Central Bedfordshire Council
Priory House
Monks Walk
Chicksands,
Shefford SG17 5TQ

please ask for Paula Everitt
direct line 0300 300 4196
date 27 March 2014

NOTICE OF MEETING

SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE

Date & Time
Monday, 7 April 2014 10.00 a.m.

Venue at
Council Chamber, Priory House, Shefford

Richard Carr
Chief Executive

To: The Chairman and Members of the SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE:

Cllrs Mrs R J Drinkwater (Chairman), N J Sheppard (Vice-Chairman), Mrs A Barker, R D Berry, Mrs G Clarke, P A Duckett, Mrs S A Goodchild, Mrs D B Gurney and M A Smith

[Named Substitutes:

P N Aldis, C C Gomm, Ms A M W Graham, K Janes and Miss A Sparrow]

All other Members of the Council - on request

MEMBERS OF THE PRESS AND PUBLIC ARE WELCOME TO ATTEND THIS MEETING

AGENDA

1. **Apologies for Absence**

   Apologies for absence and notification of substitute members

2. **Minutes**

   To approve as a correct record the Minutes of the meeting of the Social Care Health and Housing Overview and Scrutiny Committee held on 03 March 2014 and to note actions taken since that meeting.

3. **Members' Interests**

   To receive from Members any declarations of interest and of any political whip in relation to any agenda item.

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

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

5. **Petitions**

   To receive petitions from members of the public in accordance with the Public Participation Procedure as set out in Annex 2 of Part A4 of the Constitution.

6. **Questions, Statements or Deputations**

   To receive any questions, statements or deputations from members of the public in accordance with the Public Participation Procedure as set out in Annex 1 of part A4 of the Constitution.

7. **Call-In**

   To consider any decision of the Executive referred to this Committee for review in accordance with Procedure Rule 10.10 of Part D2.

8. **Requested Items**

   To consider any items referred to the Committee at the request of a Member under Procedure Rule 3.1 of Part D2 of the Constitution.

Part A: Health Scrutiny

to consider matters relating to health of adults, children and young people and 'substantial' changes to NHS provision in Central Bedfordshire.

Reports

Item	Subject		Page Nos.
9	**Executive Member Update** To receive a brief verbal update from the Executive Member for Social Care, Health and Housing.	*	verbal
10	**Hospital Discharge Performance** To receive performance monitoring data relating to Hospital Discharge.	*	11 - 16
11	**Biggleswade Hospital Information Update** To consider the information update on Biggleswade Hospital.	*	17 - 32
12	**Planned Changes to the Provision of Mental Health and Community Services** To consider the proposals for a Cost Improvement Programme in the provision of Mental Health and Community Services.	*	33 - 38
13	**Mental Health Procurement** To consider and comment on the proposed models of care and plans for consultation on Mental Health procurement.	*	39 - 144

Part B: Social Care and Housing

To consider matters relating to adult social care and housing services and any other matters that fall within the remit of the Social Care, Health and Housing Directorate.

Reports

Item	Subject		Page Nos.
14	**Tenant Scrutiny Panel Report** To consider a report prepared and presented by Members of the Tenant Scrutiny Panel.	*	145 - 182

15 **Meeting the Accommodation Needs of Older People** *

To receive a presentation on the progress made in meeting the accommodation needs of older people.

16 **Revenue, Capital and Housing Revenue Account (HRA) Budget Monitoring Presentations** *

To receive a presentation on Q3 Budget reports for relevant services.

17 **Performance Monitoring Report (Q3)** * 183 - 192

To receive Q3 performance monitoring reports for relevant services.

18 **Work Programme 2013-14 & Executive Forward Plan** * 193 - 200

To consider the currently drafted Social Care Health and Housing Overview and Scrutiny work programme for 2014/15 and the Executive Forward Plan.

CENTRAL BEDFORDSHIRE COUNCIL

At a meeting of the **SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE** held in Council Chamber, Priory House, Monks Walk, Shefford on Monday, 3 March 2014.

PRESENT

Cllr Mrs R J Drinkwater (Chairman)
Cllr N J Sheppard (Vice-Chairman)

Cllrs	Mrs G Clarke	Cllrs	Mrs D B Gurney
	P A Duckett		M A Smith
	Mrs S A Goodchild		

Apologies for Absence:	Cllrs	Mrs A Barker	
		R D Berry	
Substitutes:	Cllrs	C C Gomm (In place of R D Berry)	
Members in Attendance:	Cllrs	C Hegley	Executive Member for Social Care, Health & Housing
		A M Turner	Deputy Executive Member for Social Care, Health & Housing

Officers in Attendance:	Mrs P Coker	– Head of Service, Partnerships - Social Care, Health & Housing
	Mr N Costin	– Head of Housing Solutions
	Mrs P Everitt	– Scrutiny Policy Adviser
	Ms C Gurney	– Public Sector Housing Manager
	Mr S Mitchelmore	– Assistant Director, Adult Social Care
	Mrs J Ogley	– Director of Social Care, Health and Housing
	Mrs E Saunders	– Assistant Director Commissioning

Others in Attendance	Dr D Bell	Director of Strategy and System Redesign (Bedfordshire Clinical Commissioning Group)
	Ms R Featherstone	Chair - Healthwatch Central Bedfordshire
	Mrs H Smart	Director Integrated Adult Services & Lead Nurse, SEPT Integrated Services

SCHH/13/117 **Minutes**

RESOLVED that the minutes of the meeting of the Social Care Health and Housing Overview and Scrutiny Committee held on 27 January 2014 be confirmed and signed by the Chairman as a correct record.

SCHH/13/118 **Members' Interests**

There were no disclosures of interest.

SCHH/13/119 **Chairman's Announcements and Communications**

The Chairman made announcements relating to the following:-

- Cllr Angela Barker had been appointed as a Member of the Committee. Cllr Barker would report back to Children's Services OSC, of which she is the Chairman, on any health related issues that impact on children.
- That the Housing Asset Management Strategy item be deferred as there were no significant changes to the strategy to report.
- A recent Centre for Public Scrutiny Regional Health event in Chelmsford that the Chairman attended. Of particular interest was the undertaking announced by the CQC representative to work more closely with scrutiny committees in the future.
- A recent meeting of the Joint Health Overview and Scrutiny Committee for which a full summary would be given at next month's meeting.

SCHH/13/120 **Petitions**

None

SCHH/13/121 **Requested Items**

None.

SCHH/13/122 **Questions, Statements or Deputations**

None.

SCHH/13/123 **Call-In**

None.

SCHH/13/124 **Executive Member Update**

The Deputy Executive Member for Social Care Health and Housing updated the Committee on issues that were not included on the agenda, these included:-

- Attendance at a recent performance meeting.
- Attendance at a regional public health event at which examples of good practice on preventative measures and approaches were highlighted.

SCHH/13/125 **Biggleswade Hospital Monitoring Information**

The Chairman welcomed Helen Smart, Director Integrated Adult Services and Lead Nurse (SEPT) who provided an update to Members on usage of beds at Biggleswade Hospital. Ms H Smart advised there had been little change in the number of patients on the wards since the previous meeting. However, the beds were open for use and were currently no delays in discharge. An Emergency Care Intensive Support Team (ECIST) had recently carried out a positive review of service provision from SEPT.

In light of the update, Members discussed the following:-

- Whether SEPT were actively encouraging male and female patients to attend the hospital. Ms H Smart advised that there had been no demand for male patients' beds. 19 female patients had attended the hospital recently.
- Where Members or GPs could review the criteria for admissions to Biggleswade Hospital. Diane Bell, Director of Strategy and System Redesign at Bedfordshire Clinical Commissioning Group advised that the criteria would be made available to Members and, that the criteria had been expanded due to the receipt of money provided by the Government to respond to winter pressures.

In light of the issues that were discussed a number of Members identified specific incidents where local residents that had been informed by SEPT staff why they could not be cared for at Biggleswade Hospital. Ms H Smart commented that generally patients who were treated in their own homes would achieve better outcomes. Members were requested to forward any examples of problems regarding access to Stuart Mitchelmore, Assistant Director, Adult Social Care, who would discuss them with SEPT.

RECOMMENDED

1. **That Members be provided with the admissions criteria for Biggleswade Hospital.**
2. **That SEPT provide a report to the next meeting of the Committee that included evidence of better outcomes for patients treated at home.**
3. **That SEPT also provide a breakdown of the numbers of patients cared for at Biggleswade Hospital and at home.**

SCHH/13/126 **Better Care Fund**

The Director of Social Care Health and Housing delivered a presentation and provided a report on the Better Care Fund (formally Integration Transformation Fund) that was being provided by the Government to support the delivery of the Care Bill. Access to funding in 2015/16 was dependent on the agreement of a local 2-year Better Care Plan. The Health and Wellbeing Board had submitted the first stage of the Better Care Plan template on 14 February 2014 and work was in progress to complete the second stage submission by 04 April 2014.

The Better Care Fund would be made up of a pooled budget that would include NHS and CCG funding.to the sum of £15m for Central Bedfordshire. The Committee were informed, that this was not new money.

In light of the presentation and report and further clarification provided by officers present, Members discussed the following issues in detail:-

- The need for a better understanding of the proposed reforms. The Executive Member agreed to schedule a briefing session for all Members of the Council on the Care Bill and the Better Care Fund proposals.
- That reliable information was of paramount importance during the transformation of services and must be available to everyone associated with the provision or in receipt of care.
- That transformation of the workforce was required to deliver the proposed care services. The Director SCHH advised there was a huge challenge for the Council that would require a cultural change to move to 7 day working to support patients. There was not, however, enough fully trained staff to meet the level of need. It was discussed that there was a short period of time to educate residents on the cultural change required to deliver services effectively. The Director of SCHH advised that the Joint Health OSC review of Health Services in Bedfordshire would help to deliver cultural change.

RECOMMENDED
That an all Member briefing be arranged on the Care Bill and Better Care Fund before the 04 April deadline of the second stage submission of the Better Care Fund and that a further report be submitted to the Committee in May.

SCHH/13/127 **Empty Homes Performance**

The Head of Housing Solutions introduced the Empty Homes Review of Performance report and presentation. The Empty Homes strategy had been approved in 2010 and had been instrumental in bringing good quality accommodation back into the housing market to help meet housing need. The Head of Housing Solutions explained the process that had seen 28 empty homes returned to use in 2012/13 and to date 32 priority homes returned to use in 2013/14.

In light of the presentation and report Members discussed future enforcement action on dwellings left unoccupied for 12 months or more and those identified by officers. Council Tax data had provided evidence of empty homes and further clarification was sought on e-home loans and how the Council ensured it received payment. The Head of Housing Solutions advised that the Council would pay a loan on completion of works carried out to a property to bring it back into use and it would become a charge on the property. Members were able to identify empty properties in their wards and the Public Sector Housing Manager would investigate all properties reported to the team. The Empty Homes Agency also provided an ‘app’ to report an empty home. A Member comments on the shortage of rentable properties in the north of Central Bedfordshire and nationally, and supported efforts to bring empty dwellings back into use.

NOTED the report and thanked officers present for the excellent service provided.

SCHH/13/128 **Housing Asset Management Strategy**

This item was deferred to a future meeting as there were no specific information to report to the Committee at this time.

SCHH/13/129 **Work Programme 2013/14 & Executive Forward Plan**

The Committee considered its current work programme which would be updated to include the two items detailed in the body of the Minutes.

RECOMMENDED that the work programme be approved subject to the addition of two items detailed in the body of the Minutes.

(Note: The meeting commenced at 10.00 a.m. and concluded at 11.50 a.m.)

Chairman ………………………..

Date ……………………………..

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Meeting: **Social Care, Health and Housing Overview and Scrutiny Committee**

Date: **07 April 2014**

Subject: Report of the Hospital Discharge Task Force

Report of: **Cllr Rita Drinkwater, Chairman of the Task Force**

Summary: The report updates Members of the implementation of the recommendations of the previous task force review of performance relating to the pathway for leaving hospital.

Contact Officer: Jonathon Partridge, Corporate Policy and Scrutiny Manager

Public/Exempt: Public

Wards Affected: All

Function of: NHS

CORPORATE IMPLICATIONS
The recommendations contained in the task force report were primarily for NHS agencies and not the Council itself. The implementation of these recommendations will however support the Council by promoting health and wellbeing and protecting the vulnerable. The implications of these recommendations have not been identified but officers will be in attendance at the meeting to discuss their implementation.

RECOMMENDATIONS:

1. **That the Social Care, Health and Housing Overview and Scrutiny Committee considers the recommendations of the task force and recommend to the responsible bodies that they be implemented.**
2. **That appropriate NHS bodies submit an update to the Committee in two months outlining progress in implementing those recommendations agreed by the Committee**

Background

1. At the Social Care, Health and Housing OSC (SCHHOSC) on 27 January 2014 the Committee approved the final Task Force report of the review of performance relating to the pathway for leaving hospital. At the meeting it was noted that the content of the report was largely historical in nature due to the time taken to gather information and events that had overtaken the initial piece of work. The Committee recommended that:-
   (a) That the recommendations contained in the report of the Task Force be endorsed
   (b) That the appropriate NHS bodies submit an update to the Committee in two months time outlining progress in implementing the recommendations detailed in the Task Force report.

(c) That the Committee receive regular monitoring reports on hospital discharge performance.

2. To support feedback to the Committee appendix B outlines the recommendations that have been agreed by the Committee. Where no update it provided officers will be in attendance to provide an update verbally.

Conclusion and Next Steps

3. The Committee are asked to consider the report and recommendations of the task force and agree that the recommendations be provided to providers for their implementation. It is also suggested that NHS providers provide an update on the progress if implementing the recommendations of the review within 2 months.

Appendices:

Appendix Update on the recommendations

Background papers and their location: (open to public inspection)

Final Task Force report

http://www.centralbedfordshire.gov.uk/modgov/documents/s46985/Final%20Hospital%20Discharge%20Task%20Force%20report%20v6.pdf

Minutes of the SCHHOSC meeting on 27 January 2014

http://www.centralbedfordshire.gov.uk/modgov/documents/g4447/Printed%20minutes%20Monday%2027-Jan-2014%2010.00%20SOCIAL%20CARE%20HEALTH%20HOUSING%20OVERVIEW%20SCRUTINY%20COMMIT.pdf?T=1

Appendix A

Responses relating to the implications and feasibility of the recommendations proposed by the review.

