st December 2013 a total of 77 Section 47 enquiries were started averaging 38 per month. This was a reduction of 26% on the average number of Section 47 enquiries over the previous 10 months.
- The progression of cases from strategy meetings to section 47 enquires and initial child protection conference has been kept under close review by operational managers and managers within the Conference and Review Service.
- Initial analysis indicates that as a result families are more appropriately being supported through Child in Need planning than child protection.

- A further audit in January 2014 confirmed the trajectory and further scrutiny will continue in order to embed the learning.

Length of time on a child protection plan. From time to time, there will be a cohort of children who need a child protection plan longer than most. The England average for children exceeding 2 years subject to a child protection plan was 5.2%, statistical neighbours were 4.9% (both in 2012/2013). Central Bedfordshire performance was 7.5% in 2013/2014. This is slightly higher than our target rate of 6%.

Children who became the subject of a child protection plan who had previously been the subject of a child protection plan. There will always be a cohort of children in need of a protection plan more than once. The England average was 14.9% and, statistical neighbours 15.1% (2012/2013) . The Central Bedfordshire rate is 15.8%. This exceeds the target for the year which was in a range between 9-15%. All cases where children have been subject to a second or subsequent child protection plan in less than 2 years are audited jointly by a conference chair and an operational manager in order to identify practice improvements and learning. Careful investigation and monitoring of each individual child indicates that this is appropriate for these children.

Private fostering - There are 3 carers caring for 7 children in private fostering arrangements and there is 0.5 FTE social worker allocated resource to raise awareness, carry out assessments and provide appropriate support to carers. Feedback from carers indicates a high degree of satisfaction with the assessment process and support services. Raising awareness is a continuing challenge. Work with schools, children's centres and a range of child care settings involves the distribution of a range of communications materials, including leaflets and flyers. Awareness raising in 2014-2015 will involve increasing collaboration with the Fostering Recruitment Officer to align energy and resources.

Conclusions. Early help assessments are increasing, enabling access by more children, earlier and so enhancing the possibility of long term sustainable improvements. Early help is located with the referral and assessment team in readiness for a multi-agency safeguarding hub. Social care has re-modelled internal structures to ensure that teams have manageable caseloads and that there are clear lines of management accountability. Performance Management Teams are run on a monthly basis and there is individual and collective alertness to emerging issues and swift responses to challenges.

Partners regularly assure the LSCB and/or the practice and performance group on routine and emerging performance issues. Overall performance is improving as new organisational arrangements stabilise across the partner agencies in Central Bedfordshire.

Social work alignment to GPs has greatly enhanced partnership working at local level, with improvements in information sharing and communications. A new information sharing tool has been developed for GPs in collaboration with

the Council and the CCG. Systems are in place to effectively ensure that vulnerable families are identified and members of the primary health care team informed.

The LSCB performance framework reflects the priorities set and will continually develop to reflect strategic direction and priorities. The LSCB performance framework gathers data on core child protection, workforce data and the priorities of the LSCB. It is monitored 7 times per year by the Practice and Performance group and 4 times per year by the Strategic Board. The Practice and Performance group will continue developing the performance framework for 2014-2015 to align with the LSCB business plan and produce clear, user friendly data with an analytical.

Workforce challenges

Workforce instability and sufficiency are national challenges that appear locally too, and this is especially relevant for key professional roles working in social care, health and the police. Central Bedfordshire is located within commuting distance of London with its variety of competing offers for front line workers.

The LSCB performance framework started this year to monitor recruitment and retention for a number of professional roles in these key agencies in order to ensure effective risk management results in minimum negative impact on performance and outcomes for children. Children's social care and the NHS Bedfordshire Clinical Commissioning Group have provided reports to the strategic board on areas of concern to assure the board of their risk reduction strategies and Bedfordshire police provide regular input to the performance framework. Reports to the LSCB have assured the Board of the mitigation in place and highlighted the following:

- South East Essex Partnership Trust strategy to recruit to health visitor and school nursing vacancies is showing early signs of success with ambitious targets for filling vacancies and careful regular scrutiny of key performance indicators such as new birth visits and is monitored by the LSCB and by the Health and Well Being Board.
- Partners maintain relentless focus on performance impact, individually and collectively, and regularly assure the LSCB of developments.
- Bedfordshire Police have successfully recruited 60 new officers increasing overall police capacity and have increased capacity for responding to child sexual exploitation and domestic violence.
- Social care's performance improvement programme provides regular assurances on impact on performance and allows for immediate remedial action.
- Many agency staff in social care remain with the local authority for considerable lengths of time which means that the workforce is more stable than might otherwise be expected and this reduces possible negative impacts for children and young people.

NHS Bedfordshire Clinical Commissioning Group

The NHS Bedfordshire Clinical Commissioning Group (CCG) has developed a resilient safeguarding governance structure withstanding the impact of disaggregation of the Local Authorities and LSCB's in Bedfordshire. The Director of Nursing and Quality leads on the comprehensive range of safeguarding responsibilities in the CCG and, with the Designated Nurse represent the CCG on the LSCB. There is demonstrable evidence of this influence at the CCG governing body and the executive team; decisions on resourcing the LSCB budget contribution and the range of safeguarding responsibilities in the CCG are made at this level.

Designated Professionals for safeguarding children and Looked After Children, are experienced and supported, and have access to appropriate training, specialised supervision peer advice. The role of the Designated Professionals are explicitly defined and in line with national guidelines.
A regular integrated safeguarding meeting provides a forum for advice, support and professional development as well as a sound network for information sharing. This ensures a swift response to emerging need at the highest levels with immediate "table top" in-house review to fact find on individual cases.

Focus for improvement

A Central Bedfordshire Academy for Social Work and Early Intervention has been developed and brings together a comprehensive range of learning and development programmes for social workers, enhancing their career prospects, valuing the workforce and making Central Bedfordshire a better place to live and work. Social work salaries have been reviewed and an enhanced Market Rate Supplement has been agreed and implemented in key teams where recruitment of permanent staff has been an issue.

4. Progress on priorities in 2013-2014

Priority 1: Evaluating the impact of work undertaken by partners in relation to domestic abuse

The LSCB carried out a detailed strategic overview of domestic violence in Central Bedfordshire to understand the issues in relation to children and families living with domestic violence. This report informed the LSCB of the incidence and prevalence of domestic abuse and the levels of service provision and resourcing issues and enabled the Board to identify the challenges ahead.

The strategic overview report has identified the persistent nature and prevalence of this problem and has identified challenges relating to service provision and pathways, capacity, resources, governance and leadership - all of which are fundamental to addressing this issue and effective delivery to our growing population.

Key facts

- Children are present in 37% of all incidents of domestic abuse attended by Bedfordshire Police
- In 2013 there were 419 children living in high risk domestic abuse situations being dealt with through MARAC
- 56.4% of social care assessments feature domestic violence
- Domestic abuse continues to be a factor in the majority (62%) of cases where children become subject to a child protection plan for the second or subsequent time
- MARAC (Multi-Agency Risk Assessment Conference) – There are, on average 24 cases referred to MARAC each month with around 36% of these being repeat referrals. This compares to an average of 18 cases per month in 2012 with around 27% being repeat referrals. Repeat referrals were lowest in 2011at 15%. Referrals to MARAC have been identified as lower than they should be.
- In 2013/13 there were around 12 referrals per month with 31% repeat referrals to specialist case workers/advisors working with victims most at risk of homicide or serious harm. In 2011/12 there were around 18 referrals per month with 32% referrals.

Two **inspection reports** fed into the review conducted by the Board and these highlighted significant concerns in relation to domestic abuse.

Bedfordshire Police were the subject of a formal H.M.I.C inspection in November 2013 (HMIC report: Bedfordshire Police's Approach to Tackling Domestic Abuse). An action plan was devised and reported to the Board and immediate steps have been taken to address the key issues. In response to the HMIC findings around Bedfordshire Police's response to Domestic Abuse numerous pieces of work have been undertaken; the most notable being the redesign of Bedfordshire Police's domestic abuse structure and processes. It is a strength that all households where children reside are identified and

subject to further scrutiny and referral. Work continues with other agencies to improve the quality of this information sharing to support the most appropriate signposting to early help for those children affected by Domestic Abuse.

Bedfordshire Police have provided assurance to the LSCB on strategic and operational issues and have delivered on capacity building to improve, including a review of available services for both high and medium risk victims. Bedfordshire Police are working in collaboration with the local authority to deliver on the Multi-Agency Safeguarding Hub to improve swift decision making at the front line. Bedfordshire Police are committed to regular reporting to the LSCB on improvements.

Bedfordshire Probation services were the subject of an inspection by Her Majesty's Inspectorate of Prisons (HMIP). The report found that Probation involvement in LSCB's in the three Local Authority areas was strong and effective. The report also identified areas for development in relation to safeguarding children, including identification and appropriate referral to social care as well as some concerns about the targeting of resources only to highest risk victims. The Probation Service representative on the LSCB provided an account of these areas and of the Probation service response in full and assured the Board of its risk reduction strategies. The probation service will report to the Board on developments.

Focus for improvement
The LSCB has initiated work with leaders of the Community Safety Partnership, the Safeguarding Adults Board, the Health and Well Being Board and the Children's Trust Board to **provide clarity on Pan Bedfordshire leadership in relation to domestic violence** and agreed actions in relation to:
• Accelerating information protocols to improve the quality of information sharing.
• Prioritising domestic abuse pathways for multi-agency working
• Accelerating training for domestic abuse and ensuring co-ordination is improved.

Additionally the LSCB has challenged the community Safety Partnership in relation to the future funding for the Independent Domestic Violence Advocacy service (IDVA) and requested a position statement on this.

The LSCB training programme has been re-designed to increase emphasis on domestic violence, adult mental health problems and substance misuse, including the impact on children and young people.

The case audit programme has been re-modelled to enable case audit of children living with these features, engaging practitioners and their managers in the process so that the voice of front-line workers is heard and informs strategic decision making.

As a result of the strategic overview, the LSCB has agreed that domestic violence and the associated risk factors, adult mental health problems and substance misuse, will be a priority for 2014-2015.

As a result of these and other discussions throughout 2013-2014, the Board has also committed to the development of a Multi-Agency Safeguarding Hub, speeding up access to early intervention and prevention services with domestic violence as a strong feature in taking this work forward.

This will be monitored through the LSCB business plan and the LSCB performance framework during 2014-2015.

Priority 2 : Ensuring an effective response to the sexual abuse of children and young people through exploitation (CSE)

Working in collaboration with Bedford Borough and Luton LSCBs, a Pan Borough strategy for Child Sexual exploitation is in place and this is complemented by a local Central Bedfordshire LSCB strategy agreed by the Board in February 2014. The co-ordination arrangements at a strategic level are managed through a strategic group that has now been established. This Pan Bedfordshire Strategic group supports co-ordinated activity across the county to deliver to the National CSE Action Plan. Further work is to be undertaken in the new year to ensure delivery in this area.