	Recommendation	Lead agency	Comments and update
1.	CCG be requested to continually review hospital discharge performance and that performance be presented to the SCHHOSC on a quarterly basis	Bedfordshire Clinical Commissioning Group (BCCG)	
2.	That a report be presented to a future meeting of the Social Care, Health and Housing OSC by BCCG to provide greater clarity of its plans for the system redesign of acute and emergency care pathways.	BCCG	
3.	That the Ivel Valley Locality Team be asked to review performance in relation to hospital discharge at the Lister Hospital and the numbers of delays of discharge for Central Bedfordshire residents.	BCCG	
4.	That a report be sent to other LAs to consider whether a review of performance by scrutiny was necessary.	CBC Scrutiny and Policy Manager	The report was circulated to other relevant local authorities several of whom have recently undertaken their own reviews of hospital discharge performance or, in the case of one authority, are considering undertaking one later in the year. Hertfordshire County Council have asked to be kept informed of any response in relation to recommendation 3.
5.	That Bedford Hospital employ a person specifically to communicate between the hospital and community healthcare services to support more effective discharges from hospital by ensuring that equipment is available for patients and that appropriate community healthcare needs	Bedford Hospital	

DRAFT

	Recommendation	Lead agency	Comments and update
	are met.		
6.	That Bedford Hospital ensure staff fully understand the discharge pathway so that there is a consistent approach and that accurate expected dates of discharge can be provided.	Bedford Hospital	
7.	That Bedford Hospital put appropriate procedures in place to ensure a consistent approach to hospital discharge across the week, including the weekends to ensure that unnecessary delays do not occur just because it is Saturday or Sunday.	Bedford Hospital	
8.	That Bedford Hospital provide one named person who is responsible for an individual patient's entire hospital pathway to ensure that all aspects of that persons care have been considered, including appropriate transport and equipment being available at the other end once they had been discharged.	Bedford Hospital	
9.	That Bedford Hospital provide a single point of contact when discharging patients from hospital and proactively encourage patients to use this single point of contact if they have any issues in the two week period after discharge.	Bedford Hospital	
10.	That Bedford Hospital hold patient information on one central system so that persons need only ring one number in order to obtain any relevant information on that patient.	Bedford Hospital	
11.	That Bedford Hospital seek input from Carers using the Carer Lounge as to whether staff strike the right balance between engaging carers at an early stage and finding the appropriate	Bedford Hospital	

DRAFT

	Recommendation	Lead agency	Comments and update
	time to discuss an issue.		
12.	That the CCG encourage hospitals from whom it commissions services to standardise hospital discharge forms with a view to creating one familiar form that contained all the necessary information in one place to support effective planning for hospital discharge speeding up the process and making it more efficient.	BCCG	
13.	That a review be undertaken of the Clinical Navigation Team (CNT)to determine whether it has delivered against its objectives and whether its role remains suitable. In light of this review it should be considered whether the CNT or another appropriate body could be responsible for the following:- 1. making available a greater quantity and quality of information for patients on the services provided by community organisations and others. 2. providing a visible interface for communication between the Council, the NHS and community organisations, particularly to encourage more detailed discussion between providers in the north and south of Central Bedfordshire.	Central Bedfordshire Council (CBC)	Due to the historical nature of this report it is felt that these recommendations should now be incorporated into the work and preparation of the Better Care Fund (BCF). The implementation of these recommendations need to take into account the BCF proposals and also be considered within the context of the Strategic Review and in relation to the re-commissioning of community health services.
14.	RECOMMENDED that more effective coordination be undertaken between the discharge planning team, rapid intervention team and the district nurses and that the roles of these teams be considered to provide greater clarity.	CBC	See comments above regarding Recommendation 13

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Meeting: **Social Care Health and Housing Overview and Scrutiny Committee**

Date: **07 April 2014**

Subject: Biggleswade Hospital Information Update

Report of: **Richard Winter, Executive Director of Integrated Services, SEPT**

Summary: The report provides Members with additional information on the utilisation of the commissioned beds at Biggleswade Hospital.

Advising Officer:	Richard Winter, Executive Director of Integrated Services, SEPT
Public/Exempt:	Public
Wards Affected:	All
Function of:	Council

CORPORATE IMPLICATIONS are as detailed in the attached report.

RECOMMENDATION(S):

The Committee is asked to:-

1. **Consider and comment on the actions being taken to support the ulitalisation of beds at Biggleswade Hospital (appendix A) and the admissions policy for in-patient units (appendix B)**

Appendices:
Appendix A – SEPT report on Biggleswade Hospital Information Update
Appendix B – NHS Admissions Policy for In-patient Units.

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Appendix 1

SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Biggleswade Hospital Information Update for Overview & Scrutiny Committee

1.0 BACKGROUND

In way of context: As part of the Governments 'The White Paper Our Health, Our Care, Our Say: A New Direction for Community Services (DH 2006)' sets out government policy for bringing care closer to home. One of the main strands involves delivering specialist care in local settings, particularly near to or in the patient's home, moving away from the traditional outpatient model and towards innovative community approaches that make use of multidisciplinary teams.

As part of regular service reviews, SEPT ensures that they are providing the right care, at the right time and in the right place for our patients. This means that for many of our patients, we are able to provide the best care for them within their own homes. This is also in line with the national agenda of providing 'Care Closer to Home' which is advocating this as the preferred option, where possible and appropriate.

Research demonstrates that individuals have better outcomes when there is a quicker response and rehabilitation and enablement care is provided in their homes where at all possible. We can already demonstrate that patients who require their confidence building after a fall respond better when receiving these services at home instead of spending 4-6 weeks in an inpatient unit only to then have to have separate kitchen and stair assessments in their own home. The Performance scorecard for Rehabilitation and Enablement services indicated that in 2013/14 79% of patients receiving intervention from Community Therapy services required no further support after 6 weeks. This reduces the need for on-going packages of care. The patient and carer feedback and experience has been extremely positive. This was demonstrated by the Net promoter score averaging 9.3 out of 10 in February 2014 and a 'Friends & Family' test of 100% in January 2014.

As a result of increased rehabilitation care packages at home, beds at Biggleswade Hospital have not been utilised as much.

There was some confusion around the increased provision care at home and the bed reduction at Biggleswade Hospital and SEPT was issued a contractual performance notice by the Bedfordshire Clinical Commissioning Group (CCG). This was thoroughly investigated and the outcome was, there was no case to answer for SEPT. However, there was recognition that communication could have been better. The 'performance notice' was removed and a joint action plan put in place.

2.0 ADMISSION CRITERIA

The admission criteria for Biggleswade Hospital were further reviewed in partnership with the CCG and local GPs. The CCG undertook a bed review which was to ascertain the inpatient bed requirements moving forward. This has now been superseded by the Healthcare Review currently taking place for Bedfordshire and Milton Keynes.

The admission criteria for the inpatient unit are attached in appendix 2.

The criteria was flexed over the winter period to include none weight bearing patients who require a longer rehabilitation period of rehabilitation from 4-6 weeks to 4-18 weeks. The flexed criteria also included patients waiting for continuing healthcare assessments, patients waiting for residential or nursing home placements and patients with a mild confusion.

The 2011 criteria are currently under review with commissioners to establish 2014 criteria to include patients who require lengthier periods of rehabilitation.

3.0 CURRENT POSITION

Irrespective of having reviewed and agreed the criteria and process for admission the use of the beds has remained low. SEPT and partners undertook an audit of patients who had a prolonged stay at Bedford Hospital to establish if the beds could be utilised better for a different cohort of patients based on need. At this point the criteria for admission were flexed further but the beds continue to be underutilised. The increased activity for caring for patients in their own homes is now stabilising at an increase of 38%.

A common theme in both local acute trusts is patients exercise choice and decline a bed at Biggleswade Hospital mainly due to its location and poor transport links.

Our view is the current bed capacity outstrips the current demand. It was hoped the commissioned bed review would establish requirements and changes moving forward.

	Nov 13	Dec 13	Jan 14	February 14	March 14
Patients admitted	9	8	11	19	12
Patients offered but refused bed at Biggleswade	5	1	2	7	6

As part of recent developments in relation to Winter Planning we have further reviewed admission criteria with all partners and flexed the criteria even further to include Local Authority patients however the bed utilisation still continues to be low.

4.0 CONCLUSION

As a provider SEPT are keen to provide services that are required and based on patient need.

Report prepared by: Richard Winter, Executive Director of Integrated Services, SEPT

March 2014

Appendix 2

Bedfordshire Community Health Services

ADMISSIONS POLICY FOR IN-PATIENT UNITS

January 2011

Lead Post: Head of Service
Policy approved by: Clinical Governance and Risk Committee
Date Approved:
Recommended By Integrated Governance Committee
Ratified by NHS Bedfordshire
Review Date: December 2011

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Introduction

This policy sets out the required processes and standards for admission to the Bedfordshire Community Health Services (BCHS) in-patient units:

- Biggleswade Hospital
- Archer Unit
- BCHS funded beds in Tamar and Knolls Nursing Homes

It sets out the criteria for admission and promotes safe and clinically appropriate placement of patients within the Units. The objective is to ensure admission which is appropriate to the case mix, within the capacity and capability of the nursing and support teams, and safe to the individual.

This policy should be read in conjunction with other policies (see section 0)

Scope of this Policy

The purpose of this policy is to ensure that the community hospitals/intermediate care beds are used appropriately within the health economy.
This policy sets out the criteria and processes for admission to ensure effective working with partner agencies and clinicians, particularly General Practitioner (GP) and local acute hospital referrers.

This policy supports the role of the Clinical Services Manager and Bed Manager in the safe and satisfactory placement of patients, and the management of Bedfordshire Community Health Services (BCHS) bed capacity.

Key Principles

The following principles underpin the implementation of this policy.

- The safety, comfort and quality of care for the patient is the primary concern.
- BCHS has a responsibility to ensure that clinical accommodation is appropriately staffed and equipped to support available beds.
- BCHS is committed to ensuring that service users have a timely, appropriate and service user focused entry to BCHS services. The admission process is fundamental to achieving this aim.
- BCHS are committed to eliminating racism, sexism and all forms of discrimination. We will not discriminate on grounds of age, colour, disability, sexuality, ethnic origin, gender, gender reassignment, culture, health status, marital status, social or economic status, nationality or national origins, race religious belief.

Responsibilities

- Bed Manager acts as a link for all acute trusts and rapid intervention services regarding bed availability. Admission to beds in relationship to the Pending List, and is responsible for managing any delayed discharges within bedded units.

- Unit team leader / matron acts as the communication lead contact for patient access to bedded units. Manages the risk assessment process and suitability of patients within the multi disciplinary team. Manages multi disciplinary team meetings and is responsible for the devolution of responsibilities to ward staff in his/her absence
- **Pharmacist** – There is no dedicated pharmaceutical support to any of the inpatient units however Biggleswade Hospital can obtain telephone support from Bedford General Hospital Pharmacy and 3/12 check of controlled drugs and safe disposal of these all ordering is completed through BGH The Archer Unit can obtain telephone support from Boots the Chemist in Bedford. With any major concerns NHS Bedfordshire Pharmacists can offer advice...
- **Taymar and Knolls prescriptions are written by GP and sent to local pharmacist , who provides support** .
- **Clinical Services Manager** - To be responsible for day-to-day operational management of the inpatient services for clinical and non clinical areas of work. To work with the Head of Service to monitor clinical governance, risk management and budgetary control within the bedded units
- **Head of Service**- To be responsible for Strategic and service development, to agree with Partners, targets and monitoring of key performance indicators. Establish appropriate systems for ensuring effective governance systems are in place. To agree and review annual budget and spend to ensure cost.
- **General Practitioner** Biggleswade Hospital provides medical overview / assessment of patients on daily ward round. Prescribing of any medicines
- Archer Unit Service User's GP to be contacted by unit as is deemed necessary out of area patients are medically managed within SLA with local GP practice as deemed necessary.
- **Named Nurse** To provide evidenced based nursing care to a designated group of patients in line with the wishes and intentions detailed in the individual care plan and to regularly take charge of a group of patients in the absence of the person with continuing responsibility where appropriate to be identified named nurse.

Criteria for Admission

The admission procedures specific to each service must include clear, written referral criteria and this information must be available to potential referring agencies and to service users. BCHS will ensure that the key referral agencies are informed of the referral criteria.

Eligibility Criteria

- The patient is over 18 years old.
- The patient is medically stable as defined by clinical assessment and not requiring acute admission.
- The patient is registered with a GP who is registered with NHS Bedfordshire.
- The patient has rehabilitation needs with identifiable rehabilitation goals and the potential to improve functions and/or independence.

- The patient's mix of rehabilitation, medical and nursing needs, cannot be met in the range of services available in the community.
- The patient and family/carers have agreed to admission.
- The patient has the mental capacity to participate in and/or is able to benefit from the rehabilitation programme.
- Patient must be motivated to participated to take part in a rehabilitation programme.
- Clear discharge arrangements must be identified for the patient prior to admission.

All patients referred will be assessed against criteria.

Referral Process

Referral to the inpatient unit is either through:

- An acute hospital via discharge planning team.
- A General Practitioner for step up care
- Through an emergency presentation eg Onecall
- The BCHS Rehabilitation & Enablement Team
- Via Accident and Emergency department to avoid acute admission
- Via Community Matron
- Via Rapid Intervention Team

Referrals can be made by telephone and email, followed by letter and single assessment process (SAP).

Referrals are made to the Bed Manager, who must check whether there are any special requirements needed for the patient's admission. All referrals must be logged, including the date, time, referrer and patient details including diagnosis.

The Bed Manager has the right to refuse admission where he/she has assessed the unit as full, or the patient does not meet the criteria set out in section 5.

Documentation required for admission

From community setting

- Single Assessment Process (SAP) and Contact Assessment Form.
- Referral letter outlining current episode giving rise to admission.
- Summary of medical history including current conditions.
- Full current medication list.

From acute setting

- Comprehensive reports from Occupational Therapist/Physiotherapist
- Discharge summary, including infection status[1]
- Summary of medical history including current conditions
- Full current medication list on appropriate documentation
- SAP and Contact Assessment Form

[1] In line with infection control reporting policy, all uninformed infections will be reported back into acute hospitals via incident reporting and the infection control lead

Unplanned Admissions
All unplanned admission must have been triaged through the Onecall process, and a bedded unit assessed as the appropriate place of care.

When an inpatient admission is unplanned and relevant information is not available, a member of staff must be nominated to gather this information (as above) at the first available opportunity to ensure patient safety.