Work undertaken by the Bedfordshire Safeguarding Children Boards and the joint Task and Finish Group has contributed to raising awareness, identifying work streams and completing tasks in relation to the identification and management of child sexual exploitation.

Operational arrangements are agreed and in place and local multi-agency arrangements involving the creation of a multi-agency panel have been successfully developed across Bedfordshire – this panel is the CSE Panel (formerly known as the Sexual Exploitation Risk Assessment Conference - SERAC). The CSE panel meets monthly to share information, referrals and monitor intelligence. Bedfordshire Police have created a bespoke team to prevent and respond to child sexual exploitation. The development of a focussed CSE team has allowed for direct activity around the improvement of CSE intelligence and awareness across all partners and the analysis of that intelligence to support the response to young people who have been identified as being at risk of exploitation.

A CSE Panel is held monthly which supports practitioners in problem solving around complex cases and identifying support options for those identified as a concern. The CSE Panel has heard cases in relation to 101 young people during 2013-14, of these 36 referrals were in relation to children and Young People from across Central Bedfordshire. Additionally there was progression of 69 referrals and 11 intelligence reports.

Ofsted have attended an operational meeting in respect of a group of young people about whom there have been concerns regarding sexual exploitation. Ofsted expressed no concerns about the way in which these concerns were being managed and reviewed.

Multi-agency training is embedded in the LSCB training programme and there is strong commitment from partners to continue to prioritise this throughout 2014-2015.

Information on the arrangements is widely disseminated throughout the professional and volunteer community and has been posted on the LSCB website to ensure visitors are drawn to this information.

Focus for improvement

An evaluation of the multi-agency CSE panel is being commissioned with specific reference to impact on outcomes for children and young people. The Pan Borough strategic group will oversee this review and recommendations will go to the three Bedfordshire LSCBs.

Priority 3: Evaluating the impact of early help

Quantitative and qualitative evaluation of the impact of early help assessments and intervention has been developed by:

- monitoring the number of early help assessments carried out
- monitoring the quality of training provided to professionals, and
- by developing an impact evaluation tool to assess the impact on lives of children and young people.

Three case audits were completed and reported to the LSCB in December 2013. The main lessons learnt involved the length of time that there were identified needs for children before a practitioner, in these cases within schools, acted. The Early Help Assessment appeared to have been a last resort after failing to be able to successfully make referrals elsewhere. This identified a training need for some schools that have not regularly been using the Early Help Assessment process.

This key learning relating to schools has been communicated through newsletters and through training and workshop sessions at termly headteacher and governor meetings.

Communications, training and advice to the professional community on Early Help has led to an increase in the numbers of assessments carried out and an associated increase in multi-agency meetings to deliver early intervention services. The majority of cases resulted in successful identification of appropriate services and delivery. Where service gaps were identified, resources were identified to commission bespoke services to meet the needs of the children concerned. For example, a number of children with parents in prison were identified as having additional needs. A specialist service was then commissioned to provide counselling for the children with successful outcomes for them.

Over 660 professionals from all partner agencies received training which includes application of thresholds. This training reached GPs, schools, health and the voluntary sector. Evaluation of this learning has demonstrated that it

is of high quality and highly valued by attendees. Further work to align the learning on thresholds, early help and safeguarding in line with the developing integrated referral and assessment work will support professional practice in navigating thresholds and understanding the importance of assessment of need.

Retrospective analysis of early help provision is carried out month by month looking back a year and this is beginning to show early signs of positive impact - this work began in November 2013. So far it is indicating that the majority of children (70-80%) did not require escalation to formal statutory social care provision and those referred because of a risk of school exclusion have had successful outcomes.

An evaluation tool has recently been designed to assess impact of early help provision at the end of an episode of intervention. This is sent to parents, the children concerned and the professionals involved. It is too early to measure impact. Work to ensure a high response rate is underway.

The Council's Early Help Service has been re-aligned so that it operates within the referral and assessment service, in readiness for a Multi-Agency Safeguarding Hub.

Early Years settings - There are agreements in places with over 108 private, voluntary and independent providers and 110 child minders who are able to receive Nursery Education Funding. They are regulated by Ofsted within the Early Years Framework and supported by the local authority's Childcare Development Officers, e.g. with model policies, telephone help and support at Child Protection meetings if needed. Their arrangements regarding safeguarding training, policy and safer recruitment are regularly reviewed and their continued registration is contingent upon effective safeguarding arrangements in provider units.

The Child Care and Early Years Sufficiency and Quality Officer is the designated lead for safeguarding within this sector. She ensures that safeguarding information is disseminated regularly via a 6 weekly newsletter. Urgent emerging news items such as national research and serious case reviews and information from the LSCB are disseminated immediately to ensure professionals are updated with contemporary national and local evidence.

Actions to improve:
Ongoing development of early help includes:
• Ongoing training to promote consistency in relation to thresholds, early help and safeguarding children and to ensure schools and early years settings engagement.
• To refine and develop the evaluation tool used at the end of an episode of intervention to assess impact on outcomes for children and to learn from multi-agency audits.
• To monitor the impact of the inclusion of early help services with the referral and assessment team.
• To develop a Multi-Agency Safeguarding hub incrementally, learning from

national and local experience and ensuring a focus on risk assessment and safety is maintained.

Priority 4: Implementation of Working Together 2013 and findings of the Review of Joint Working with Bedford Borough LSCB

The year started with the publication of the long awaited Working Together 2013 at the end of March 2013, coming into force on 15 April 2013. The new document continues the reforms identified as part of Professor Eileen Munro's independent review of children protection which puts the child in focus at all stages. Alongside existing statutory objectives in relation to co-ordinating and ensuring the effectiveness of the safeguarding work of partners, this brought with it a range of new requirements for our LSCB, including:

- expectations around developing a learning and improvement process to include Serious Case Reviews so that they form an integral part of our work to improve services to children
- the requirement to monitor the effectiveness of Early Help
- defining the safeguarding responsibilities of LSCB partners, including NHS Commissioning Board, Clinical Commissioning Groups and Police and Crime Commissioners – these include staff induction and child protection
- promoting the involvement of children and young people in the work of the LSCB and for the local authority to take reasonable steps to ensure that the LSCB includes two lay members representing the local community

Outcome of review of joint working with Bedford Borough Safeguarding Board

During the year Bedford Borough decided to withdraw from the remaining joint working arrangements with the Central Bedfordshire Safeguarding Board and at the end of September the Boards formally separated their joint working arrangements. This included disaggregating the business unit providing support to the Board, reviewing the shared multi-agency training functions and disaggregating the joint working arrangements sitting beneath the Board structure.

This provided unique challenges for all partners involved, including recruitment of new staff to the newly created business unit for Central Bedfordshire, attendance at additional meetings and the review and development of new protocols and strategies.

As part of this review the Training Review reported at the end of December and key recommendations have been implemented and multi-agency LSCB training is now the only remaining function shared by the two boards - this service continues to be hosted by Central Bedfordshire Council. A Training and Development Strategy for Central Bedfordshire has now been agreed and this sits within the wider Learning and Improvement Framework agreed by the

Board. This sets out how the LSCB will learn lessons from a range of sources to inform front line practice and multi-agency working.

Implementing Working Together 2013
The LSCB reviewed the Working Together 2013 guidance and the new inspection arrangements. These were used as a framework for self evaluation at the LSCB development day in January 2014. This resulted in an assessment of current activity and an agreement on the LSCB priorities for 2014-2015 as well as areas to improve the functioning of the LSCB. A new business plan for 2014-2015 was agreed and is used at each meeting to measure progress.

> The LSCB's role is "to **coordinate** what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area" (Working Together 2013).

In order to deliver on its statutory duties to co-ordinate the safeguarding work of partners, the Board reviewed the following co-ordinating functions:

Developing policies and procedures

The LSCB collaborates with neighbouring LSCB's to maintain shared multi-agency safeguarding procedures and ensure that local protocols and procedures are clearly understood at practice level. These responsibilities include thresholds, multi-agency training, recruitment of staff working with children, investigation of allegations, safety of children privately fostered and co-operation with neighbouring children's services authorities and Boards.

The **Thresholds** for identifying which children needed additional support and intervention were reviewed and agreed in October 2013. These have been widely disseminated to the professional community and are easily accessible on the LSCB website. They are used in the LSCB multi-agency training and early help training programmes, helping practitioners to navigate and understand eligibility and need. In addition, a letter was sent from the Chair of the LSCB directly to the wider professional community drawing attention to the revised threshold document as well as lessons learned from case audits.

Multi-agency training - A rigorous training review was carried out across Bedford Borough and Central Bedfordshire and resulted in a new shared Training and Development Strategy agreed by Bedford Borough and Central Bedfordshire Safeguarding Boards in February 2014. The commissioning arrangements for training have been clarified and agreed.

One training commissioning unit provides a shared service to Central Bedfordshire and Bedford Borough LSCB's. Training is informed by evidence, using case audits and drawing from the needs identified through partners on both LSCBs. In Central Bedfordshire this has been informed by the learning

log created in January 2014. A detailed end of year training evaluation, including quantitative and qualitative analysis, provided a basis for the learning and development programme for training in 2014-2015.

Over 950 days of multi agency training were delivered to 625 attendees across all CBSCB partner agencies, including schools in 2013-2014. Evaluation demonstrated that the training was high quality, interactive and highly valued by attendees. All courses are highly valued by practitioners with 100% indicating that the course met its objectives “completely” or “mostly”. The impact of this training was also assessed and positive change in practitioners’ responses to improved safeguarding knowledge and understanding was demonstrated. Practitioner feedback is established using end of day evaluations, follow up impact evaluations, (4-6 weeks after a course) and trainers’ evaluation. Course evaluations have not been attached to the report however these can be supplied on request.

A total of 779 learners completed on-line e-learning packages over the year. These courses are all very well evaluated and some constitute a prior learning activity for face to face training. Smaller organisations in the voluntary sector and faith groups use the Introductory e-learning level package for Induction purposes and to stimulate further facilitated safeguarding discussions. The completion rate is 75% for the year and of 87% since the e-learning began in 2008.

The 2014-2015 programme will reflect the needs of both LSCB’s, the views of practitioners and lessons from case audits and national experience. The training review carried out by both Boards concluded that the new training programme for 2014-2015 needs to be aligned with the priorities of the boards and evidence from audits. Fewer courses of shorter duration and increasing learning opportunities through modular learning will help reach the right staff on the right topic. The 2 day course revision will use a modular approach to learning, enhancing cost effectiveness, and ensuring that training is tailored appropriately to meet the needs of professionals. The programme will meet the needs of individual agencies seeking to develop and enhance practitioners’ understanding of multi-agency processes and optimise outcomes for children. The programme will respond promptly to local need and commission specialist training providers in a timely way. A revised pricing structure will further improve completion rates for E-learning.