Procedure prior to admission

Prior to admission, and except in an unplanned admission, a member of the clinical team will be responsible for the referred patient and an assessment will be completed and documented in the patient's notes by the responsible clinical team member. The pre-admission assessment will include the following which the referrer must provide:

- A full medical history.
- Details of medications.
- Nursing and therapeutic requirements.
- Full assessment provided by Occupational Therapy, Physiotherapy and any other clinicians involved in the assessment or care of the patient.
- MRSA/C.Difficile status (Where appropriate)

An admission date will be provided, and if no bed is immediately available, the likely waiting period will be explained to the referrer and the patient/carers.

Admitting decisions will remain with the units. This will ensure that dependency remains within safe parameters allowing the identified health needs of the new admission to be met without compromising both the existing patients and staff on the unit.

It is the referrer's responsibility to arrange transport to the unit.

It is the referrer's responsibility to ensure that the client has all relevant medications with them on admission.

Information for the patient

Patients must be given information about their planned assessment and treatment. It is responsibility of the admitting nurse to ensure this is done. This information will be given verbally and supported with written information. The information will include:

- The name of the named professional/key worker.
- Information about the specific condition/diagnosis.
- Information about the assessment process.
- Information regarding bringing own drugs to the Unit
- Information about treatment/management plans, including medication.
- The estimated date of discharge.

Written information may be in the form of leaflets prepared by the clinical team or be provided by an external organisation. In either case the clinical teams

within the service areas must ensure that the information is relevant and up to date.

Information for patients and carers/relatives

Services which operate on an inpatient basis must provide written/ verbal information for service users, their relatives and carers. This will include:

- Information on how to get to the unit by car or public transport.
- Information about visiting times and access to telephones.
- Advice about suitable clothing to bring.
- Advice about electrical equipment (to meet Health and Safety requirements).
- Information on what to do in an emergency e.g. a fire.
- What must not be brought into the unit (e.g. alcohol, illegal substances).
- Discharge process and estimated date of discharge

Process on admission

General procedure

The Ward Manager is responsible for ensuring that appropriate arrangements are made to admit the patient, including any arrangements for special needs, including language, dietary requirements, mobility, cultural or communication needs.

On admission the patient and their carers/relatives, if appropriate, must be greeted by a designated member of staff.

The patient should be orientated to the unit and the staff, including toilets, and the nurse call system. Information must be provided on accessing information, the advocacy service and the housekeeping arrangements.

The ward routine must be explained, including meal times and visiting times, and any arrangements for an emergency.

The policy for screening patients on admission to BCHS inpatient beds for Methicillian-resistant Staphylococcus Aureus (MRSA) must be followed.

Patients with Communicable Infections

Patients with a known or suspected infection, which poses a risk to other patients, must be cared for in a single room with full isolation precautions.

An incident form must be completed, in accordance to NHS Bedfordshire’s incident reporting procedure, for all uninformed infections; these will be reported back to acute hospitals via incident reporting and the Infection Control Lead.

Assessment processes, including risk assessment

The assessment of the patient must be conducted using Waterlow score and following local guidelines. to be found in the single assessment process.

The patient must wear a wristband throughout their admission detailing their full name, date of birth and NHS number.
Registered nurses are responsible for initial and continuing assessments of patients, and for recognising and acting upon changes in the patient's condition including:

- Moving and handling assessment .
- Malnutrition Universal screening tool (MUST).
- Morse Falls risk assessment tool.
- Waterlow score.
- Observations including Blood pressure, Pulse, respirations.
- Risk of falls assessment
- Top to Toe assessment.
- Slipper exchange.

Medicines management

General issues

It is the responsibility of the admitting nurse to ensure that the GP is aware of all admissions.

Medicines Reconciliation (ref. 1)
Comprehensive medicine reconciliation must be completed within 24hrs of admission by the admitting GP and any medicines prescribed written up on the patients Prescription & Administration Record chart. This will include a comprehensive comparison of the patients own medicines brought in, the information given by the referrer and by patients relatives or carers.

A pharmacist shall be involved in medicines reconciliation for each patient as soon as possible after admission for each patient.

Any discrepancies found, by the admitting nurse, GP or pharmacist will be confirmed and recorded. Any drug allergies and their effect shall be identified and recorded on prescribing documentation.

Patients will be assessed for their ability to manage their own medication safely where appropriate.

Patients are encouraged to bring their own medication, which must be checked by the GP and the pharmacist, for identity, quality and integrity.

Supply of medication

Further supplies of medication are obtained as follows:

Archer Unit
Prescription is faxed to Boots the Chemist in Bedford and delivered with in 24 hours to the unit. No stock is held on the unit.

Biggleswade Hospital
Stock is ordered weekly from Bedford Hospital Pharmacy and a limited stock is held on the ward including controlled drugs.

Tamar Nursing Home (BCHS funded beds)
Prescriptions are written by GP and sent to local pharmacist

- Prescriptions are copied prior to sending medicines checked by two nurses on return.

Knolls Nursing Home (BCHS funded beds) **prescriptions are written by GP and sent to local pharmacist to supply**

In all cases items received must be checked against the prescription by the named nurse, who must also contact the dispensing pharmacist if any discrepancies are noted.

Storage of medicines

All medicines must be stored in their original packaging, and must never be decanted to another container

All controlled drugs must be entered into the Controlled Drugs Record Book and kept locked in the designated cupboard.

Medicines storage varies at each of the units, and will include bedside cabinets, medicines trolleys/cupboards and medicines fridges. In all cases the storage must be lockable, and kept locked when not in use. Local procedure must be followed within each unit. A registered nurse ensures safe administration of medication to patients and records this, or the reasons for non-administration, on medicines administration chart.

Clinical records

General standards

- Registered nurses must adhere to their professional standards of record keeping.
- Documentation specific to individual in patient units must be completed as required following local policy regarding record keeping.

Procedures in event of local health community bed pressures

Emergency Team Meeting

The Head of Service or Clinical Services Manager may, at any time, convene a meeting of a Bed Emergency Team in order to agree action to be taken to place patients safely and appropriately.

The Bed Emergency Team consists of:-

- Bed Manager
- Clinical Support Managers
- Unit Team Leader
- Head of service
- Discharge Co-ordinator

- Rapid Intervention Team

The role of the team is to agree actions to be taken over the prospective 24 hours period, and beyond, in order to accommodate admissions and to support acute hospital escalation policy. The team will rely extensively on the guidance of the Bed Management Team and their awareness of the overall capacity situation.

The Bed Emergency Team will attempt to balance clinical risks for all patients and across all services, giving particular consideration to prioritising the appropriate care of patients in the A&E Department, AAU and appropriate safe discharge.

Where there is a possibility of avoiding admission from A and E to the acute trust. The community beds will endeavour to offer a bed ASAP. In hours the bed manager will liaise with the units . Out of Hours, A and E should ring the units directly to secure the bed.

Bed Capacity and Bed Closure

It is essential that BCHS keep as many of its inpatient beds open as possible. From time to time it may be necessary to close beds because of such things as infection outbreaks estates issues and staffing shortages below safe levels.

If closure of beds is being considered the BCHS Bed Closure Guidelines must be followed. The policy requires that any closure must be authorised/ratified by the relevant Head of Service or their deputy, and must notify the Chief Operating Officer and Commissioning Lead. The Bed Management Team must be advised of any bed closures immediately.

Before any bed closure all possible solution would have been explored including redeployment of community nursing/rehabilitation staff to the bedded units.

Additional Beds

Where safe to do so, BCHS will support, within a county-wide escalation policy, the opening of additional beds when:

- Delayed discharges are highlighted.
- Staffing levels with the unit are at an optimum level to support safe discharge/care of patients.
- The whole systems escalation policy identifies amber/red status and these beds can safely support discharge of medically fit patients.
- The Chief Operating Officer (or his/her deputy) must authorise the opening of additional beds which are funded above the core contract per open bed day.

Related documents

This policy should be read in conjunction with other BCHS policies and legislations, including:

- Consent Policy

- Data Protection Policy
- IT Security Policy
- Infection Control Policy
- Incident Reporting and Management Policy
- Records Management Policy
- Medicines Management Policy
- Risk assessment Policy
- Service Continuity Plan
- Health and Safety Policy
- Moving and Handling Policy
- Discharge Policy

Document Replaces

Admission Policy for in-patient units 2009-2010

Review of this policy

The range of inpatient beds within BCHS and the way they are used is always changing. Any changes will require that the Admissions Policy is reviewed and updated accordingly. This version of the Admissions Policy (January 2011) should be reviewed no later than December 2011.

Reference

1. NICE & NPSA Guidance NICE/NPSA/2007/PSG001: Technical patient safety solutions for medicines reconciliation on admission of adults to hospital. December 2007

Meeting: **Social Care Health and Housing Overview & Scrutiny Committee**

Date: **7 April 2014**

Subject: **Planned Changes to the Provision of Mental Health and Community Services**

Report of: **Richard Winter, Executive Director for Integrated Services, SEPT**

Summary:
This report provides information on a change SEPT wishes to implement to meet cost improvement targets arising from financial and inflationary pressures facing the local health and social care economies. SEPT's Trust Board has agreed a number of guiding principles to ensure that frontline services are protected where possible and the quality and safety of our services is not compromised. In preparing plans SEPT has also consulted with partner organisations and stakeholders on all savings options. SEPT has met over half of the health cost savings through reorganising support functions, improving procurement and contract management, income generation and estate and management changes. The Trust is continuing to work with health Commissioners over the future changes required over the life of the current SEPT health contracts and will be seeking to secure financial balance in relation to these contracts over the coming months.

The Social Care Health and Housing Overview and Scrutiny Committee (SCHH OSC) will be aware that South Essex Partnership University NHS Foundation NHS Trust (SEPT) provides an integrated mental health service across Bedfordshire and Luton and community services across Bedfordshire. In addition, the Trust has a Section 75 agreement in place for adult social care services with Central Bedfordshire Council.

Advising Officer: Richard Winter, Executive Director Integrated Services, SEPT

Public/Exempt: Public

Wards Affected: All

Function of: Council

CORPORATE IMPLICATIONS

Council Priorities:

The resources available in the form of government funding to both the Health and Social Care sector are decreasing and there is an expectation that services will be provided in the most cost-effective and efficient manner. Through these proposals SEPT is seeking to minimise the impact on local services through integration and avoiding duplication in delivery or financial payments. It is intended that the proposals in this document will provide a balanced plan for existing health contracts.

Financial:

The proposals align with the current health strategies and direction for the CCGs. SEPT must also demonstrate to the independent regulator, Monitor that the Trust is sustainable in the short, medium and long term as part of the Annual Planning process within the NHS and achieving cost improvement targets are a key part of this process. The Trust's Annual plan for 2013/14 included these schemes for Bedfordshire. The plan is available on the Trust's website.

Legal:

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies to consult with the relevant Local Authorities where there is a variation or development in health services in the area.

Risk Management:

SEPT and partner agencies have carefully considered the risks relating to the service-changes proposed in this paper and evaluated these to be low. The Trust is continuing discussions with the Clinical Commissioning Group in relation to cost improvement plans and balancing the recurrent financial position for the contract.

Staffing (including Trade Unions):

Not Applicable.

Equalities/Human Rights:

The Trust has also completed Equality Impact Assessment in line with Trust policies and the Equality Delivery System for the NHS. The Trust also undertakes a Quality Impact assessment on all potential savings schemes. These assessments have concluded that the proposal is robust.

All areas will be quality assured whilst any changes are implemented and measured through patient and carer experience feedback, complaints and compliments and audits where appropriate. SEPT is performance managed by commissioners through their contract and via the quality schedule monthly meetings (Equality & Diversity), prior to the publication of the report.

Public Health:

No implications have been identified by the authors of this report.

Community Safety:

Not Applicable.

Sustainability:

Not Applicable.

Procurement:

Not applicable.

RECOMMENDATION(S):

The Committee is asked to:

Note the proposal to adjust the current provision of Continence Services and assure the committee that delivering these services differently will not incur further costs to commissioners or providers.

Proposal

11. To adjust the current provision of Continence Services by changing the supply of products to new patients and removing the provision of pads to Nursing homes (Health funded –value of saving £150k on a current spend of circa £1m).

Reasons for Proposal

12. The community continence service provides specialist assessment, treatment and provision of products for patients with incontinence. The continence service has a significant recurrent cost pressure as a result of increased demand in their services resulting in a cost that is no longer sustainable. SEPT has introduced a number of controls and is re-tendering the supply of continence products, including pull up's, continence pads with fixation pants and 'all in one' continence pads. However, these steps are insufficient to meet substantial demand and the Trust wishes to adjust the formulary of products for new patients coming into the service and extend the current delivery cycle for direct supplies to patients from 8 to 12 week delivery cycles. In addition SEPT has agreed with commissioners to bring the service into line with other local health providers by ceasing provision to nursing homes as the funding for continence supplies is included within the Nursing Homes contracts. A contract variation has been approved by the Bedfordshire Clinical Commissioning Group. It is worth noting that no other community service provides products to nursing homes this has been benchmarked and can be fully evidenced. (See table in appendix A).

13. The provision to nursing homes will affect 6 nursing homes in Luton (262 patients) and 21 in Bedfordshire (505 patients). There are 11 nursing homes in Central Bedfordshire. This means that nursing homes will no longer receive their products from SEPT but they will purchase their continence products directly from either the current continence products supplier or from another supplier of their choice, purchased directly by the nursing home. The provision of continence products can continue directly from the current continence product supplier (Attends) as SEPT will arrange an opportunity for each home to meet with Attends prior to the cease of the service from SEPT to ensure continuity of product supply for patients, this will also be an opportunity

for staff and public engagement. Both Local Authorities have been informed and there will be a meeting with nursing home managers to discuss the intentions and then a three month notice period will be served. This is not a service stoppage but a change in continence products supplier.

14. There will be no reduction in services for patients; SEPT continence service will continue to provide specialist advice and training for Nursing home staff and patients. Therefore the patients clinical status will not be compromised in fact nursing homes and therefore, patients, will have an increased choice of continence product and supplier. This will allow local continence service costs to come back in line nationally with an efficiency of approximately £150k per annum which can be utilised in another healthcare area. SEPT has undertaken a quality impact assessment for this intention as part of the agreed Cost Improvement Programme required process. Alongside the required process SEPT have also considered the Department of Health's four tests. - "First, there must be clarity about the clinical evidence base underpinning the proposals. Second, they must have the support of the GP commissioners involved. Third, they must genuinely promote choice for their patients. Fourth, the process must have genuinely engaged the public, patients and local authorities if there is significant change".,
which are covered above.