Members will now determine “reach” i.e. the numbers of staff in each agency who need identified learning opportunities. Members will set targets and monitor this reach throughout the year. This will result in an improved understanding of global learning saturations levels.

Core Group working has been identified as an area for improvement via local case audits and Agency uptake for this training will increase. Parenting capacity is adversely affected by domestic abuse, adult mental health and parental substance misuse and the programme will continue to offer a variety of learning opportunities thus reflecting the LSCB priorities for 2014-2015.

Early years settings' access to training has already been revised and the emphasis is now being shifted from single sector training to multi-agency training. This means only multi-agency safeguarding training will be promoted to this sector. There is also a wide ranging educational programme for providers and practitioners which ensures competencies in enabling and effectively supporting children's growing understanding of how to keep safe and healthy. Practitioners and child minders encourage children to gain an understanding of risk through activities that encourage them to explore their environment and to be able to share their concerns with a trusted adult.

Arrangements for validation and oversight of training offered within agencies (single agency training) will continue and assist in ensuring that local practitioners are clear about individual safeguarding roles and responsibilities

Targeted work with schools
Through the Children's Trust Strategic Workforce Development Group, Schools representatives identified a need for safeguarding training in schools and while this is not multi-agency training, a "Training for Trainer" course has been commissioned by Central Bedfordshire Council's Workforce Development Team in conjunction with the LSCB and the Teaching School. The take up to date has been good and so far representatives from over 60 schools have attended the 5 training sessions offered (some schools have sent more than 1 person). Those schools that have not attended will be contacted and encouraged to take this offer up and a further two sessions are being planned before the end of the year.

Bedfordshire Clinical Commissioning Group ensures professional development of senior staff and provides encouragement to consider future safeguarding roles, including shadowing and training with a long term view to succession planning. Additionally, the Designated Professionals give clinical advice and specialised supervision in complex cases, to health colleagues and partner agencies as required.

CCGs are not directly responsible for commissioning primary medical care, however BCCG has commissioned a Named GP to work with and support GPs on safeguarding children issues. The named GP for safeguarding children is well established and has dedicated sessions to provide advice and support to GP colleagues as required.

Level 3 multi-disciplinary training is provided in line with the Intercollegiate Document (2010), to GP's with input from various agencies, including the Local Authority. GP's with lead roles in safeguarding children attend the LSCB multi-agency level 3 training with other experienced lead professionals in partner agencies, providing them with the competencies required to effectively lead and support practitioners at a local level. Comprehensive data on GP's and their attendance at training is maintained and regularly reviewed. Each GP practice has a Lead GP for Safeguarding Children and a nominated deputy.

Bedfordshire Police - All staff are provided with safeguarding children training and all new recruits are provided with mandatory training at induction. Frontline officers are provided with regular training on safeguarding children with an emphasis on child sexual exploitation, child abuse and domestic abuse. Bedfordshire Police support the delivery of multi-agency training and anticipate an increase in police attendance in the coming year due to a successful recruitment drive and new Police Community Support Officers and a continued commitment to the development of partnership working in practice with an emphasis on Domestic Violence. The force training strategy provides a range of training materials and ensures that officers in key positions are appropriately targeted for safeguarding training.

CAFCASS - The core safeguarding training curriculum includes information on the requirements around reporting concerns about significant harm. This is delivered to all new practitioners and to students on placement. Business support staff complete an e-learning programme as part of their induction, which covers how they should report concerns.

All **schools** in Central Bedfordshire have a designated professional for safeguarding children, explicitly defined in job descriptions. Designated professionals attend the LSCB multi-agency level 3 training. Schools are also taking part in the LSCB "Training for Trainers" course so that they can disseminate learning to the whole school and also provide a range of internal training. The new Teaching School gains input from Heads and Partners via a reference group and safeguarding children is part of this agenda**.**

Focus for improvement
The new programme (2014-2015) will reflect the priorities of the LSCB identified through the needs and views of practitioners and partners and lessons from case audits and national experience. Partners have agreed to:
• determine "reach" i.e. the numbers of staff in each agency who need identified training and set targets and monitor this reach throughout the year. This will enable an understanding of whether multi-agency training is reaching the people it needs to.
• participate in training relating to core group working, domestic violence, adult mental health and substance misuse.

Safer recruitment of those who work with children
A section 11 audit was completed with all partners taking an active role in auditing their services and safe recruitment has been identified as one of the subjects of this audit. Findings will be provided to the LSCB during 2014.

Investigation of allegations concerning persons who work with children
During 2013/14 the Allegations Manager responded to 73 concerns and 64 allegations against adults. This compares with 72 concerns and 49 allegations in 2012/13. The LADO provides an annual report to the LSCB and full details are available in this report. The outcomes of allegations during 2013/14 are as follows:

The outcomes of allegations during 2013/14	
Advice / Support / Training	35
Dismissal	6
Final Written Warning	2
No Further Action	9
Case not concluded	7
Resigned	4
Transferred to Other Local Authority	1

The Allegations Manager **(LADO- Local Authority Designated Officer)** continues to provide a single point of contact in Central Bedfordshire for responding to concerns and allegations against adults working with children in an employed or volunteer capacity. The service oversees the process of managing allegations and aims to contribute to good practice in this area and prevent those adults who pose a risk to children from working with them.

The advisory role of the Allegations Manager (LADO) in relation to lower-level concerns is a well-used aspect of the service, making up in excess of half of all contacts to the service. More serious concerns and allegations are responded to by means of a Joint Evaluation Meeting which brings together employers, Human Resources personnel, social workers and the police to plan a response to the reported allegation and the protection of children.

In addition training has been provided during the year to Heads and Chairs of Governors, foster carers, Early Years, independent care providers and the Voluntary sector.

Co-operation with neighbouring children's services authorities and their Board partners

The LSCB collaborates with neighbouring LSCBs on strategic issues and examples of this include the work on Child Sexual Exploitation, the Child Death Overview Panel arrangements and shared policies and procedures. Pan Bedfordshire arrangements are reflected in the governance structures in section 7.

A challenge from partners was presented at the February 2014 LSCB meeting with partners requesting a common Bedfordshire wide form for CAF/Early Help Assessment. Although there have been discussions to move to one form this has not yet been resolved and will require further discussion in 2014.

Communicating and raising awareness about safeguarding children

LSCB communications have prioritised the professional community, ensuring they are updated on developments and receive the training and support they need to operate effectively. For example, a practice note was sent from the chair of the LSCB to the professional community to inform them of lessons learned from recent audits and revisions to thresholds. The Training

Commissioning Unit regularly sends communications to the professional community on emerging issues from national and local experience.

For Early years settings, local professional support networks provide for sound partnership working and relationships with health positively support information sharing and response to emerging issues and concerns.

Bedfordshire Police has run an education programme throughout all Schools focussed upon priority issues within particular areas across Bedfordshire. Within this review year the focus has been around the developments of social Media, Online safety advice and Safe relationships. These inputs have been delivered to children and young people of all school ages and have equally been supported by direct delivery to both professionals and parents to support their own children in this developing area.

Communications with schools have included Heads and the Director meet termly and in 2013-2014 safeguarding children, early help, thresholds and information sharing were regularly discussed, clarified and communicated at these meetings. Papers are also disseminated to all schools on these issues through *Central Essentials* the weekly schools' newsletter. For example, a letter from the Chair of the LSCB was disseminated to all schools summarising lessons learned from case audit and the LSCB plans to ensure these lessons impact on practice through training and communications.

A communication strategy and action plan is a priority for the Board in 2014 and this will include the launch of a new website and involving children and young people.

> The LSCB's role is to **ensure the effectiveness** of what is done by agencies for the purposes of safeguarding and promoting the welfare of children in the area.(Working Together 2013)

In order to deliver on its statutory duties to ensure effectiveness of what is done by agencies, the Board reviewed the following co-ordinating functions:

Learning from practice

A Learning and Improvement Framework was agreed by the LSCB in February 2014. It describes the LSCB approach to learning from performance data, case audit, case review, training evaluation and national experience and research. Other key actions to ensure the building blocks of a learning strategic partnership are in place include:

- New protocols on case review have been created, using local and national experience and reflecting the LSCB priorities.
- A case audit toolkit has been designed and will be piloted in 2014.
- An LSCB learning log has been created. This is a repository of learning to track impact and ensure lessons learned are used to improve practice.

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Learning from **multi-agency case audit** activity took place during a period of organisational change and while these changes slowed progress down, the work nevertheless continued, reaching a conclusion and lessons learned in February 2014. The audits were carried out using a combination of chronology building and facilitated group discussions, using an external consultant who drew together the learning in reports and analyses.
8 cases were reviewed and the following is a summary of lessons learned:

Neglect - Practitioners identified the link between neglect and the pre-disposing factors of domestic violence, substance misuse and/or adult mental health problems. Understanding the cumulative nature of neglect and being able to recognise the problem while having a positive relationship with the family requires practitioners to have a particular skills set. Practitioners need the support of their managers and supervisors to help them work through these complexities. Training on neglect in 2014-2015 will emphasise these pre-disposing factors.

Thresholds and information sharing - The LSCB learned that this remains a continuing challenge for practitioners. Upon recognition that a child is suffering or likely to suffer significant harm there is a straightforward intention to share information. However, putting the pieces of information together to inform the decision to refer can sometimes be challenging. The LSCB identified that understanding thresholds in practice can be challenging when working with families with complex needs. Practitioners and managers identified practice challenges in articulating the problems seen and establishing where to go to get help. The benefits of early intervention are indisputable, but practitioners sometimes find it difficult to comprehend the seriousness of a case and decide on appropriate action and referral.
The LSCB has delivered the threshold document through a practice communication from the LSCB chair, posting it on the website and disseminating it through partners internal infrastructures. The document was also disseminated to schools, through newsletters and through the Heads and Directors meeting. The training programme 2014-2015 emphasises thresholds and their application. Further case audit in 2014-2015 will assess impact.

False and non compliance- The LSCB learned from practitioners about their experience of the practice challenges when working with parents who can be very convincing in their attitude towards interventions. Some will refuse outright, but others will indicate a willingness to co-operate but will avoid interventions which lead to change and positive impact on the child. This issue has been incorporated into the LSCB training programme and is included in the case audit programme.

Core group working- The importance of core groups in facilitating information sharing was identified as practitioners need support with practical arrangements to ensure timely and efficient information sharing and core group processes have been revised.

In the light of experience in 2013-2014, a new case audit methodology has been designed. Partners will use an analytical tool to assess cases using

agreed practice standards. The audit tool will assess the impact of learning from the findings above as well as information on a range of basic child protection standards. A learning log has been created to capture learning from experience and this will be updated and used as evidence to inform the LSCB priorities and training for 2014-2015. The cycle of learning will be embedded and impact evaluation tools will be reviewed to ensure training is delivering improvement in practice.

Learning from serious case reviews - There have been no serious case reviews in Central Bedfordshire in 2013-2014, however learning from those published by other local authorities has been communicated to practitioners.