15. **Conclusion & Next Steps**

The following have been consulted in preparing this report:

Management Group
Joint Management Group, Bedford Borough, Central Bedfordshire and Luton Borough Councils.

Relevant Managers
Executive Director for Adult and Community Services , Bedford Borough Council
Executive Director of Adult and Community Services, Central Bedfordshire Council
Chief Operating Officer Bedfordshire Clinical Commissioning Group

Organisation(s)
Bedford Clinical Commissioning Group
Luton Clinical Commissioning Group
Central Bedfordshire Borough Council

No adverse comments were received in relation to the proposals in this paper.

Appendix A

Continence Pad Provision in other areas, October 2013

Area	**Supply pads to Nursing Homes**	**Comment**
Hertfordshire	No	
Oxfordshire	No	
Hampshire	No	
Berkshire	No	
Essex	No	Separate budget and nursing homes manage their own supply/costs
Surrey	Yes but restricted	Only started in 2011 and the money that the then PCT spent on pads (only to funded nursing care patients), was given to the CHS to manage. Nursing homes are expected to follow stringent process (including regular staff training) to assess for pads, and pad provision is dependent on homes compliance. Very limited formulary, and only for funded nursing home patients.
Enfield	No	
Cambridgeshire	Very limited	Restricted number of homes are provided to but mostly homes do their own assessments and claim directly from CCG Very restricted formulary and provide no pull up pads

Funding for continence products for CHC funded patients is included as part of the funded nursing care payments. The local health service is effectively paying twice for the provision of continence products to patients in nursing homes. Patients, carers and nursing home staff will continue to access the Continence Service for specialist advice, training and support.

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Meeting: **Social Care, Health and Housing Overview and Scrutiny Committee**

Date: **07 April 2014**

Subject: Mental Health Procurement

Report of: **Dr Diane Bell, Director of Strategy and Redesign, Bedfordshire Clinical Commissioning Group**

Summary: The report provides the Committee with the opportunity to comment on proposed models of care and plans for consultation.

Advising Officer: Dr Diane Bell (Director of Strategy & Redesign)

Public/Exempt: Public

Wards Affected: All

Function of: Council

CORPORATE IMPLICATIONS

Council Priorities:

1. This report supports the promotion of health and wellbeing and protecting the vulnerable as it relates to the future of mental health services for the population of Central Bedfordshire.

Financial:

2. The procurement of Mental Health, Learning Disability and Child and Adolescent Mental Health Services is within four identified lots.

- Lot 1 (Steps 1-3; primary care MH services) = £**2,336,347,**
- Lot 2 (Steps 4-5; secondary care services= £**29,266,031** BCCG and £**1,894,578** Section 75 CBC , ,
- Lot 3 (Rehabilitation and Recovery) = £**1,178,917** BCCG, £**255,131** Section 75 for CBC
- Lot 4 (CAMHS) =£**4,442,600** BCCG, £**220,000** CBC

Legal:

3. The procurement process that is being completed is as advised by Attain, who provide procurement advice to Bedfordshire CCG, their processes and the documents to be completed during the procurement have all been assured by their legal advisors

Risk Management:

4. There is a Procurement Steering Group which is overseeing the process, with representation from all relevant parties, this group meets fortnightly. There is a risk register that is reviewed at each meeting; high risks are escalated to the Bedfordshire CCG's Delivering for Patients Board.

Staffing (including Trades Unions):

5. As part of the quality monitoring of all existing contracts, assurance on the communication of the process and the support for staff within organisations affected by this process has been requested and will be monitored through the contract monitoring meetings.

Equalities/Human Rights:

6. An Equality Impact Assessment has been completed for each of the projects identified in this paper. Due to the nature of these services, pathways to ensure the most vulnerable people are able to access support are key factors in the assurances requested from potential bidders. There is also a requirement to ensure that people with disabilities are not excluded from Mental Health services and reporting against the protected characteristics will be matched against demographic information through the contract monitoring.

Public Health

7. The procurement of mental health and learning disability services will support public health priorities in relation to mental health and improve the health outcomes of hard to reach communities. The outcome based specifications being developed will include public health outcomes and services will be monitored against these contractually.

Community Safety:

8. The procurement seeks to address current concerns for police and probation, working together with Mental Health services. These partnerships have been identified as a key outcome for the new service.

Sustainability:

9. Providing services that are more locality focussed should improve accessibility for people, no concerns regarding sustainability have been identified through the individual projects.

Procurement:

10. This paper is regarding the procurement process for Mental Health and Learning Disability Services and the details are included in the body of the report.

RECOMMENDATION(S):

The Committee is asked to provide feedback in relation to the level of engagement that has taken place and support the procurement as detailed in the report.

Current situation

1. In 2009, the decision was made to transfer the Mental Health and Learning Disability Services run by Beds and Luton Partnership Trust to an existing Foundation Trust in order to secure a sustainable future for the Trust and to ensure the provision of high quality mental health and learning disability services.

2. NHS England, in conjunction with NHS Bedfordshire and NHS Luton commissioners and Local Authority leads undertook an open procurement process to identify the most capable Foundation Trust to acquire the business and assets of BLPT and to provide the future services. South Essex Partnership Trust (SEPT) were awarded this contract in 2010. The contract has run for three years and is now in its fourth.

3. The contract with SEPT for the delivery of Mental Health and Learning Disability Services in Bedfordshire and Luton ends in March 2014.

4. Luton CCG has expressed a wish to have a sole contract going forward and have commenced their procurement process for Mental Health services with the aim of having their new providers delivering services in Luton by the end of October 2014.

5. The decision for procurement of Bedfordshire's Mental Health and Learning Disability Service was taken to the BCCG Governing Body on 4th February 2014 and an agreement to proceed was made. The procurement is being undertaken through four individual lots;

   - Steps 1-3 (Mental Health services in primary care, including counselling and Improved Access to Psychological Therapies)
   - Steps 4-5 (Mental Health services in secondary care)
   - Rehabilitation and Recovery
   - CAMHS

   Central Bedfordshire Council agreed for their Section 75 for Mental Health services to be included in the procurement process.

6. SEPT have agreed to continue to deliver Mental Health and Learning Disability services from April 2014 for a further year, to enable the procurement process to be completed.

Development of a new model for Adult Mental Health Services

7. Over the last eighteen months, BCCG's Mental Health and Learning Disability Change Board has been managing a number of projects that will meet BCCG's strategic objectives, support the priorities within the Mental Health Strategy for Central Bedfordshire and develop new models for mental health and learning disability services for the people of Central Bedfordshire.

8. These projects have been managed in accordance with the Programme Board processes for BCCG. The projects are;

   - **Steps 1 – 3** Increased mental health support in primary care services, in order to provide appropriate treatment at the earliest point in a persons' mental illness and to increase the number of people accessing psychological therapies
   - **Steps 4 – 5** Five locality specialist integrated mental health teams that meet the needs of all adults with mental health needs in their area.
   - **Dementia** Specialist post diagnosis support for people with dementia and their carers
   - **Specialist Learning Disability Services** Increased access to mainstream services, focused specialist support integrated with Adult Learning Disability Teams and Crisis and in-patient care.

- **Autism** Provision of a local assessment, diagnosis and longer term support service for people with autism
- **Rehabilitation and Recovery Services** A community team that works in a person centred way in supporting people to recovery through specialist interventions and additional support to access general services

9. BCCG has developed its Mental Health Strategic Objectives for 2013 -2016, which provide information on the proposed models for these services and these have now been published.

Stakeholder Engagement

10. Over the past two years, there has been a significant level of stakeholder engagement with patients, carers and other stakeholders regarding mental health services in Bedfordshire. During this engagement , key priorities were identified to improve mental health services;

- To commission services that help people to recover
- To have a greater focus on prevention
- To provide more employment support for people with mental health and psychological disorders
- To simplify the structure of mental health services and the referrals process to make it easier to access support and treatment earlier
- To increase the provision of talking therapies, including for children and young people, and reduce waiting times
- To improve the physical health of people with mental health problems, and provide better mental health support for people with physical conditions
- To ensure that everyone with a mental health problem has access to assessment, treatment and support from primary care mental health link worker with earlier access to help and intervention and improved communication with GP's.
- To improve the transition from children's services.

11. In partnership with Central Bedfordshire, we have used the engagement forums to develop models for local services and these can be found as appendices (a) – (f). A full report on the engagement events and a summary of the information obtained from them is available at Appendix (f).

12. Specialist Learning Disability Services

The first stakeholder events started in June 2012, this was followed by patient, carer and professionals questionnaires and further additional engagement with wider stakeholders. This included information provided to the Learning Disability Delivery Partnership and meetings with the provider. A further stakeholder event was held in December 2013, outlining the proposed model and this was also sent out to all stakeholders.

The key things that people identified that they would like to change, included;

- Hours of work for services (increasing availability outside of 9-5pm)
- Location of the service (currently based in North Bedfordshire and difficult to access)

- Length of time people stay in the service (some people staying for many years)
- Waiting times (reducing the wait for some key services)
- Difficulty in getting an appointment

Some of the things that people identified as working well and that they would like to keep included in the services were;

- Nurses at the hospital
- Health Facilitation Team
- Providing training and on-going support to staff
- Sensory services

The feedback we received has influenced the model in many ways. Examples of this include that The Health Facilitation Service and the Acute Liaison Nurses will remain in place within the new model, the accessibility of services has been considered and will be addressed by having a Central Bedfordshire Specialist Learning Disability Team and we will be working with the new provider to look at opportunities for locating this more centrally.

Rehabilitation and Recovery

13. In May 2013, a stakeholder event was held where there was representation for a wide audience again, including people who access the service, carers, the voluntary sector and providers. A further full stakeholder engagement was arranged for December 2013, but due to poor planned attendance this was moved to March 2014. In addition, through the Stepped Care Model Workshops (covering Steps 1-5), feedback has been sought in relation to this service.

The workshops were used to engage with stakeholders about the model and feedback on what made a good service included;

- A step up or step down care pathway
- Intensive package of support that reduces over time
- On-going pathway of recovery which doesn’t stop once a service user is in the community
- Extra care housing
- Access to employment support
- Access to peer support
- Wellbeing centres
- Short term and medium term rehab beds.

The model that has been developed has been influenced by our engagement work and will be delivered through a three tiered approach, providing high support, medium support or standard support.

The proposed service will be delivered in partnership with other agencies, including supported housing schemes, employment, providers, and deliver a range of therapeutic interventions as well as providing peer support and work in a more person-centred way to support people to achieve their goals and to minimise the risk of relapse , as referral back to services will be possible.

Steps 1-3

14. There have been several workshops to review the proposed stepped care model and in addition, a couple of very focussed workshops to consider Steps 1-3. On 25/10/13 stakeholders were engaged in a number of key questions, including considering a Single Point of Access, referrals and triage;

    - Stakeholders supported a single point of access, but wanted to understand how many calls that would mean and could it crash as a result. It was agreed that the single point of access for Steps 1-3 would not be the same as Step 4-5, so that the demand could be sustained.
    - People felt that being signposted to the right treatment was really helpful so fully supported the need for triage in the pathway. People also said that they wanted to be able to self-refer and this will be possible.

Steps 4-5

15. There have been several workshops to consider the proposed stepped care model and during a number of these, there has been discussion around key areas to help develop the proposed model. Some of the feedback and the actions taken as a result of these are as follows;

    - People said that they felt safe when they were admitted to hospital but wanted more support when they were discharged. This will be achieved through the rehabilitation and recovery model of care being developed. Stakeholders questioned if detox beds should be in the mental health units and said that it could be quite disruptive for the other people on the ward.
    - Stakeholders wanted to have a crisis service for adults of all ages and this has been included in the model. People generally felt that there shouldn't be an adult and an older persons team as mental health wasn't about age, however the importance of expertise in Consultants for older people was recognised.
    - There was a mixed opinion about whether the functions of the Crisis Resolution and Home Treatment Team should be split or stayed together and so this will be explored further through the procurement dialogue.
    - There were a lot of views about people going to Accident and Emergency when they are in crisis, people understood why it was necessary, but felt that that they would like a quiet place to wait away from the waiting room. This will be fed into the strategic review that is taking place.
    - People raised concerns about the impact that Department of Work and Pension has on their mental health and this has been fed back into work streams within the local authority.
    - Stakeholders supported the role of Mental Health Link Workers in primary care but people felt that there should be more of them. This is being addressed within the model.
    - One stakeholder was concerned about splitting Children and adolescent Mental health Services from Adults. To ensure this doesn't fragment an individual's care pathway, the need for these services to work together has been included in the procurement process.

Dementia

16. The current dementia support, including Memory Assessment Services, are not affected by this proposal. There have been a number of workshops to consider how best to provide additional support people to live well with dementia. This has resulted in the proposal of a post diagnostic support service that supports people with dementia and their carers throughout the journey of dementia. The engagement has resulted in various changes to the initial project, including;

- Improving communication prior to appointments at the Memory Assessment Service
- Patients choosing which clinic they would like to be seen in and where they would like to receive their post diagnostic support
- Provision of emotional support as well as practical assistance

People who use the service also identified the following key areas as important to them:-

- Single point of contact
- Dementia nurses who offer proactive and on-going support throughout the journey of dementia
- Two way communication channels
- Timely information and support
- Moving Memory Assessment Services away from hospital setting

Development of a new model for Children's Mental Health Services

17. In addition, the Children's and Young Peoples' Change Board has been leading on the development of a model for Tier 3 Child and Adolescent Mental Health Services

In order to inform the development of a revised service specification and model of services delivery for tier 3 CAMHS, Bedfordshire Clinical Commissioning Group (BCCG) has undertaken a review of tier 3 CAMHS as currently provided and Public Health colleagues undertook simultaneous reviews of Tier 1 and 2 services

A significant level of engagement has already been carried out with service providers and other key stakeholder recently. This included questionnaires from GPs and Social Workers, individual interviews, focus groups.

Findings have been shared with The Acting Early, Reducing Poverty and Improving Health group (Central Bedfordshire) The Child Health and Wellbeing Group (Bedford Borough) the Children's Overview and Scrutiny Committee (Bedford Borough) and the Child and Maternity Programme Board (Bedfordshire Clinical Commissioning Group)

This review benchmarked current service provision against best practice models of service provision and national guidance. The review report has been completed and submitted to BCCG Executive Management Team and both OSC Committees it made a number of recommendations which include:-

- Develop a pathway of care across all tiers to ensure coherent patient journey across providers and tiers. This should include Tier 4 specialist commissioning.