Learning from child deaths - Child death rates are reducing in Central Bedfordshire, although demonstrable links with campaigning activities cannot always be made. The numbers of Sudden Unexplained Deaths in Infancy across Bedfordshire is also decreasing. Numbers are low and therefore it is not possible to draw any conclusions on this.

The Child Death Overview Panel (CDOP) in Bedfordshire is County wide and is well developed. The CDOP is a statutory function of the LSCB and BCCG hosts the Child Death Overview Panel manager's post ensuring sound links to both the Designated Office for Safeguarding Children & Young People and public health activities to ensure impact. A full account of the CDOP activities is in the CDOP annual report (Bedfordshire CDOP annual report 2013).

Learning from child deaths have been communicated through discussions with health care professionals and campaigns where robust messages are shared. Examples include safer sleeping practices, smoking cessation and weight management of pregnant women:

- A campaign to discourage co-sleeping has also been widely shared in the community following review of child deaths. Infant mortality and morbidity rates associated with deprivation have been identified, with raised awareness among professionals working in these areas.
- Findings from one death by drowning have led to the delivery of a leaflet advising parents on safety issues whilst swimming; this has been disseminated to all schools and has been posted on the LSCB website.

Additionally, information sharing sessions on the role and function of the child death review process have been delivered over the past year to police, health and social care professionals across the local authority. The aim was to increase awareness of the process and to share learning with them about why babies/children in this area die and what interventions and messages can be given to parents to try and prevent future child deaths.

The child's voice and shaping practice

The voice of children and young people is heard through the work of the police in supporting the Youth forum and work with the police cadets. There is

a strong emphasis in case work practice to ensure the child is seen and listened to alone. This applies even to very young children and is recorded in the management log. This is emphasised in training and is assessed via quality assurance and audit.

There is a strong emphasis in social case work practice to ensure the child is seen and listened to alone. This applies even to very young children and is recorded in the management log. This is emphasised in training and is assessed via quality assurance and audit.

The BCCG quality assurance framework provides safeguarding indicators for the BCCG and for providers. Contracts with all providers ensure schedules emphasise duties in relation to safeguarding children and the importance of listening to the child both at case level and in strategic planning.

At a practice level, expectations around direct engagement with children who are subject to court proceedings, and ascertaining their views, needs, wishes and feelings are set out within the Cafcass Operating Framework (2012) and quality.

LSCB effectiveness: overall analysis

The LSCB development day was used as an opportunity for self-evaluation using the Working Together 2013 guidance and the Ofsted Inspection ratings. Below a summary analysis of this self-evaluation.

While the board has experienced some changes during the year as a result of the disaggregation of some of the shared arrangements with Bedford Borough Safeguarding Children Board, these changes have had no impact on the management and operation of the Board. A continued focus on performance and the safety of children remained high on the agenda for all partner agencies, reflected in their commitment to meetings and their contributions to this report.

Multi-agency performance evaluation of safeguarding children is in development and local performance measures are consistent with approaches being taken regionally and nationally. Partners are agreed on the need to develop evaluation techniques using analytical models, concentrating on the interpretation of the data more than the data itself. There is a consensus that learning from data and learning from practice experience are incorporated into the agreed Learning and Improvement Framework.

The LSCB has heard the messages from the front line through case audit. They suggest that priorities are further refined to include concern in practice for children living in households where adults and caregivers have problems with substance misuse, domestic violence and/or adult mental health issues. Commonly referred to as the “toxic trio” in practice, these elements, taken individually or combined, demonstrate increasing risks to children. Added to this, the evidence from the data on children with child protection plans demonstrates a high proportion of children with these factors in the household.

The Board has been concerned to improve arrangements for referral and assessment processes and supports the council's new arrangements to include early help services into the referral and assessment team. The Board is working on a multi-agency safeguarding hub approach that is incremental and learns the lessons nationally. The partners have therefore agreed to work on a model which is appropriate for Central Bedfordshire using best practice from other areas, but not necessarily following them exactly. This incremental approach will ensure the application of sound risk assessment processes at each stage of development and allowing opportunities to ensure robust evidence informed decision making at identified intervals to ensure the safety of children is central to decision making. This preparation does ensure we are in a good position to enter any Bedfordshire wide MASH arrangements.

Conclusions

This LSCB has delivered within the context of organisational change in the Local Authority and partner agencies. A consistent focus on Safeguarding Children as a priority has been sustained by individual members and for the LSCB as a whole. Partners' commitment is seen through attendance at meetings as well as co-operating with work streams, such as case audit and training evaluation. The board self evaluation process has enabled partners to work together to gain collective insight into the areas of weakness and the challenges ahead. Informed by evidence from the front line, case audit and performance data, the LSCB has a clear set of priorities and monitors them at each meeting. There is effective challenge by partners seen in the examples provided in this report. The LSCB influences other partnerships to focus on safeguarding children. There is good progress on Child Sexual exploitation and early help. Subject to successful recruitment for schools, membership will be compliant with Working Together guidance and there is an agreed budget. The Learning and Improvement Framework is effectively used by the LSCB to gather evidence to inform priority setting and forward planning. The Threshold document has been widely disseminated with plans to assess impact through case audits.

However, impact on the lives of children is the primary focus of the LSCB and our core business. Performance is steadily improving with the numbers of children with child protection plans reducing. Multi-agency and internal quality assurance systems ensure transparency, speedy management and sustainable improvement.

5. LSCB priorities for 2014-2015

The LSCB self evaluation, performance analysis, case audit and overall effectiveness conclusions serve to inform the priorities for 2014-2015 which are to;

- Ensure children and families have faster, easier access to early help and safeguarding support through the delivery of a multi-agency support hub (MASH);
- Ensure the effectiveness of safeguarding support for children living with domestic abuse, adult mental health problems and/or substance misuse; and
- Ensure the effectiveness of the strategy to deal with child sexual exploitation.

In order to ensure the LSCB functions effectively, it has identified the following areas for development;

- Keep governance of the LSCB under review to ensure the two key statutory objectives are being delivered
- The Learning and Improvement Framework drives improvement in practice.
- Implement the training strategy and evaluate its impact.
- Review and revise policies and procedures to ensure they are fit for purpose, up to date and effective
- Ensure that the workforce and the general public are aware of key safeguarding priorities and that practitioners have information to drive best practice and outcomes for children.

The LSCB business plan outlines the detailed actions and targets agreed to monitor progress.

6. Governance and accountability

Delivering the LSCB - The local authority has prioritised the management of transitional arrangements during disaggregation from a joint LSCB with Bedford Borough to a single LSCB for Central Bedfordshire. Interim management arrangements and leadership from the highest level in Children Services has ensured that priority setting and agenda management were not adversely affected by the changes. Recruitment to a full time permanent business manager's post resulted in a successful appointment and the post-holder commenced in post on April 2nd. The 3 year tenure for the independent chair expires in June 2014 and the re-tendering process is under way at the time of writing.

Membership
The membership of CBSCB meets the statutory requirements set out in the Children Act (2004) and the Working Together 2013 guidance. Details of the governance arrangements and full membership and attendance details of the Strategic Board for 2013/14 are set out in appendix A.

Schools were represented on the LSCB by a representative from the Barnfield Academy Trusts and the school governors' representative. This has provided challenge and influence from the schools to the LSCB and information is disseminated from the LSCB to schools through termly meetings with headteachers and governors and through the schools' information bulletins: *Central Essentials and Governor Essentials*. The schools' governor representative also ensures that safeguarding children is high on the agenda at the local school governors' forum which is chaired by the Executive Member for Children's Service who is also a participant observer member of the LSCB. The virtual head teacher is a member of the LSCB practice and performance group and provides regular input and reports on the educational needs of Children Looked After**.** Schools' representation on the Board needs further development and headteacher representatives will be invited to participate.

CBSCB demonstrates clear priorities through its business plan and specific areas of achievement such as the impact of multi-agency training and improvements in the quality of practice resulting from multi-agency audits. The CBSCB Independent Chair also meets frequently with the Director of Children's Services and has full access to director level representatives from other partner organisations. The Chair also accounts to and meets regularly with the Chief Executive of the Council.

Representatives from the voluntary sector sit on the Board and are actively engaged in a wide range of strategic and operational groups through the Central Bedfordshire Safeguarding Children Board and Children's Trust. They are able to influence the development of services to support children and families.

The Lead Council Member is a participating observer of the CBSCB who routinely attends the Strategic Board and receives all its written reports. The Deputy Chief Executive / Director of Children's Services ensures that all Local Authority services engage effectively with the CBSCB and is held to account for the effective working of

the CBSCB by the Chief Executive and challenged where appropriate by the Lead Member. The CBSCB has effective relationships with the Health and Wellbeing Board and the Children's Trust and the Independent Chair of CBSCB is a full member of the Children's Trust and attended all of its meetings in 2013-14. The development of a protocol to confirm the joint working with partner Boards is a priority for development.

Financing and staffing 2013/14. The work of the CBSCB is funded through contributions from partner agencies in line with a funding formula agreed by agencies in 2010 and adhered to since that time. The funding arrangements now reflect the disaggregation of the Boards from 1 October 2013 and the contributions to and expenditure from the CBSCB budget for 2013/14 were as follows:

Income 2013/14	
Agency	**Contribution (£)**
Bedford Borough (share of costs prior to disaggregation)	27,828.73
Central Bedfordshire	72,299.10
Police	25,146.37
NHS Bedfordshire CCG	69,437.10
Probation	7,906.10
Cafcass	1,100.00
Income - from training, grants, receipts in advance etc.	79,650.18
CDOP	6,761.60
Total:	**290,129.18**

Expenditure 2013/14	
	Budget (£)
Staffing costs*	155,521.22
Cost of Independent chair	45,000.00
Professional services/consultancy	40,142.82
General costs - website maintenance, office supplies, equipment.	2846.71
Training – venue costs, catering, trainers, e-learning licenses, agency administrator	39,856.83
CDOP**	6,761.60
Total:	**290,129.18**

* Staffing costs include salaries for the 1.0 FTE Business Manager, 1.0 FTE administrator, 1.0 FTE Training Officer, 0.5 FTE Training Commissioning and Development Manager

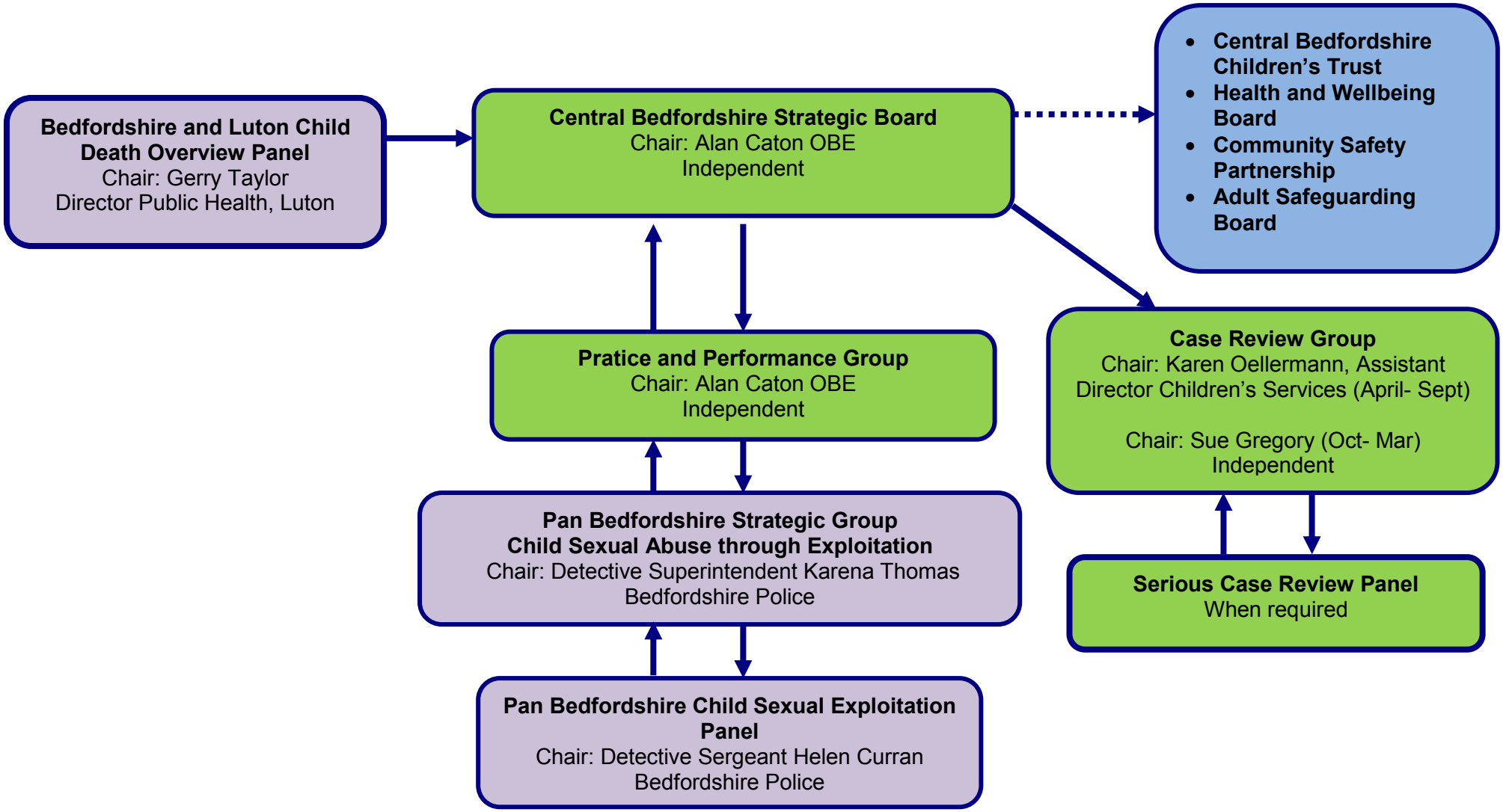
** The total cost of CDOP is £33,808. The CDOP Manager is employed 3 days per week to manage the process. The cost of funding this post is met by the 3 Local Safeguarding Children Boards, Luton Clinical Commissioning Group (LCCG) and Bedfordshire Clinical Commissioning Group (BCCG).

Appendix A - LSCB attendance

Membership and attendance at the four meetings of the Strategic Board for the Central Bedfordshire Safeguarding Children Board during April 2013 – March 2014 (Meetings held: 17th May 13, 17th Sept 13, 05th Dec 13 and 27th Feb 14).

Agency	Officer	Attendance by Agency
Bedfordshire Police	Nigel Trippett, Assistant Chief Constable or Karena Thomas, Detective Superintendent	4
Bedfordshire and Luton Clinical Commissioning Groups	Anne Murray, Director of Quality & Nursing or Helena Hughes, Designated Nurse for Safeguarding Children & Young People	4
SEPT Community Health Service Bedfordshire	Dawn Andrews, Head of Service Safeguarding Children	3
Bedford Hospital	Nina Fraser, Director of Nursing or Lynda Fitzgerald, Clinical Business Unit Manager Women & Children's Services	3
Luton and Dunstable Hospital (joined 11/11/13)	Patricia Reid, Director of Nursing	1
NHS England	Heather Moulder, Director of Nursing & Quality	4
Lead Member for Children's Services	Cllr Mark Versallion, Executive Member for Children's Services	3
Deputy Chief Executive / Director of Children's Services and Youth Offending Service	Edwina Grant, Central Bedfordshire Council	2
Central Bedfordshire Council	David Jones, Interim Assistant Director/ Stuart Mitchelmore, Assistant Director for Adult Services	3
Central Bedfordshire Council	Sue Ioannou, Head of Quality Assurance CRS	
Central Bedfordshire Council	Karen Oellermann, Assistant Director Commissioning and Partnerships	
Central Bedfordshire Council	Gerard Jones, Assistant Director Operations	4
Bedfordshire Probation	Emma Osborne & Linda Hennigan, Chief Executive	3
Cafcass Luton, Herts and Beds	Jane Stuart, Service Manager & Carol Pennington, Senior Service Manager	1
Voluntary Organisations for children, young people & families	Linda Bulled, VOCypf Officer	4
Home-Start Central Bedfordshire	Linda Johnson, Chief Executive Officer	2
Lay Members (Board Membership reviewed after meeting held on 17th May 2013) joined?	Joan Bailey (CBE)	2
	Linda Hockey	1
	Sue Howley (MBE)	3
Independent Chair for (CBSCB)	Phil Picton	4

Appendix B - The LSCB governance structure 2014-2015



Appendix C - Glossary

ACC	Assistant Chief Constable
BBSCB	Bedford Borough Safeguarding Children Board
BCCG	NHS Bedfordshire Clinical Commissioning Groups
BDAP	Bedfordshire Domestic Abuse Partnership
BPT	Bedfordshire Probation Trust
BYOS	Bedfordshire Youth Offending Service
Cafcass	Children and Family Court Advisory and Support Service
CAF	Common Assessment Framework
CAMHS	Children & Adolescent Mental Heath Services
CBC	Central Bedfordshire Council
CBSCB	Central Bedfordshire Safeguarding Children Board
CDOP	Child Death Overview Process
CEOP	Child Exploitation Online Protection
CPP	Child Protection Plan
CQC	Care Quality Commission
CSE	Child Sexual Exploitation
CSP	Community Safety Partnership
CTB	Children's Trust Board
CYPP	Children and Young People's Plan
DA	Domestic Abuse
DARO	Domestic Abuse Repeat Offender
DfE	Department for Education
EHA	Early Help Assessment
GP	General Practitioner
HMIP	Her Majesty's Inspection of Prisons
LA	Local Authority
LADO	Local Authority Designated Officer
LSCB	Local Safeguarding Children Board
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MST-PSB	Multi Systemic Therapy – Problem Sexual Behaviours
NHSCB	National Health Service Commissioning Board
PPU	Public Protection Unit (Police)
SALT	Speech and Language Therapy
SCIE	The Social Care Institute for Excellence
SCR	Serious Case Review
SEPT	South Essex Partnership Trust
SLA	Service Level Agreement
SMART	Specific, Measureable, Achievable, Realistic, Timely
SUDI	Sudden Unexpected Death in Infancy
TAC	Team Around the Child

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by telephone: 0300 300 8000
by email: customer.services@centralbedfordshire.gov.uk
on the web: www.centralbedfordshire.gov.uk
Write to Central Bedfordshire Council, Priory House,
Monks Walk, Chicksands, Shefford, Bedfordshire SG17 5TQ

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information No

Title of Report Joint Protocol between the Local Safeguarding Children Board and:

- Central Bedfordshire Health and Wellbeing Board
- Central Bedfordshire Children's Trust
- Bedford Borough and Central Bedfordshire Adult Safeguarding Board
- Central Bedfordshire Community Safety Partnership

Meeting Date: 2 October 2014

Responsible Officer Karen Oellermann, Assistant Director, Commissioning and Partnerships, Children's Services, Central Bedfordshire

Presented by: To be confirmed.

Action Required:

1. For the Health and Wellbeing Board to agree and adopt the Joint Protocol.
2. For the Chairman of the Health and Wellbeing Board to sign the Joint Protocol on behalf of the Board.

Executive Summary	
1.	This document sets out the expectations of the relationship and working arrangements between the above listed Boards. It covers their respective roles and functions, membership, arrangements for challenge, oversight scrutiny and performance management. It will be reviewed yearly from the date of signing or with any changes in legislation.

Background	
2.	Ofsted inspection reports have been critical of Local Safeguarding Children Boards (LSBCs) as they have not been clear about their working arrangements with strategic partnerships operating in their area. In Central Bedfordshire the LSCB has good working relationships with both the Health and Wellbeing Board and the Children's Trust and challenge and reports have in the past been shared where there are common priorities.

3.	At the 3 April 2014 Health and Wellbeing Board meeting, in discussing a report from the local Safeguarding Children Board, partners concurred with the suggestion that reports that had been presented to the Board revealed the need for protocols to be agreed between the Health and Wellbeing Board and the Local Safeguarding Children Board.
4.	It was resolved by this Board that the protocols setting out the relationship between the Local Safeguarding Children's Board and this Board be developed to clarify respective roles.
5.	The above listed Boards cover a wide range of issues. However there are a number of shared priorities where Boards will need to ensure that leadership and accountability for issues is clear and that information is effectively shared. These shared priorities relate to protecting vulnerable adults and children from harm and include: • domestic abuse • mental health • substance misuse • other safeguarding issues such as antisocial behaviour, hate crime and human trafficking, and • workforce sufficiency.
6.	This Joint Protocol sets out the expectations of the relationship and working arrangements between the above listed Boards. It covers their respective roles and functions, membership, arrangements for challenge, oversight scrutiny, risk and performance management.
7.	Members of the Health and Wellbeing Board are asked to comment and agree on the draft Joint Protocol.

Detailed Recommendation	
8.	For the Health and Wellbeing Board to agree and adopt the Joint Protocol.
9.	For the Chairman of the Health and Wellbeing Board to sign the Joint Protocol on behalf of the Board.