- Develop a Single Point of Access and communicate to users and professionals how it works. Ensure that they can refer in an appropriate manner. It was reported that for a Single Point of Access to operate effectively, the professional would have to be appropriately trained, skilled and knowledgeable.
- Explore reducing waiting times from referral to assessment and assessment
- The length of treatment should be reduced thus allowing new referrals to be assessed, treated and discharged quickly
- More outreach work is required based on consultation with children and their families/carers, as well as asking questions at the beginning of their initial assessment about what their needs are in terms of location and timings. This should include exploring options of using alternative venues e.g. GPs surgeries/Health Centre, School, home and community venue (e.g. local Children's Centre) etc.
- Having agreed our vision and strategic priorities and undertaken a comprehensive review of current services the scope of this project is to design and procure a service that meets the needs of children and delivers the interventions required.

The project will have the following objectives :-

To reduce inequalities. By having one contract with one lead and one service specification across tiers 2 and 3, the aim will be to reduce current inequalities.

To improve Access. Waiting times are currently different for each provider and up to 16 weeks for specialist CAMHS and 12 weeks for CHUMS. The new service will have waiting times targets of 6 weeks for non-urgent cases. Access thresholds and referral information are also different or differently interpreted. There are gaps in some aspects of provision. The revised model will offer a single point of access for all CAMHS (tiers 2 and 3)

To improve outcomes.

18. Current outcome measures and reporting is not consistent across providers and is poor for specialist providers. This means that it is difficult to measure outcomes in all services and to compare effectiveness. A single outcome measure will be consistently used across all levels of service as part of an outcome measure framework. However BCCG are interested in obtaining the views and feedback from children and young people to ensure our future procurement of mental health services for children and young people are appropriate and responsive to their needs.

A formal consultation will run for one month between 10th March and 11th April 2014. Questionnaires for Children and young people and for parents/carers will be distributed, in hard copy and available online. A number of focus groups will also take place with service users and with specific target groups such as Looked After Children In March/April 2014.

Background papers and their location: (open to public inspection)

BCCG Mental Health Strategic Objectives
https://www.bedfordshireccg.nhs.uk/page/?id=3713

Central Bedfordshire Mental Health Strategy DRAFT Central Bedfordshire Council Joint Commissioning Strategy for Mental Health Services

Appendices

Appendix A – Stepped Care Framework

Appendix B – Proposed Stepped Care Model for Mental Health Services

Appendix C – Proposed Model for Specialist Learning Disability Services

Appendix D – Proposed Model for Rehabilitation and Recovery Services

Appendix E – Autism Pathway

Appendix F – Stakeholder Engagement Report

Appendix G – CAMHS Tier 1 & 2 review

Appendix H – CAMHS Tier 3 review

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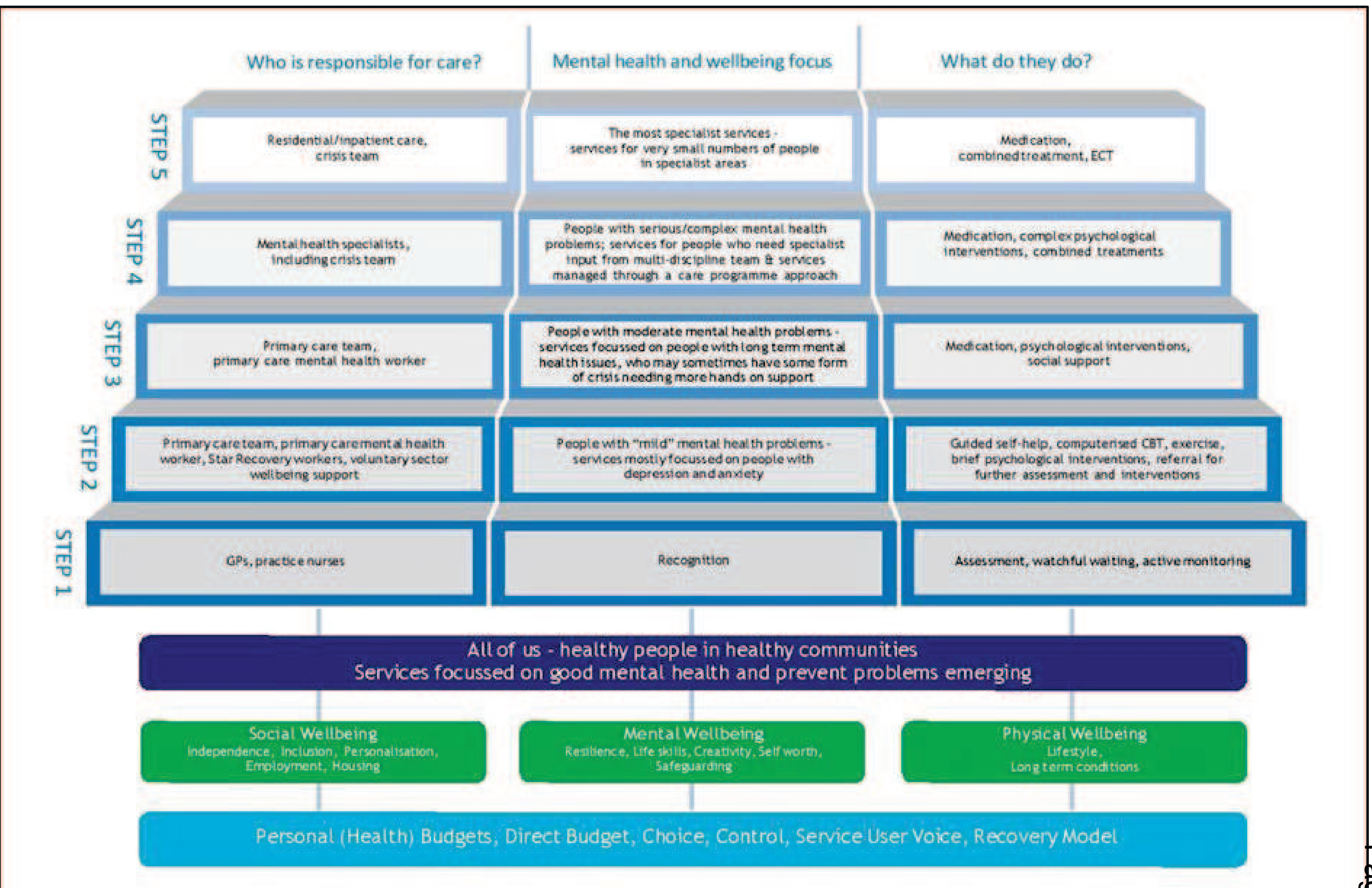
Appendix(a)



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Appendix (b)

Bedfordshire Mental Health and Wellbeing Model

Locality Integrated Mental wellBeing Service (LIMBS)

Mental Health
Self Referral
& Professional Referrals
(Primary/Secondary Care)

Single Point of Access

Rehabilitation Service Provision

In-Patients Service Provision

Crisis Service Provision

LIMBS

Step 4-5
(PbR Cluster 4 -17)
(Functional)
Clinical Team
CMHTs - Adult Team
(x1) Consultant Psychiat

MAS

Step 4-5
(PbR Cluster 18 -21)
(Organic)
Clinical Team
CMHTs - Old Age Team
Nurse Specialist
Consultant Psychiatrist
(Rota)

CORE

Step 1-3
(PbR Clusters 1-4)
Clinical
Primary Care Counsellor/
IAPT Service

Complex Treatment within Specialist Services

Chiltern Vale Locality
(10 GP Practices/ Popu 79k)

Leighton Buzzard Locality
(4 GP Practices/ Popu 44k)

Step 3

Leighton Buzzard Locality
(4 GP Practices/ Popu 44k)

Bedford Locality
(26 GP Practices/ Popu 176k)

Wellbeing Control Hub

Administration
Single Point of Access

Administrative Staff
Admin (Volunteers)

Triage and Assessment

Mental Health
Multi Disciplinary Team(MDT)
(Collaborative Assessments)

MDT Team

MH Wellbeing Workers
Psychological Wellbeing Practitioner
Cognitive Behavioural Therapy
Counsellors
Link Workers

Primary Care Services

Voluntary Sector Services

Specialist Psychological Services

West Mid Bedfordshire Locality
(6 GP Practices)

Ivel Valley Locality
(9 GP Practices/ 87k)

Step 1
Initial Assessment and Watchful Waiting

Mental Health Core Service Provision

Specialist Psychological Services

Secondary Care Services

Secondary Care Services

Eating Disorder Service

Complex Needs Services

Community Services

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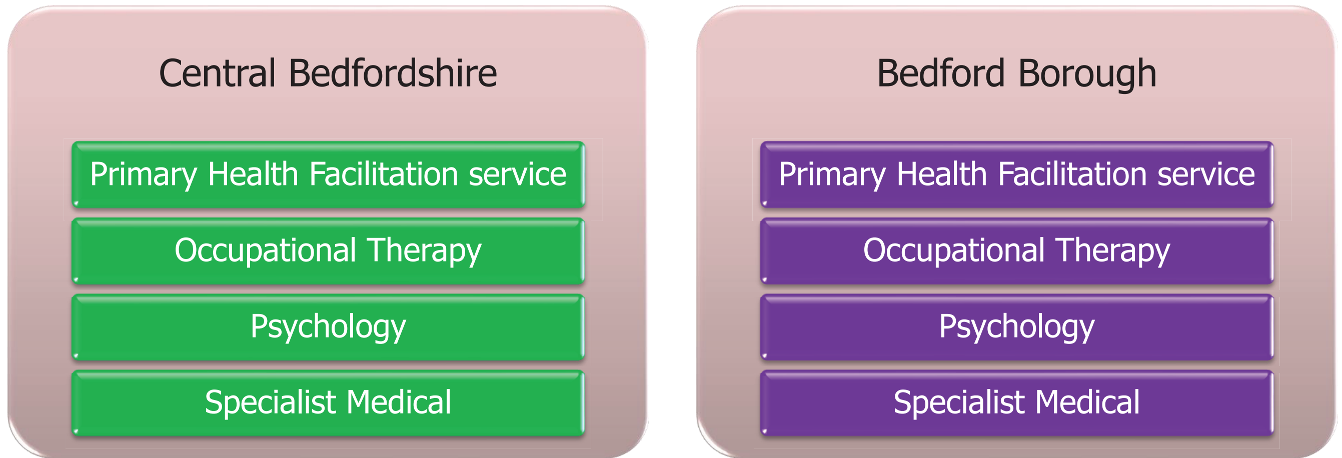
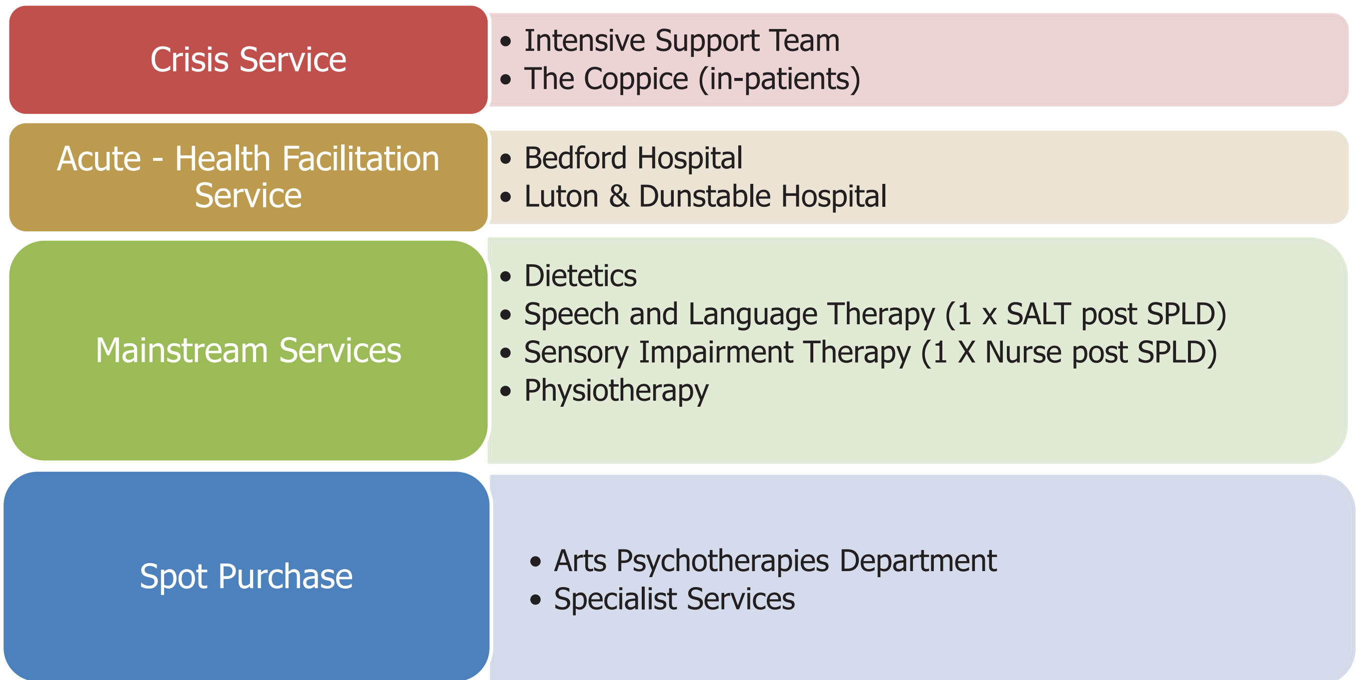
Specialist Learning Disability Proposed Model

December 2, 2013





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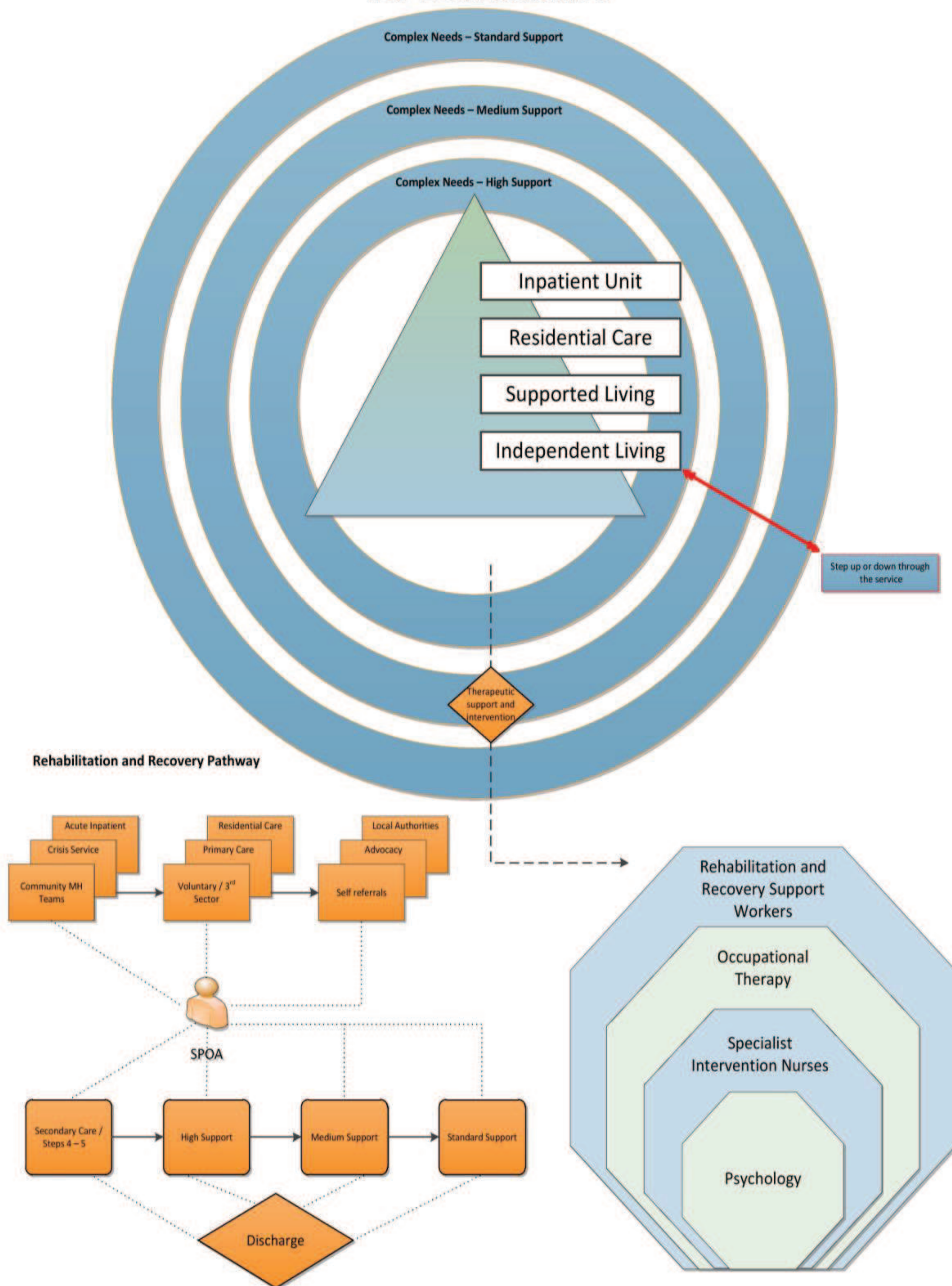
Appendix (d)

Mental Health Rehabilitation and Recovery Model & Pathway for Bedfordshire



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Appendix (e)

Autism Spectrum Condition Pathway

Person of family/carer

General Practitioner
Secondary/tertiary healthcare. Prison mental healthcare
A&E and liaison, NHS Direct, Social services
Access determinant on local areas

Person with diagnosis (including young person in transition from children's services)

Community Care Needs Assessment (FACS) Carers Assessment

Meet FACS?

Yes

No

Allocation of Care Manager

- Care package
- Direct payment/individualised budget

Personal support etc

Multi-disciplinary diagnostic assessment
ASC diagnosis given care plan agreed

No

Yes

- Signpost
- Refer elsewhere if needed

- Post diagnostic support
- Carer support
- Liaison/sign posting
- Preventative intervention
- Needs assessment

ADW on going support

Is person eligible for Mental Health or Learning Disability Services?

MH/LD team undertake
- Diagnostic assessment
- MDT assessment of need
- Community care needs assessment

Presence of non-severe enduring MH problems?

No

Yes

Treatment by IAPT

Need for specialist tertiary services?

No

Yes

Treatment by secondary services

Treatment by tertiary services

Financial Management

Housing support

Education and training

Employment

Autism Bedfordshire

Support networks

Primary Care

Social networks

Advocacy

ASC Team Scope

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Appendix F

NHS
Bedfordshire
Clinical Commissioning Group

Mental Health, Learning Disability and CAMHS Procurement Review

ENGAGEMENT REPORT

A summary of stakeholder engagement activities with service users, providers and other key stakeholder groups

27th January 2014

better care, better value, better health

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Contents

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2.0	Specialist Learning Disability Review	Page 5
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4.0	Additional engagement meetings	Page 7
5.0	Plans for forthcoming meetings and events	Page 7
6.0	Rehabilitation Service Review	Page 8
7.0	How this has influenced the development of the Community Mental Health Rehabilitation and Recovery Service	Page 9
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9.0	Plans for forth coming meetings and events	Page 10
10.	Dementia	Page 12
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1.0 Background

On 1st April 2013, as part of the national NHS reforms, the responsibility for commissioning a range of health services transferred from NHS Bedfordshire (also previously known as Bedfordshire PCT) to NHS Bedfordshire Clinical Commissioning Group (BCCG). Responsibility for commissioning certain other local health services was transferred either to Bedford Borough Council, Central Bedfordshire Council or NHS England (Hertfordshire and South Midlands Area Team).

'The Bedfordshire Plan for Patients' is BCCG's operational plan for the delivery of health services, and has been developed by local clinicians, working with its partners, to deliver improvements in the quality (experience, safety and outcomes) of care and life for the residents of Bedford Borough and Central Bedfordshire.

BCCG acknowledges the need to take a longer term view of the planning of services to reflect the significant changes required to tackle the unprecedented Challenges facing the public sector. The operational plan details the local ambitions for improving outcomes within the funding available to BCCG.

In February 2014, BCCG published its Mental Health Strategic Objectives which describes its commitment to the improvement of Mental Health services within Bedfordshire. These can be found at:
https**://www.bedfordshireccg.nhs.uk/page/?id=3713**

Within the Mental Health Strategic Objectives, BCCG have committed to a programme of transformation which has already started; to redesign and integrate mental health services, to improve quality, improve health outcomes, increase Capacity and reduce gaps in provision. BCCG is keen to increase the volume and range of services for people with mild to moderate mental health issues, which are provided within primary care, enabling people to receive help earlier, improve their recovery and should reduce the number of people developing more severe problems.

Changes also need to be made to secondary care services. This will ensure that Services for people with more serious or complex needs, and for people with Dementia, are more accessible and responsive. Generally, there is a need for greater access to psychological therapies across the whole mental health pathway.

The Commissioning Organisations (including BCCG, Bedford Borough Council and Central Bedfordshire Council) are committed to the development of Mental Health services and have developed the model for delivery of care across both the health and social care systems that will be high quality, safe, fit for purpose and sustainable.

In order to achieve the necessary transformation, and secure a strengthened,

integrated framework for Mental Health services, the BCCG Governing Body gave its approval for a formal procurement process. In addition, both Bedford Borough Council and Central Bedfordshire Council have formally agreed that those services commissioned through Section 75 arrangements would also be part of this procurement process.

Local Context

BCCG, Bedford Borough Council and Central Bedfordshire Council work together in the commissioning of Mental Health and Learning Disability Services, and in monitoring existing services to ensure the best outcomes are delivered for their respective populations.

There are challenging financial targets for all Commissioning Organisations over the coming years and this must be considered alongside an increased demand for services.

The Commissioning Organisations have worked hard over the last eighteen months to engage all of their stakeholders and to develop service models which will transform local Mental Health and Learning Disability Services.
BCCG's Strategic Objectives for Mental Health describe how Mental Health services will be developed within Bedfordshire. These were developed following stakeholder engagement, using public health data and reviewing national best practice.

BCCG will continue the work it has already started with its partners to redesign all of its mental health services, to improve quality, improve health outcomes, increase capacity, reduce gaps in provision and remove duplication. This will require services to be integrated and commissioned jointly with the Local Authorities
whenever possible.

Within this 3-year plan, BCCGs key priorities are:

- Prevention and early intervention
- Improving quality in general practice
- Steps 1 – 3 of the Stepped care model
- Steps 4 – 5 of the Stepped care model
- Complex needs
- Rehabilitation and Recovery
- Dementia
- Liaison Psychiatry
- Transition to adult services
- Services for children and young people
- Preparing for the full introduction of the new Payment System for Mental
- Health Services

Engagement Report Summary for the Mental Health Projects

2.0 Specialist Learning Disability Service Review

A stakeholder event was held in July 2012 where the following areas were discussed:

1. Eligibility criteria
2. Arts Psychotherapies
3. Health Facilitation Service
4. Physiotherapy
5. Occupational Therapy
6. Specialist Medical Team
7. Sensory

Overview of the feedback received from this event is outlined as follows:

What people would like to keep?

- Sensory
- Health Facilitation Team
- Nurses at the hospitals
- Forensic Community Treatment Team
- Going to people's homes
- Providing training and on-going support to staff
- Good access to specialist Medical service
- Good use of community services

What people would like to change

- Hours of work, not just a 9 – 5 service, especially Liaison Nurses and Health Facilitation Team
- Venue
- Waiting times and waiting lists
- Difficulty in getting an appointment
- Having same staff supporting a person
- Better communication
- Shorter referral forms
- More input from Intensive Support Team
- Length of time some people stay in the service

3.0 How the feedback obtained influenced the development of the model of service

Currently the services are located north of Bedford at the Twinwoods site in Clapham. The location has been an issue particular to those who are situated in the south of the county. The proposed redesigned model recommends that the specialist services are based within the Local Authority locality areas. As a result it is anticipated that these services will be more accessible to everyone who resides within Bedford Borough or Central Bedfordshire. Specialist Learning Disability Services will include:

1. Health Facilitation Team
2. Specialist Medical Team
3. Occupational Health
4. Psychology

The Intensive Support Team (IST) and the inpatient unit will remain a county wide service. The health facilitation team and the Liaison Nurses who are located within both Bedford and Luton and Dunstable hospitals will remain the same.

Speech and Language Therapy (SALT) and the Sensory department will transit over to mainstream services. There will be a 6 – 12 month transition from specialist to mainstream services and the transition will be supported by specialist teams who will offer training and advice on making reasonable adjustments for people with a learning disability.

The dietetic service will transit across to mainstream services with a transition period anticipated to be between 6 – 12 months so that staff and service users can be supported through the transition of services.

Arts Psychotherapies will be decommissioned and spot purchased on an individual basis. The current provider (SEPT) have informed us that they have carried out their own review of the service and are planning to stop the Arts Psychotherapies as part of their review. An email was sent to Gary Kupshik requesting an update in relation to this service review.

The role of the health facilitation team is to support service users and their carer's in accessing primary and mainstream services. They also offer support and training to the GP practices and mainstream services in making reasonable adjustments and supporting people with a learning disability.

A further stakeholder event was held in December 2013 outlining the proposed new model. The model and supporting paper was also circulated out to stakeholders for those who were unable to attend the event.

Following the period of consultation, it became apparent that there were stakeholder uncertainties around losing the specialism - SALT and the sensory team. As a result the model has been amended to retain two nursing posts, one from either team to continue to support the development and transition across to

mainstream services. These posts will be reviewed after a two year period, so as to continue to have specialists supporting this arena for a longer time frame.

4.0 Additional Engagement Meetings

Date	Meeting / Event
17/09/2013	Meeting was held with colleagues from Luton Borough Council Adult Learning Disability Team
19/09/2013	Half day workshop with Local Authority leads to discuss the model
09/10/2013	Meeting with the current SPLD manager
11/10/2013	Meeting with the Lead Liaison Nurse at Bedford Hospital
26/11/2013	Meeting with the Luton Clinical Commissioning Lead for SPLD
03/12/2013	Meeting with Diane Meddick to discuss the transition between SPLD and Mainstream services
06/12/2013	Stakeholder event workshop
16/12/2013	Meeting with IST to discuss their project to combine MH and LD crisis service
09/01/2014	Meeting with the East of England Health Education
21/01/2014	SPLD steering Group
21/01/2014	Meeting with Maria Brown to discuss the transition from SPLD to Mainstream services

5.0 Plans for forthcoming meetings / events

- A meeting has been arranged with the current provider for 25/02/2014 to discuss the outcome of the consultation
- Presentation of the proposed model will be held at both the Central Bedfordshire and Bedford Borough Learning Disability Partnership Boards in March 2014
- The SPLD steering group will continue to meet to support the development of the service specifications and the procurement process on a monthly basis
- A further two workshops are being planned for the outcome based service specification for MH and LD services

6.0 Rehabilitation Service Review

A stakeholder event was held in May 2013 where there was representation from a wide audience, including service users, carers, voluntary sector and providers. The workshop was centred on 4 key themes:

1. What should a good Mental Health Rehabilitation Service look like?
2. What should we have in the Acute Sector and Services?
3. What rehabilitation should we have in the community sector and services?
4. What rehabilitation should look like in the future?

An overview of the feedback has been set against each of the themes –

- What should a good Mental Health Rehabilitation Service look like?
  - A step up or Step down Care
  - High package delivered at start then reduced as required (Review process having a way back up stepped up care again if needed)
  - Expanded variety of third sector provider services
  - On-going pathway of recovery (not stopping at service user entry to community)
  - Personalised care based on person recovery aspirations
  - Adaption of the Learning Disability model with residential supported living (Carer extra care model 1:1 hours to suit need in community house and flats).
  - Day Centre access (with options around)
  - Rapid response to communications for help with
  - Appropriate workforce and staffing levels to cover work in urgent situations
  - Access to employment support
  - Access to association with peer (facilitating peer to peer support)

- What should we have in the Acute Sector and Services?
  - Service user involvement
  - Initial Assessment of service user needs
  - Multi-disciplinary communication from point of referral
  - Early discharge planning (with care package, regular reviews and monitoring)

- What rehabilitation should we have in the community sector and services?
  - Service user at the centre of care
  - Service user leads (where possible .i.e. recovering service users help new service users)
  - Service not time limited (Sessions will be time limited but the number of sessions will not)
  - Service re-enactment (Two way recovery to start at the beginning or go back to where the user is right now)
  - More choice of services

- What rehabilitation should look like in the future?
  - Better supporting information

- Supported housing
- Wider choice - more options keeping people local
- Wellbeing centres (Hub + Spoke buildings)
- Recovery focused on-going support - not time limited (to maintain recovery)
- Process to 'Step up' – urgently or quickly
- Access impact of DWP and Job centre on patients (Training need for day opportunities)
- Resource enough qualified staffs to deliver
- Care pathway (where everyone understands how to go up and down)
- Short term rehab beds (without going through multiple referrals and long waits)
- Community Rehab Team (Multi-disciplinary community team)

7.0 How this influenced the development of the Community Mental Health Rehabilitation and Recovery Service

The model concentrates on a Community team that will cover Bedford Borough and Central Bedfordshire locality areas. The team will have a therapeutic focus and will link in with the Local Authorities in relation to supported housing, employment, leisure, education and peer support.