Issues	
Strategy Implications	
10.	This protocol is aligned to the Central Bedfordshire Health and Wellbeing Strategy 2012-2016, (January 2013), which outlines the vision for improving health and wellbeing and reducing health inequalities in Central Bedfordshire. It's core priorities are: • Improving the health of looked after children • Safeguarding and quality of care • Reducing childhood obesity • Reducing teenage pregnancy • Improving outcomes for frail older people • Promoting independence and choice • Helping people make healthy lifestyle choices • Improving mental health for children and their parents • Improving mental health and wellbeing of adults. A significant number of the core priorities overlap with those of the LSCB and therefore a protocol will support a more integrated approach to the work that the LSCB and H&WB are responsible for.
11.	This protocol is a multi-board protocol and has been endorsed by the LSCB for consultation with other Boards and therefore is endorsed by those agencies represented on the LSCB and listed in Joint Protocol under 'statutory partners'.
Governance & Delivery	
12.	The Boards through their chairs or at their direction will provide constructive challenge to each other across issues identified above. This is to ensure that core priorities and business aims are met, and the commissioning of services is in line with safeguarding practices. The relevant Board will need to be alerted to any issues identified either through the chairs or via a report that is referred if the issue is complex and detailed.
Management Responsibility	
13.	Members who sit on more than one Board are expected to attend meetings regularly. They have a key role in ensuring they represent their organisations and share information on the issues and concerns being discussed at both Boards. They are a key mechanism for linking and sharing information at this strategic level.
14.	Board managers, their equivalent or administrators will act as single points of contact to support flows of information as required or requested.

Public Sector Equality Duty (PSED)	
15.	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 *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**
The listed Boards do not adopt and implement the Joint Protocol effectively and partners are not clear about leadership, accountability and risks in relation to key priorities and outcomes for children.	Low	High	Listed Boards to adopt the attached protocol.

Source Documents	**Location (including url where possible)**
LSCB Business Unit	Will be published online at http://www.centralbedfordshirelscb.org/lscb-website/home-page when approved by all Boards.

JOINT PROTOCOL BETWEEN:
Central Bedfordshire Local Safeguarding Children Board and;
Central Bedfordshire Health and Wellbeing Board
Central Bedfordshire Children's Trust
Bedford Borough and Central Bedfordshire Adult Safeguarding Board
Central Bedfordshire Community Safety Partnership

Author(s):	
Date reviewed:	
Date Agreed:	
Date to be reviewed:	

1. Introduction

This document sets out the expectations of the relationship and working arrangements between the above listed partnerships. It covers their respective roles and functions, membership of the partnerships, arrangements for challenge, oversight scrutiny and performance management. The chairs of the various partnerships have endorsed this document. It will be reviewed yearly from the date of signing or with any changes in legislation.

2. Local Safeguarding Children's Board

The role of the LSCB is set out in legislation 'The Children Act 2004' and this is explained in government guidance "Working Together to Safeguard Children" (2013). http://www.workingtogetheronline.co.uk/

Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals that should be represented on LSCBs.

The LSCB has a range of roles and statutory functions including developing local safeguarding policies and procedures and scrutinising local arrangements. The statutory objectives and functions of the LSCB are described below:

- To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area.
- To ensure the effectiveness of what is done by each such person or body for those purposes.

The main functions through development and application of protocols are around:

- Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority.
- Action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
- Training of persons who work with children or in services affecting the safety and welfare of children;
- Co-operation with neighbouring children's services authorities and their Board partners.
- Communication to persons and bodies in the authorities area as to the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so.
- Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve.
- Supporting around Individual Management Reviews and Serious Case Reviews.

Core Priorities

- Ensure children and families have faster, easier access to **early help** and safeguarding support through the delivery of a **multi-agency support hub** (MASH);
- Ensure the effectiveness of safeguarding support for children living with **domestic abuse, adult mental health problems and/or substance misuse**; and
- Ensure the effectiveness of the strategy to deal with **child sexual exploitation**.

Statutory partners
The LSCB is chaired by an independent individual and LSCB regulations stipulate that the following are represented on the LSCB..

- District councils in local government areas which have them. Central Bedfordshire is a Unitary Council.
- The Chief Officer of Police.
- The Local Probation Trust.
- The Youth Offending Team;
- The NHS Commissioning Board and Clinical Commissioning Groups.
- NHS Trusts and NHS Foundation Trusts all or most of whose hospitals, establishments and facilities are situated in the local authority area.
- CAFCASS
- The governor or director of any secure training centre in the area of the authority.
- The governor or director of any prison in the area of the authority which ordinarily detains children.
- Two lay members
- The governing body of a maintained school.
- The proprietor of a non-maintained special school.
- The governing body of a further education institution the main site of which is situated in the authority's area.

In Central Bedfordshire it is recognised that non-statutory partners have a valuable contribution to make to safeguarding children and the following are also represented:

- the Voluntary Sector through the Voluntary organisation for children young people and families (Vocypf) and Home-Start Central Bedfordshire
- a key local provider of services to children, South Essex Partnership Trust.

Arrangements in Central Bedfordshire
The Strategic Board of the LSCB meets quarterly. It provides a strategic overview of performance and provides leadership and direction on partnership issues and safeguarding children in Central Bedfordshire.

The Practice and Performance Group; meets 8 times per year, has clear Terms of Reference and provides detailed scrutiny of performance and carries out multi-agency case audits to deliver on the LSCB learning and improvement framework.

The Multi-Agency Case Review Group; Meets in response to emerging needs to carry out case reviews, including formal case reviews carried out using Working Together guidance and other reviews.

The Child Death Overview Panel meets regularly to review all child deaths of children normally resident in Central Bedfordshire. This panel covers Bedfordshire and provides annual reports to each of the LSCB's.

The LSCB Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area.

3. Local Safeguarding Adults Board

The Care Act 2014 will set out the first ever statutory framework for adult safeguarding, which stipulates local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect.

These provisions require the local authority to:

- Carry out enquiries into suspected cases of abuse or neglect (clause 34)
- Establish Safeguarding Adults Boards in their area (clauses 35-36). The role of these Boards, described in Schedule 1, will be to develop shared strategies for safeguarding and report to their local communities on their progress.

Government policy
The coalition government policy on adult safeguarding states "The Government's policy objective continues to be to prevent and reduce the risk of significant harm to adults from abuse or other types of exploitation, whilst supporting individuals in maintaining control over their lives and in making informed choices without coercion. The Government believes that safeguarding is everybody's business, with communities playing a part in preventing, identifying and reporting neglect and abuse. Measures need to be in place locally to protect those least able to protect themselves." (Department of Health Statement of Government Policy on Adult Safeguarding May 2013)

The six principles which set the strategic aim of the Bedford Borough and Central Bedfordshire Safeguarding Adults Board are:

- Empowerment
- Protection
- Prevention
- Proportionality
- Partnership
- Accountability

The purpose of the joint Safeguarding Adults Board is to work in partnership to protect adults from abuse, maltreatment, neglect and prevent avoidable harm. To achieve this, the Board will:

- Challenge bad practice.

- Hold all local providers and partners to account
- Provide timely and proportionate interventions based on accurate assessment of risk and need.
- Prevent and reduce the risk of significant harm to adults at risk of abuse or other types of exploitation.
- Support individuals in maintaining choice over their lives and in making informed choices without coercion.

Through the Multi Agency Adult Safeguarding Policy, Practice and Procedures, members of the Safeguarding Adults Board and the organisations they represent, aim to achieve their commitment to:

- Safeguarding and promoting the independence, wellbeing and safety of adults at risk.
- Raising public awareness of safeguarding.
- Promoting work on the prevention of abuse.
- Tackling abuse in all settings.
- Ensuring that all staff and volunteers understand their roles and responsibilities in respect of safeguarding.
- Involving people who access services and carers in continual service improvements and the management and development of Safeguarding arrangements across Bedford Borough and Central Bedfordshire.
- Contributing and applying learning from serious case reviews.
- Ensuring that staff and volunteers are provided with appropriate training in safeguarding.

The Bedford Borough and Central Bedfordshire Safeguarding Adults Board is chaired by the Director for Adult Social Care, Central Bedfordshire. The Board will publish an annual report describing the activity undertaken in respect of the Board's strategic aims.

The Adult Safeguarding Board consists of representatives from the following agencies:

- Bedford Borough Council
- Central Bedfordshire Council
- Bedfordshire Clinical Commissioning Group
- SEPT NHS Trust
- Bedford Hospital Acute Trust
- Luton & Dunstable Acute Trust
- Bedfordshire Police
- Bedfordshire Probation
- East of England Ambulance Trust
- H M Prison Bedford
- CAN Partnership
- Bedfordshire & Luton Fire and Rescue Service
- Bedfordshire Advocacy for Older People and POhWER
- Bedford Council of Community & Voluntary Services
- Voluntary & Community Action
- Health watch Bedford Borough
- Health watch Central Bedfordshire

- Bedfordshire Care Group
- NHS England

The Bedford Borough and Central Bedfordshire Safeguarding Adults Board is a joint partnership board between the two local authorities. It operates the same principles for shared priorities, responsibilities and information sharing with the Bedford LSCB, CSP and Health and Well Being Board and shares a number of common statutory partners. The Bedford Borough partnership boards operate a separate protocol which addresses local shared priorities, responsibilities and information sharing. The two protocols are complementary and have received inter-authority approval.

4. Health and Wellbeing Board.

The Health and Social Care Act 2012 created a common flexible framework, by requiring the establishment of a Health and Wellbeing Board. There is also a statutory duty on Bedfordshire Clinical Commissioning Group in the legislation to work in partnership with local authorities.

Central Bedfordshire Health and Wellbeing Strategy 2012-2016, (January 2013), outlines the vision for improving health and wellbeing and reducing health inequalities in Central Bedfordshire. This has been informed by the Joint Needs Assessment 2013.

Health and Well Being Board Vision.

- A place where everyone can enjoy a healthy, safe and fulfilling life.
- We will do this by working in partnership with our communities and residents.
- Provide opportunities to Central Bedfordshire residents to improve their health and wellbeing.

Core Priorities

- Improving the health of looked after children
- Safeguarding and quality of care
- Reducing childhood obesity
- Reducing teenage pregnancy
- Improving outcomes for frail older people
- Promoting independence and choice
- Helping people make healthy lifestyle choices
- Improving mental health for children and their parents
- Improving mental health and wellbeing of adults

Partners

- Bedfordshire Clinical Commissioning Group
- Central Bedfordshire Council
- Healthwatch
- NHS Commissioning Board Area for Hertfordshire & South Midlands

5. The Children's Trust

The Children Act (2004) provided the legislative underpinning for Every Child Matters (2003). This requires each local authority to appoint a Director of Children's Services and designate a Lead Member for Children's Services to have responsibility for education and children's social services, to work with partners to produce a single Children and Young People's Plan and to create a Local Safeguarding Children Board. It also requires local authorities and their "relevant partners", under section 10, to cooperate to improve children's wellbeing.

The main priorities of the Children's Trust are:

- Improve educational attainment
- Protecting vulnerable children
- Early help and improving life chances
- Being healthy and positive.

The Central Bedfordshire Children's Trust is a local partnership that brings together those organisations that work together to improve children's lives and deliver the best possible services for families.