The team will consist of specialist recovery support workers, occupational therapy, specialist intervention nurses and psychology.

The team will work with people who present with enduring mental health and will support people to either step up or step down through service provision. There will be a SPOA and the service will accept referrals from a range of sources including self-referrals.

This service will be person centred and will aim to support people through a 3 tiered approach –

1. Complex Needs – High Support
2. Complex Needs – Medium Support
3. Complex Needs – Standard Support

It is anticipated that this service will support people within inpatient settings who are preparing for discharge, people residing in residential care homes, supported living and people who live in their own homes.

The service will aim to support people who present with an enduring mental health condition who require support to keep them well through therapeutic intervention, who may require support to regain living skills, social inclusion and physical health needs.

This service will work in close partnership with secondary mental health services so that if a person has more serious and complex needs then the individual is supported to step up to a more appropriate level of support. The service will also

be expected to work in close partnership with the Local Authorities so that peoples recovery is enhanced by linking with supported housing schemes, tenancy sustainment support, support around accessing education, voluntary work and employment, support accessing leisure activities and peer support.

Currently there are Support Time and Recovery workers (STR) who work within both the Assertive Outreach Teams (AOT) and the Community Mental Health Teams (CMHT) within SEPT. Through the procurement process these posts will not continue within Secondary Mental Health Services and instead will be replaced with the new model.

MIND is currently commissioned by the BCCG, CBC and BBC to deliver a recovery focused service for people with a MH condition. Their contract is due to be reviewed on 31/03/2014 and notice has been served to the provider. Moving forward through the procurement process, this service will be delivered through the new proposed model that is subject to the procurement process. Likewise the Bedford Resource Centre will also be combined within this new model of service.

8.0 Additional Engagement Meetings

1. *Central Bedfordshire Mental Health Partnership Board in January 2014*. The proposed model was discussed with members of this group.
2. *Meetings with Bedfordshire Housing Link during January and February 2014*. Where the housing links have been discussed in terms of linking into this model of service.
3. *Meeting with MIND (current provider) in January 2014*. In relation to serving notice on the current contract and highlighted the procurement of this service.
4. *Meeting with the YMCA (Provider) in January 2014*. The model and the procurement of this lot were discussed.
5. *Meetings have taken place with the 'Supporting People Directorate' in Bedford Borough throughout January 2014*. Bedford Borough are contributing to the budget for this service to include support around day resource, employment and tenancy sustainment support.
6. *A meeting was held with the Richmond Fellowship (provider) in January 2014*. This was discussing their current areas of responsibility and how they may link into the proposed model of service.
7. *On-going Rehabilitation steering groups are held monthly*. The membership of this group includes colleagues from both Local Authorities.
8. *A meeting was held with the current provider SEPT at their Rehabilitation service in Luton in December 2013.* The current model and the proposed model were discussed.
9. *There were two workshops held in November 2013 in relation to outcome based service specifications.* The outcomes of these workshops are on-going and the work is continuing.

10. *A* meeting was held with the AD of SEPT to discuss the current and proposed model in November 2013*.*

9.0 Plans for forthcoming meetings and events

- 17/02/2014 – Meeting with Bedfordshire Housing Link, Bedford Borough Council and Central Bedfordshire Council.
- 18/02/2014 – An outcome based service specification steering group meeting.
- 25/02/2014 – Meeting with the SEPT to discuss the model.
- A further two workshops are being planned based on the outcome based service specification.
- A stakeholder event is being planned for March 2014.

10.0 Dementia

How patient and carer engagement has shaped the project

Patient and carers engagement has resulted in various changes to the project. This includes:-

- Ensuring that the memory assessment service contacts people with dementia and their carers prior to their appointments
- Allowing patients to be seen in whichever clinic best suits them
- To consider the use of admin staff and volunteers as well as dementia nurses.
- Staffing to be based on skills required to achieve the outcomes
- Provision of emotional support as well as practical assistance

Patients and carers felt the following areas were important:-

- Single point of contact
- Proactivity of the service
- Two way communication
- All the updated information in one central point
- Home visits
- Dementia nurses
- Timely information and support

How clinical engagement has shaped the project

Clinical engagement has resulted in various changes to the project. This includes:-

- Screening carers for depression
- Basing the speech and language therapy dementia specialist within the memory assessment service
- Banding of the nurses at Band 6
- Dementia medicine reviews element to be removed from the role of the nurses.

Clinicians felt the following aspects of the project were important

- Someone to be there through the journey of dementia
- Proactive telephoning especially for those patients living alone
- Two way channel of communication to deal with issues as they arise rather than at a crisis point

11. Stepped Care Model 1-5

A stakeholder event and workshops were held in October 2012, May 2013, October 2013 and January 2014, where there was representation from a wide audience, including local service users, carers, voluntary sector and service providers.

The final workshop was centred on the Stepped Care model where the following areas were discussed:

1. Mental Health Care Step Care 1 - 5
2. Stepped Care Model Presentation
3. Assessment and Single Point of Access Team (ASPA)
4. Crisis Team
5. In-Patient Beds
6. NSF Teams (National Services Framework)
7. Link Workers

These are an overview of the questions and feedback received from this event:

11.1 Mental Health Care Steps 1-3

a) *What level of triage and Multi-Disciplinary Team do we need in practice?*
It was noted that there should be a level zero, which should focus on self-help, signposting and advocacy particularly as a preventative/early intervention measure. There should be a single tool (possibly IT based) for triage with links to services which are available and information/self-help leaflets. People were concerned about transition across services now and wanted assurance that's this would be addressed.

b) *Can a Single Point of Access work across Steps 1 - 5?*
This will need to work in partnership across all steps of the model (1-3 and 4-5) and not in silo with speedy referrals as appropriate between both. It was important to note that in the overall model, the patient journey needs to be as seamless as possible and based around the patient. People wanted to understand how many referrals there would be but supported the idea.

11.2 Health Assessment and Single point of Access teams (ASPA)

a) *Can there be one ASPA for steps 1 – 5?*
Stakeholders felt that this would not be appropriate as we need to keep steps 1-3 and 4-5 separate but need to have good communication and links between the two levels across provider services.

11.3 Mental Health Crisis Team

a) *Should home treatment function be split from the Crisis Team and incorporated into the locality integrated Mental Health teams?*
There was a difference of opinion across the groups about whether Crisis Team and Home Resolution Team should be split or stay together. This is still being considered in the proposal.

Stakeholders wanted a clear pathway for people to access the Crisis Team, especially out of hours and at weekends and that the patient journey needs to be as seamless as possible.

11.4 Crisis Team

a) *Should there be a separate Older People in Crisis Team?*
It was agreed the Crisis Team should not be separate due to equalities legislation and a single service should cover all adults.

b) *Should the Crisis Team work more closely with the ambulance service and police when they request help?*
It was agreed that there were often a good relationships between the Police and SEPT/other agencies. However it was also felt that there could be improved communication between agencies in responding to emergency situations especially where the police are called out to respond.

It was agreed that good communications/working relationships across agencies was vital to the effective implementation of the Stepped Care 1-5 model.

c) *Is A&E right place to wait for assessment?*
It was agreed A&E environment is not pleasant. Stakeholders felt that there needs to be an appropriate and safe environment within A&E that people can have immediate access to immediately on arrival.

d) *What should be the appropriate length of time to wait for assessment?*
Stakeholders had different views about length of times but four hours was too long.

e) *Older Age Services; how would it be best managed?*
It was agreed the importance to keep functional and organic illness separate for example as Dementia has a high social element to the support required and there needs to be a focus on crisis prevention.

f) *Do we need a MAS in each locality supported by an old age psychological team covering both functional and organic problems – Based where?*
It was agreed to keep the organic services (e.g. Dementia) separate as these have different treatment/options model. However there needs to be one in each locality. They could be based in the same 'hub' but appointments offered on different days and there are good examples elsewhere of these services being kept separate.

g) *Are we doing enough for functional illness in older services?*
It was agreed more need to be done for functional illness in older services once people have been assessed and that this would benefit from stronger integration between health and social care.

11.5 Mental Health Inpatient Beds

a) *Can we manage demand?*
It was agreed more need to be done as we cannot manage the demand and people are currently going out of county due to lack of beds. The Crisis Team currently manage a process to avoid delayed discharges including to commissioned private sector beds when available.

b) *Does short stay assessments and treatment work?*
Stakeholders felt this did work, however we need to ensure that we have sufficient beds. Redesign the service to have Acute Assessment Units in inpatient wards which has a consultant on ward rounds twice a day and Consultant available 24/7.

c) *Strengths and benefits of Psychiatric Intensive Care Unit (PICU) and are there additional needs?*

It was agreed there were additional needs for high risk patients. The group did not have the occupancy rate/numbers of those using the service or beds commissioned. However transporting patients (particularly those who may be aggressive) to the unit has been an issue. Stakeholders wanted local services.

d) *Strengths and benefits to Detox Beds and are there any additional needs?*

Stakeholders agreed that in patient admission wasn't best place for detox and was unsettling for some mental health needs patients.

11.6 Mental Health National Service Framework (NSF) Teams

a) *What functions and outcomes should remain within teams?*

It was agreed services should be based around the patient and not the other way round. It was felt that the Assertive Outreach workers could be part of the CMHT and that this would improve access.

b) *What are the risks of remaining specific teams?*

It was agreed there is a risk of silo working. It was agreed that we need to maintain the responsibilities of these services, but didn't need separate teams.

c) *What are the benefits of remaining specific teams?*

It was agreed it enables and supports specialist skills which can sit within the teams, but can mean people are not getting best support.

11.7 Mental Health Link Workers

a) *Should the role be developed to include supporting service users stepping up and stepping down?*

Stakeholders weren't sure bout role. It was agreed CPN's could have direct access (rather than service users going through another layer) but the role could involve care management/working with GPs, plus being a link with locality Mental Health Teams.

b) *What role should they play in therapy?*

Stakeholders felt that currently some Mental Health Link Workers offer step 2 level assessment and treatment already and that this could further developed.

How the clinical feedback and engagement influenced the final development of the Stepped care model to integrate:

1. **Step Care 1 – 5**
   - Locality based services provision
   - Use of information Technology; social media and marketing
   - Focus on Early intervention
   - Reduction of NSF Teams to create locality teams
   - Waiting times for Crisis Service

2. **Single Point of Access**
   - Referral/GP early signpost and details on assessment
   - Triage service/ Triage tool; risk assessment to ask relevant questions
   - Streamlined and aligned steps 1-3 and steps 4-5
   - Support to prevention and signpost to social care services

Appendix (g)

Central Bedfordshire Council
www.centralbedfordshire.gov.uk

Central Bedfordshire

Tier 1 and 2 Child and Adolescent Mental Health and Wellbeing Services in Central Bedfordshire:

Review of Need, Service Provision, Gaps and Areas for Improvement

November 2013

Authors: This report was produced by Clare Ebberson, Public Health Registrar, Central Bedfordshire Council and Seana Perkins, Public Health Co-ordinator, Bedford Borough Council on behalf of the Tier 1 and 2 Child and Adolescent Mental Health Project Group.

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Central Bedfordshire

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EXECUTIVE SUMMARY

The mental health and wellbeing of children and young people is recognised as a priority through the Health and Wellbeing Board and the Children's Trust in Central Bedfordshire.

The aim of this review is to examine and evaluate the Tier 1 and Tier 2 CAMHS (child and adolescent mental health) service provision in Central Bedfordshire and identify information to inform future Tier 1 and 2 CAMHS commissioning.

A separate review of Tier 3 CAMHS services is being undertaken by Bedfordshire Clinical Commissioning Group, and the results of this review have been shared with those undertaking this review. Definitions of the Tiers of CAMHS services can be found in the main report.

Identifying Need and Evidence

- Summary of information on estimated local need for CAMHS services
- Review of National Institute of Clinical Effectiveness (NICE) guidance about what interventions are effective

Identifying Current Service Provision

- Questionnaire and interviews with service providers about service provision
- Information about commissioners regarding service provision and costs

Stakeholder Engagement: Identifying Areas for Improvement and Un-met Need

- Questionnaire and interviews with service providers about gaps, areas for improvement and outcomes data
- Summary of findings from the Health in Schools Review relating to mental health and wellbeing
- Questionnaire to a local GP practice about use of services, gaps and areas for improvement

The findings were considered by the project team who identified recommendations for action

Key findings from the review include:

Need: It is estimated that 8580 young people will have experienced mental health problems appropriate to a Tier 1 response from CAMHS, and 4,005 young people will have experienced mental health problems appropriate to a Tier 2 response from CAMHS in Central Bedfordshire in 2012. Further details are outlined in the needs section of the report.

Service Provision: A number of Tier 1 and 2 CAMHS services currently operating in Central Bedfordshire were identified. These are described in the service provision section of the report.

Gaps in Services and Areas for Improvement:

Some of the key gaps and areas for improvement identified are listed below. Further details of these are outlined in the full report:

- **Referral routes** - There are currently a number of ways in which a young person can be referred to child and adolescent mental health services in Central Bedfordshire. This has been reported as causing some confusion and delays and a need was identified for a single point of referral for such services. Bedfordshire Clinical Commissioning Group, South Essex Partnership Trust and CHUMS are working on piloting a single point of referral for Tiers 2 and 3 CAMHS as part of their CQUIN (commissioning for quality and innovation) in 2013/14 which can usefully inform development of a referral route for all Tiers of CAMHS.