The Children's Trust consists of representatives from the following agencies:

- Schools
- Bedfordshire Police
- NHS Bedfordshire Clinical Commissioning Group
- Central Bedfordshire Council
- The Youth Parliament
- The voluntary sector
- Central Bedfordshire College
- Bedfordshire Fire and Rescue
- The Diocese of St Albans
- The Catholic Diocese of Northampton
- Bedfordshire Probation Trust
- The Youth Offending Service
- Central Bedfordshire Safeguarding Children Board

6. Community Safety Partnership

Community Safety partnerships (CSPs) aim to reduce crime and disorder, anti-social behaviour and other behaviour affecting the local environment, as well as reducing the misuse of drugs, alcohol and other substances, reduce the fear of crime and increase public confidence in our service.

This coordinated approach was encapsulated in the Crime and Disorder Act 1998, which made it a statutory duty for each local authority area to have a Community Safety Partnership. In Central Bedfordshire the Community Safety Partnership is made up of representatives from five statutory partners. Community safety is an area of concern for all communities. It is consistently a high public priority, and one that can affect the quality of life for individuals and entire communities. In recent years it has been acknowledged that tackling community safety issues cannot be done by the police alone, but is dependent on a number of organisations, and services, working together to find solutions to community problems. From 1st April 2013, under the Health and Social Care Act 2012 Clinical Commissioning Groups will become a 'responsible authority' on the CSP, replacing Primary Care Trusts.

The CSP is statutorily responsible for reducing crime and disorder, substance misuse and re-offending in each local authority area. CSPs often take responsibility for the commissioning of services such as domestic violence, offender management and drug and alcohol services.

Each CSP across the country is required to produce a Partnership Plan. This plan builds on the Partnership Strategic Assessment, which sets out the analysis of crime and disorder and identifies the priorities which we will focus our efforts into addressing.

CSP priorities for 2014-2015

The priorities identified for 2014 – 2015 are:

- Reduce the number of victims of ASB and support those who are most vulnerable;
- Reduce the number of victims of Domestic Abuse and support those who are most vulnerable; and
- Reduce domestic burglary.

Responsible Authorities of the CSP

- Central Bedfordshire Council
- Bedfordshire Police
- NHS Bedfordshire Clinical Commissioning Group
- Bedfordshire Probation Trust
- Bedfordshire Fire and Rescue Service

Membership

- Central Bedfordshire Council (including Executive Councillors, Public Health and Children's Services)
- NHS Bedfordshire Clinical Commissioning Group
- Bedfordshire Fire and Rescue Service
- Bedfordshire Police
- BeNCH/Community Rehabilitation Company
- Central Bedfordshire Safeguarding Adults Board
- Youth Offending Service

7. Ensuring the Board's are working well together

Shared priorities and responsibilities
As set out above, the Boards cover a wide range of issues. However there are a number of shared priorities where Boards will need to ensure that leadership and accountability for issues is clear and that information is effectively shared. These shared priorities relate to protecting vulnerable adults and children from harm and include:

- domestic abuse
- mental health
- substance misuse
- other safeguarding issues such as antisocial behaviour, hate crime and human trafficking, and
- workforce sufficiency

The Community Safety Partnership has the strategic lead for domestic abuse issues and the Health and Wellbeing Board has the strategic lead for mental health and substance misuse issues.

The Boards through their chairs or at their direction will provide constructive challenge to each other across these issues identified above. This is to ensure that core priorities and business aims are met, and the commissioning of services is in line with safeguarding practices. The relevant Board will need to be alerted to any issues identified either through the chairs or via a report that is referred if the issue is complex and detailed.

Workforce sufficiency, across the professions that deliver services in relation to the above priorities, remains a national and local issue. Sufficiency remains the responsibility of the agency with statutory responsibility for commissioning or delivering the services. Workforce sufficiency can be scrutinised by any of the Boards in relation to delivery of support services for families or individuals dealing with the issues above. Reports may be referred to another Board where there are sufficiency or quality concerns and where it is felt that Board should be aware of the impact in relation to its priorities around protecting vulnerable adults and children from harm.

Information sharing
Information will continue to be shared across the Boards through consultation on strategies, annual reports, inspection reports and through shared membership. The chairs will receive a copy of each others agendas and minutes.

Members who sit on more than one Board are expected to attend meetings regularly. They have a key role in ensuring they represent their organisations and share information on the issues and concerns being discussed at both Boards. They are a key mechanism for linking and sharing information at this strategic level.

There is the following common membership across the Boards:

- the Chief Executive (CBC) sits on the Children's Trust Board and the Health and Wellbeing Board;

- the Director of Adult Social Care (CBC) sits on the Adult Safeguarding Board and the Health and Wellbeing Board;
- the Assistant Director, Operations (CBC) and the Assistant Director, Adult Social Care (CBC) both sit on the Central Bedfordshire LSCB and the Adult Safeguarding Boards
- the Assistant Director, Operations (CBC) sits on the Central Bedfordshire LSCB, the Adult Safeguarding Board and the Community Safety Partnership
- the chair of the LSCB is also a member of the Children's Trust Board
- the Chief Operating Officer is a member of the Children's Trust and the Health and Wellbeing Board
- the Deputy Chief Executive/Director of Children's Services and the Executive Member for Children's Services sit on the LSCB, the Children's Trust and the Health and Wellbeing Board

Board managers or administrators will act as single points of contact to support flows of information as required.

If there are any areas of significant concern that cannot be resolved in accordance with this protocol, then a meeting will be held between the Chairs of the relevant Boards. Other persons will be invited as required. This protocol should be reviewed by the Boards, on an annual basis.

The Chairs of the Boards will work together to manage the risks in relation to the shared priorities and contribute to a risk log which will be held by the Local Safeguarding Children Board.

Alan Caton OBE

Chair
Central Bedfordshire
Safeguarding Children Board

Councillor Mrs PE Turner MBE

Chair
Central Bedfordshire Health and Wellbeing Board

Councillor Mark Versallion

Chair
Central Bedfordshire Children's Trust Board

Julie Ogley

Chair
Bedford Borough and Central Bedfordshire Adults Safeguarding Board

Marcel Coiffait

Chair
Central Bedfordshire Community Safety Partnership

Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	Healthwatch Central Bedfordshire – Current Concerns
Meeting Date:	2nd October 2014
Responsible Officer(s)	Diana Blackmun (CEO)
Presented by:	Diana Blackmun (CEO)

Action Required: To receive an update on recent activities of Healthwatch Central Bedfordshire and to address the recommendations listed below.

Executive Summary	
1.	This report is submitted to the Board for information and consideration.

Background	
2.	At present there are a number of issues and concerns for the provision of health and social care in Central Bedfordshire, including: ▪ Mental Health Services – Research and Procurement ▪ Sub- acute South Services Pilot – withdrawal of services ▪ Telehealth – withdrawal of services
3.	Healthwatch Central Bedfordshire understands the priorities of the Health & Wellbeing Board and would like to highlight current areas of Healthwatch Central Bedfordshire's work with recommendations to the Board.

Detailed Recommendation	
4.	I. That the Health and Wellbeing Board support the activities of Healthwatch Central Bedfordshire and., II. That the Health and Wellbeing Board support the issues raised by Healthwatch Central Bedfordshire in this report and work with us to address the recommendations., **III.** That the Health and Wellbeing Board support Healthwatch Central Bedfordshire in carrying out our statutory functions, in particular our role as the local consumer champion.

Report – HWCB Update	
5.	**HWCB Board Directors / Trustees** ▪ Ruth Featherstone stepped down as Chair of HWCB in August 2014 having held the role since April 2013. Robin Smith was subsequently appointed Interim Chair, following his co-option as Director, and Dave Simpson (Director) was appointed Vice Chair. The Directors and staff of HWCB have thanked Ruth for all her hard work and dedication in setting up HWCB which has enabled us to make a significant contribution to the way health and social care services are planned, provided and delivered in Central Bedfordshire. Her immense enthusiasm and commitment are widely recognised by our volunteers and key stakeholders and we all wish her well for the future. ▪ In accordance with HWCB Governance arrangements additional Directors / Trustees will be recruited. Adverts have recently been placed in local media and with Voluntary Works. We have received a very positive response so far. The closing date for applications is 30th September with interviews w/c 13th October 2014.
6.	**HWCB Membership** ▪ There are various ways to become involved with HWCB and our activities, one of which is through individual or corporate membership. In addition to receiving all the benefits of being a Healthwatch participant, individual or corporate members can be involved in the governance of the organisation by nominating and electing Directors of the organisation and by voting on resolutions at General Meetings. To promote membership, HWCB have distributed membership forms and information about how to be involved with HWCB to all stakeholders across Central Bedfordshire. For more information visit our website at www.healthwatch-centralbedfordshire.org.uk ▪ HWCB are keen to involve individuals and the voluntary sector in our work, to improve and enhance our working relationships, which is key to influencing and improving health and social care in Central Bedfordshire. It is also vitally important for us to explore ways in which the consumer voice can be heard effectively. HWCB have recently acted to support this objective by inviting key members of the voluntary sector to meet with us to hear the views of the people they represent and support, particularly if they have any issues or concerns relating to health and social care services, to enable us to build on and effectively represent their views at wider forums.
7.	**HWCB AGM 2014** HWCB Annual General Meeting will be held in public on Monday 29th September 2014 in the Warrenfield Room at The Rufus Centre, Flitwick, Beds. The AGM will feature presentations from HWCB CEO and LHM Media, who will be highlighting a new HWCB interactive

	website designed to instantly capture consumer views and rate services. Invitations have been distributed to all our stakeholders. For more information contact HWCB on 0300 303 8854 or visit our website at www.healthwatch-centralbedfordshire.org.uk
8.	**HWCB Activities** ▪ **HWCB Annual Report 2013/14** was published in June 2014. This report details how HWCB was set up, our activities, recruitment of volunteers, financial information and future engagement. Copies of the report were sent to Healthwatch England, the CQC and key stakeholders. ▪ **Volunteer Event** – HWCB held its first volunteer event on 3rd June called 'meet the team'. Many volunteers attended sharing their skills, interests and talents and signed up for various volunteer roles and activities. ▪ **HWCB Aug / Oct Newsletter** – This issue, recently published, featured information about our latest activities, surveys and research and was widely distributed across Central Bedfordshire. ▪ **Healthwatch Annual Conference 2014** – HWCB staff attended HW England Annual Conference in July 2014. Over 180 delegates attended the event from across the HW network. The keynote speaker was Jon Rouse, Director for the DOH. Jon endorsed the work of all HW in England and was supportive of the role HW has in influencing the provision and delivery of health and social care services throughout the country. ▪ **Strategic Review** – HWCB continue to represent the patient voice at BCCG Stakeholder forums as part of the wider healthcare review. HWCB CEO was also recently invited to sit on the interview panel for the appointment of a lay member of the BCCG's Patient and Public Engagement Forum along with the Chair of HW Bedford Borough. ▪ **Sustaining Quality in Care Homes** - HWCB recently conducted a series of focus groups to engage and consult with the public to explore what the priorities are for individuals and their family members when choosing a residential or nursing care home, how they know what 'good' quality care looks like and how they can ensure those qualities are sustained once the choice is made. Initial findings indicate that there is less awareness of how to approach the difficult task of choosing a care home, particularly for self-funders. Ideas for sustaining quality in care homes ranged from regular and unscheduled visits from family members to inviting volunteers into the home to engage with residents and relatives and to be their 'eyes and ears'. Many participants tended to have a sound awareness of the benefits of being involved in a resident/relatives group to make recommendations and help sustain quality of care. A detailed report will be available shortly. ▪ **Dementia Awareness week** – HWCB joined the Alzheimer's society for their Dementia Awareness week in May. HWCB were able to encourage feedback and sign up many delegates to receive

	information about HWCB. ▪ **Carers Forum** – HWCB presented at CBC's Carers Forum in June and engaged with many carers and their family members to promote the work of HWCB and encourage Carers to share their experiences. ▪ **Patient Leaders Programme: Macmillan Cancer Support** – HWCB Director, Dave Simpson, has been chosen to participate in Macmillan's Developing Patient Leaders Programme. This programme encourages people affected by cancer to join their local Healthwatch. Dave will undergo a series of workshops and master classes to become a patient leader. ▪ **Public Engagement** – HWCB continue to engage with the public at our 'Just Ask' events for 2014. Remaining outreach events for this year will be Dunstable in September and Sandy in October. Full details can be found on our website at www.healthwatch-centralbedfordshire.org.uk ▪ **HWCB Website –** To further improve, enhance and future proof our work HWCB have purchased an innovative media package. This system, which includes a new interactive website, will provide a significant contribution to our research activities by instantly capturing comments and ratings directly from members of the public. Information can be recorded for each of the providers we nominate and reported via a flexible program within the system. It will allow us to obtain more relevant information on service user opinions and identify potential problems in their experiences of service delivery. Furthermore, HWCB will be able to: i. demonstrate Healthwatch Central Bedfordshire is an effective consumer champion and be service user centred; ii. build awareness of HWCB amongst local people and provide them with a voice; iii. effectively signpost local people to information about their health and social care services; iv. launch an innovative technology platform that offers value to partners by increasing the amount of data that can be obtained through 'access anywhere' devices to shape local health outcomes. This latest technology will be used to gather the views and experiences of local people in a very meaningful way and we anticipate that the new website will encourage people of all ages to give their feedback but particularly the younger generation. The new website is currently being built and will be launched shortly.
Main report – Issues and recommendations	
9.	**Mental Health Services** Healthwatch England have responded to the Chief Medical Officers Annual Report on mental health services indicating a need to invest further in these services, particularly for children and young people, echoed by feedback received from the Healthwatch Network including HWCB. We will be contributing to HW England's inquiry, in the new year, to establish where

	investment is most needed to ensure treatment of mental health is put on an equal footing with physical conditions. HWCB has seen an increase in the number of complaints and comments in relation to mental health service delivery across Central Bedfordshire, which is shared with current providers. In addition, HWCB have welcomed the opportunity to be involved in the BCCG's recent procurement of mental health services across Central Bedfordshire in order to ensure informed representation and agreement for standards of care and support. HWCB would recommend that the BCCG support the work of HWCB in this area and ensure that the new providers of mental health services across Central Bedfordshire continue to work with HWCB to enable us to influence and improve service delivery.
10.	**Review of the Sub-Acute South Services Pilot** HWCB has been notified by the BCCG that a decision was taken to end the Sub-Acute South Services Pilot provided by SEPT Community Services as this has not delivered the expected outcomes in terms of finance and impact on patient flows. HWCB understand that the end of the pilot phase will be managed in partnership with SEPT with the aim of minimising any adverse consequences for patients affected by the change. HWCB concerns have been raised in relation to the formal evaluation of these services; in particular, how were the services evaluated to reach this important decision and whether service users were consulted? Our concerns are based on the original premise that these services were supported by a robust business case that has subsequently failed to deliver the proposed outcomes resulting in a loss of services for consumers that they may have come to rely on. HWCB would recommend that the BCCG, as commissioners, advise whether there are plans in place to provide alternative services to support people to receive the care they need and/or to mitigate the impact a withdrawal of services will have on consumers. HWCB will feedback any comments, issues or concerns received from the public in relation to the end of service provision.
11.	**Telehealth** HWCB have been advised that current Telehealth services, provided by SEPT, will be de-commissioned by the BCCG. HWCB understand that only a small minority of Bedfordshire residents currently use this service and evidence has suggested that Telehealth has not represented sufficient value for money; however our concerns are in relation to the future use of technology to support vulnerable patients with long term conditions to remain in their homes for longer. In the Bedfordshire/Milton Keynes Healthcare Review, it was reported that,

	consulted clinicians, in identifying opportunities for improving the way care is delivered, have used the example of *'through better use of available technology'.* HWCB would therefore recommend, in light of the de-commissioning of Telehealth, that the BCCG show how they envisage technology being incorporated into the new models of care currently being explored in the Healthcare Review including how they will be substantiated and successful. HWCB will monitor this situation going forward and will feed back any concerns raised by current users of Telehealth.
Strategy Implications	
15.	Healthwatch Central Bedfordshire will impact upon the Health and Wellbeing Strategy for Central Bedfordshire, the Community Engagement Strategy, the Social Care Health and Housing Advice and Information Strategy and have influence and input into the Joint Strategic Needs Assessment.
Governance & Delivery	
16.	Through our contract with Central Bedfordshire Council managed by the Assistant Director of Commissioning which provides the governance and delivery of Healthwatch Central Bedfordshire including monitoring.
Management Responsibility	
17.	Update on progress of Healthwatch Central Bedfordshire to the Health & Wellbeing Board will be through the Director of Social Care, Health & Housing.
Public Sector Equality Duty (PSED)	
18.	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)

Diana Blackmun

Presented by Diana Blackmun

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Pharmaceutical Needs Assessment (PNA)
Meeting Date:	2 October 2014
Responsible Officer(s)	Dr Zoe Aslanpour, Sean Parrett
Presented by:	Muriel Scott, Director of Public Health

Action Required:

1. That the Board note that the first draft of the Pharmaceutical Needs Assessment has been completed in anticipation of the statutory public consultation starting in October 2014.

Executive Summary	
1.	The Health and Social Care Act 2012 transferred responsibility for the development and updating of Pharmaceutical Needs Assessments (PNA) from Primary Care Trusts to Health and Wellbeing Boards in April 2013. An updated PNA for Central Bedfordshire is required by April 2015, following a period of public consultation.

Background	
2.	From 1 April 2013 the Central Bedfordshire Health and Wellbeing Board (HWB) became responsible for the PNA, which had previously published by NHS Bedfordshire in 2011.
3.	The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 required the HWB to make a revised assessment as soon as is reasonably practicable after identifying changes to the need for pharmaceutical services which are of a significant extent; and Publish its first PNA by 1 April 2015.
4.	The Central Bedfordshire PNA 2015 has now been drafted and is due to go out for the statutory three month consultation period from 15 October to 15 December 2014.

5.	The PNA looks at the current provision of pharmaceutical services across Central Bedfordshire and whether they meet the needs of the population. It also identifies any potential gaps to service delivery. The PNA includes information on: • Pharmacies in Central Bedfordshire and the services they currently provide, including dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users. • Other local pharmaceutical services, such as dispensing GP surgeries. • Relevant maps relating to Central Bedfordshire and providers of pharmaceutical services in the area. • Services in neighbouring Health and Wellbeing Board areas that might affect the need for services in Central Bedfordshire. • Potential gaps in provision that could be met by providing more pharmacy services, or through opening more pharmacies, and likely future needs.
6.	At the HWB meeting in July 2013 the Director of Public Health outlined this new responsibility to the HWB and the Board agreed that the PNA be instigated.

Detailed Recommendation	
7.	The purpose of the report is to ensure the HWB is aware of the progress with the PNA in line with its responsibility to publish the document by the statutory deadline.
8.	It is expected that the recommendations within the published PNA will be used by NHS England's Local Area Team to inform commissioning decisions, in order to fill gaps in service provision and address local health needs. The PNA may also be used by Central Bedfordshire Council to influence the development and delivery of the Health & Wellbeing Strategy by considering the added value Community Pharmacies can bring to delivering Health & Wellbeing.

Issues	
Governance & Delivery	
9.	Following the formal consultation period, a final draft of the PNA will be submitted to the HWB to sign off in order to publish by the statutory deadline of 1 April 2015.

Financial	
8.	There are no additional resource implications for the HWB at this time.
Public Sector Equality Duty (PSED)	
9.	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
	The PNA includes recommendations on which NHS England will make commissioning decisions. The PNA steering group is currently working with the Central Bedfordshire Equality Impact Officer to ensure that no groups are disadvantaged in the process of producing the PNA or as a result of the recommendation.

Source Documents	**Location (including url where possible)**
Health and Social Care Act 2012	http://www.legislation.gov.uk/ukpga/2012/7/section/206/enacted
The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations) 2013	http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/
NHS Bedfordshire Pharmaceutical Needs Assessment, January 2011:	http://www.bedford.gov.uk/health_and_social_care/bedford_borough_jsna/pharmacy_needs_assessment.aspx

Presented by Muriel Scott

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	**Board Development and Work Plan 2014 -2015**
Meeting Date:	2 October 2014
Responsible Officer(s)	Richard Carr
Presented by:	Richard Carr

Action Required: That the 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 2014 -2015.

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	
7.	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.
8.	The Work plan includes key strategies of the Clinical Commissioning Group.
Governance & Delivery	
9.	The work plan takes account the duties set out the Health and Social Care Act 2012 and will be carried forward when the Board assumed statutory powers from April 2013.
Management Responsibility	
10.	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)	
11.	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 – Health and Wellbeing Board Work Programme
B – Item request form for Health and Wellbeing Board Work Programme

Source Documents	Location (including url where possible)

Presented by Richard Carr

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Work Programme for 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.	Joint Health and Wellbeing Strategy	To receive a report setting out the next steps in the refresh of the Joint Health and Wellbeing Strategy	4 December 2014		Muriel Scott, Director of Public Health Contact officer: Celia Shohet, AD Public Health
2.	Pharmaceutical Needs Assessment	To receive an update on the Pharmaceutical Needs Assessment	4 December 2014		Muriel Scott, Director of Public Health Contact officer: Celia Shohet, AD Public Health

DATES TO BE DETERMINED

3.	Reducing Childhood Obesity	To receive an update on the actions identified to maximise the opportunities for children and families to lead healthy active lives.	TBC		Muriel Scott, Director of Public Health

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Health and Wellbeing Board

Work Programme of Decisions

Title of report and intended decision to be agreed by the 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 HWB will need to make e.g. To adopt ……	Insert the date of the HWB meeting	Insert who has been consulted e.g. stakeholders, the date they were consulted and the method.	Insert the documents the HWB may consider when making their decision e.g. report.	Insert the name and title of the relevant 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 HWB date e.g. the closing date for the HWB meeting on 8 November will be 11 October.

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