- **Awareness of services –** There was a lack of clarity about current services available in Central Bedfordshire and a need was identified for a directory of services to be available, and which longer term, could be used for the development of a pathway for child and adolescent mental health.

- **CAMHS service information –** Outcomes and activity data reported by providers of Tier 1 and 2 services often did not include outcomes data as part of routine monitoring of performance. Similarly, referral and presenting issue data was not always reported routinely by local authority area. A need for a consistent way of reporting information and outcomes of services was identified.

- **Tier 2 demand and longer term Tier 2 support –** the majority of Tier 2 services are commissioned to deliver a short term Tier 2 service (e.g. 4 sessions). Few services were identified who could provide longer term support for those who need it. Many of the Tier 2 service providers also had a waiting list for services meaning services are not always delivered in a timely manner. Further group based support at both Tiers 1 and 2 was identified as an area that could be expanded.

- **Increased early prevention/Tier 1 work** – was identified as an area that could be further strengthened.

- **Family based mental health and wellbeing support** – provision of family based (rather than child only focused) mental health services were identified as an area that could be expanded, given that a high proportion of children with mental health issues are reported to also have a parent with mental health issues.

- **Pathway for children with autism** – was identified as an area that could be strengthened, both for those with autism and mental health issues and autism alone.

- **Continuity of Care** – between children's mental health services and adults' mental health services was identified as an area of weakness as eligibility criteria for children's and adults' services differ which can result in interruption or cessation of service provision.

- **Communication between Service Providers** – some areas was identified where service providers could better share information to allow more responsive service provision.

- **Gaps in specific services** – some service providers perceived there to be few services locally specifically for addressing self-harm or prevention of drug addiction (rather than treatment once an addiction has already been identified).

- **Limitations of data availability***:* There were a number of gaps identified in the data available on Tier 1 and 2 child and adolescent mental health services locally. These included limited local information on needs/prevalence (although local estimates based on national prevalence were available) and limited outcomes data on child and adolescent mental health outcomes (e.g. outcomes data not reported by local authority area).

Recommendations:

Recommendations made by the CAMHS Tier 1 and 2 project team as a result of the review are:

Recommendation	***Lead Organisation:***
1. **Develop a pathway for child and adolescent mental health services (including talking therapies), with a single referral route where appropriate (e.g. through the early help CAF service).**	Central Bedfordshire Council, Bedfordshire Clinical Commissioning Group
2. **As part of the development of a pathway, consider integration/pooling budgets to streamline the pathway and reduce duplication of services**	Central Bedfordshire Council, Bedfordshire Clinical Commissioning Group
3. **Ensure that provision of current Tier 1 specific services (school based support/training in early identification for mental health) continues in future.**	Children's Services,, Central Bedfordshire Council
4. **Embed the enhanced School Nurse (SN) Service Tier 1/2 Emotional and Behaviour Management Pathway**	Public health, Central Bedfordshire Council

	Action	Lead
	(pathway currently in draft form).	
5.	**As part of action 3 above, undertake stakeholder work with GPs, schools and health visitors to identify early intervention (Tier 1) actions that could be taken to prevent young people developing more serious mental health and wellbeing issues.**	Central Bedfordshire Council, Public Health
6.	**Develop a standard template to be used for monitoring/evaluation of child mental health and wellbeing services to include information about outcomes, quality, client feedback and breaking down service use information by local authority area.**	Children's Services, Central Bedfordshire Council
7.	**Develop an emotional health and wellbeing (CAMHS) strategy for Central Bedfordshire, to be reported to the Children's Trust Board**	Central Bedfordshire Council, Bedfordshire Clinical Commissioning Group
8.	**Raise awareness of existing Tier 1 and 2 child mental health and wellbeing services locally.** As part of this develop a directory of services (e.g. on a webpage) for child mental health and wellbeing and identify an agency to keep it up to date. This could include having information on the GP ref system and as part of early help (CAF) work training GPs	Central Bedfordshire Council, Bedfordshire Clinical Commissioning Group
9.	**Work with service providers on further analysis to map Tier 1 and 2 child mental health need on a geographic basis (localities).**	Central Bedfordshire Council, Public Health Public health
10.	**Revise and update the service specification for all Tier 1 and 2 provision, to implement the recommendations of the review and ensure outcome focus**	Central Bedfordshire Council, Bedfordshire Clinical Commissioning Group

MAIN REPORT

1. AIM

The mental health and wellbeing of children and young people is recognised as a priority through the Health and Wellbeing Board and the Children's Trust in Central Bedfordshire. The aim of the review was to examine and evaluate the Tier 1 and Tier 2 CAMHS (child and adolescent mental health) service provision in Central Bedfordshire and identify information to inform future Tier 1 and 2 CAMHS commissioning. This included collecting service providers' and local stakeholders' views on local services, gaps and areas for improvement.

2. BACKGROUND

The mental health and wellbeing of children and young people is recognised as a priority through the Health and Wellbeing Board and the Children's Trust in Central Bedfordshire.

A separate review of Tier 3 CAMHS services is being undertaken by Bedfordshire Clinical Commissioning Group, and the results of this review have been shared with those undertaking this review.

Definition of Tiers of Child and Adolescent Mental Health Services

Tier 1: Social, emotional and developmental support from professionals outside specialist CAMHS, as part of their everyday work that generates resilience and prevents mental health (e.g. teachers, social workers, SEN workers, Health visitors, school nurses and GPs).

Tier 2: Any specialist CAMHS workers using individual professional skills with children and families (e.g. primary mental health workers, psychologists and counsellors working in community and primary care settings.

Tier 3: Specialist CAMHS workers working in specialist therapeutic teams in community mental health clinics or child psychiatry outpatient service.

Tier 4: Highly specialist teams working in day and in-patient units providing services to children and young people with the most serious problems.

The tiers are based on the CAMHS four-tier strategic framework, which was laid out in 1995 (HAS) and is widely used.

3. METHODS

A project team was established to carry out the review, members of which are outlined above. Input from a range of other stakeholders was also included.

Key steps in the project included:

Identifying Need and Evidence

- Summary of information on estimated local need for CAMHS services
- Review of NICE guidance about what interventions are effective

Identifying Current Service Provision

- Questionnaire and interviews with service providers about service provision
- Information from commissioners regarding service provision and costs

Stakeholder Engagement: Identifying Areas for Improvement and Un-met Need

- Questionnaire and interviews with service providers about gaps, areas for improvement and outcomes data
- Summary of findings from the Health in Schools Review relating to mental health and wellbeing
- Questionnaire to a local GP practice about use of services, gaps and areas for improvement

The findings were considered by the project team who identified recommendations for action

4. FINDINGS

4.1 Need for CAMHS services in Central Bedfordshire and NICE Guidance

4.1.1. Summary of Needs:

- It is estimated that 3,585 children aged 5-16 in Central Bedfordshire have a mental health disorder.
- Among school aged children, the number of children with a mental health disorder is highest in the 11-16 year old age group.
- Among school aged children, prevalence of mental health disorders is higher in boys than girls at all ages.
- Across all children aged 5-16 years conduct disorders (e.g. anti-social behaviour) are the most common mental health disorder.
- It is estimated that a further 1,650 young people aged 16-19 in Central Bedfordshire have a neurotic disorder (e.g. anxiety, depression, phobias).
- It is estimated that in Central Bedfordshire, 8580 young people will experience mental health problems appropriate to a Tier 1 response from CAMHS, and 4005 young people will experience mental health problems appropriate to a Tier 2 response from CAMHS (aged 17 and younger in 2012
- Over the next 10 years in Central Bedfordshire it is estimated that there will be a significant increase in 5-9 year olds of nearly 24%. Numbers of 0-4 and 10-14 year olds are also predicted to increase by around 11%.
- Further details about need and data sources are found in Appendix 1.
- A range of effective ways of promoting and treating child mental health and wellbeing issues were identified in NICE guidance and are summarised in Appendix 1.

Estimated need for services at each tier

Estimates of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4 have been provided by Kurtz (1996). The following table shows these estimates for the population aged 17 and under in Central Bedfordshire.

Estimated number of children / young people who may experience mental health problems appropriate to a response from CAMHS (2012)

Tier 1	Tier 2	Tier 3	Tier 4
8580	4005	1060	45

Source: Office for National Statistics *mid-year population estimates for 2012*. Kurtz, Z. (1996).

Estimated number of school age children with mental health disorders in Central Bedfordshire by age group and gender

Estimated number of children with a mental health disorder (2012)								
Estimated number of children aged 5-10 yrs	Estimated number of children aged 11-16 yrs	Estimated number of children aged 5-16 yrs	Estimated number of boys aged 5-10 yrs	Estimated number of boys aged 11-16 yrs	Estimated number of boys aged 5-16 yrs	Estimated number of girls aged 5-10 yrs	Estimated number of girls aged 11-16 yrs	Estimated number of girls aged 5-16 yrs
1425	2165	3585	965	1220	2185	465	945	1420

Source: Office for National Statistics, mid-year population estimates for 2012. Green, H. et al (2004).

Looked After Children

A report on the health of looked after children (LAC) (Meltzer, H. et al. 2003) found that among LAC aged 5-17 years:

- 45% had a mental health disorder
- 37% had a clinically significant conduct disorder
- 12% had emotional disorders (such as anxiety or depression)
- 7% were hyperkinetic

Further details about mental health and wellbeing needs in Central Bedfordshire including estimated numbers of children with specific mental health conditions can be found in Appendix 1.

4.1.2. NICE Guidance

Evidence of effective interventions for promoting social and emotional wellbeing and specific mental health conditions have been developed by NICE and a summary of the guidance is shown in Appendix 3.

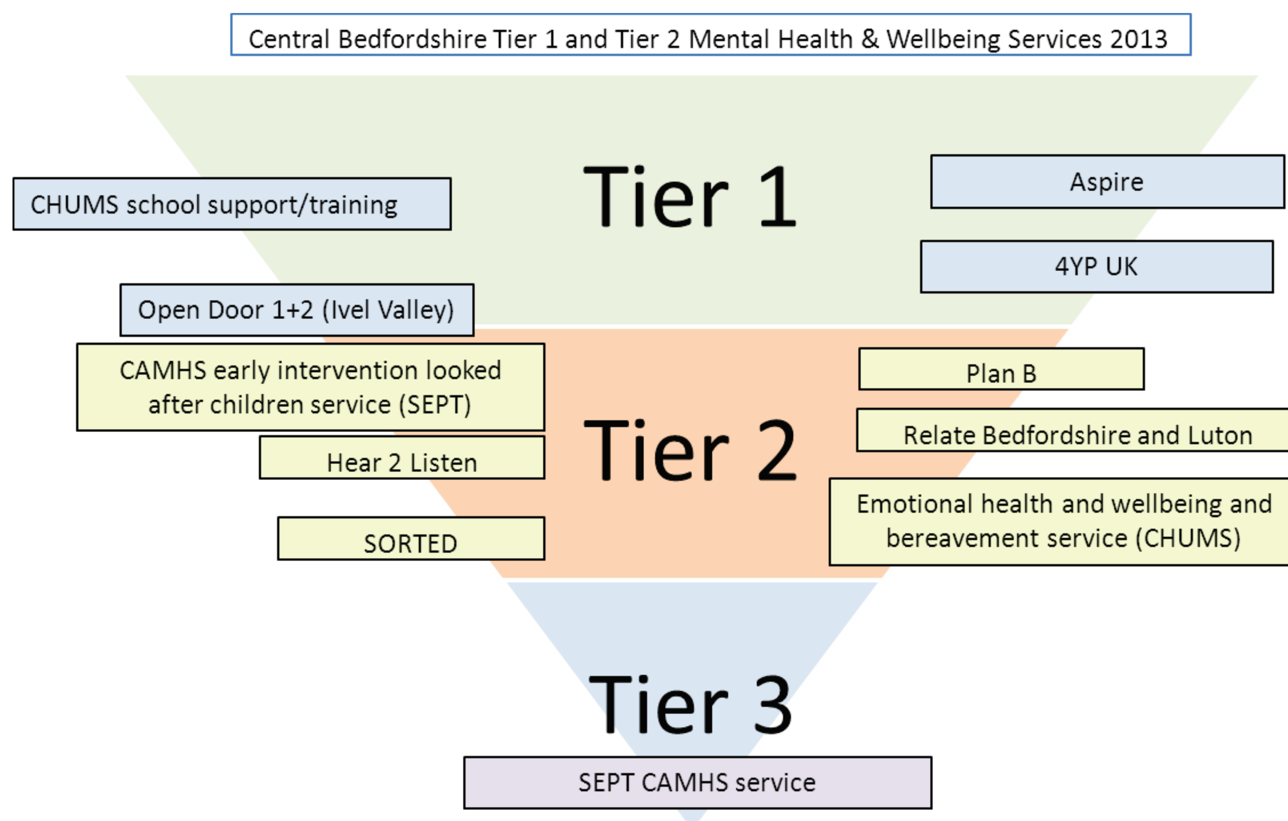
4.1.3. Cost Effectiveness

The Allen report “Early Intervention: Smart Investment, Massive Savings” concludes there is “overwhelming” evidence that intervening early in child social and emotional wellbeing is cost effective and savings delivered by such programmes can far outweigh costs (Allen, 2011). Actions to improve social and emotional wellbeing

among young people identified in NICE guidance have also been assessed as cost effective (NICE, 2012). This is particularly relevant given the significant costs of treating mental health problems and behavioural difficulties in the UK. For example, each child with untreated behavioural problems costs an average of £70,000 by age of 28. This is 10 times the cost of children without behavioural problems (Edwards et al, 2007).

4.2 Current Service Provision

Figure 1: Current service provision of Tier 1 and 2 services



The Tier 1 and Tier 2 services identified in Central Bedfordshire are shown in the above diagram. A brief description of each service is outlined below. Further details of each service are outlined in Table 1, which includes information about referral sources; numbers of referrals; commissioning arrangements and timescales; opening times; catchment areas and ages of service users for each service identified.

Service	Delivered By	Tier	How many individuals/sessions is service commissioned to see/offer (2012/13)	Catchment Area	Age Group	Referrals From	Commissioned By in Central Bedfordshire	Commissioned Until	Service use in 2012/13 in Central Bedfordshire
Aspire	CSUK	1	11 programmes in schools	11 schools in Central Bedfordshire	Children in Years 7- 9	20 children identified by each school	Early Intervention and Prevention Team and the Public Health Team- CBC	On-going	166 in total 92 boys and 72 girls
Early intervention work with Young people	4YP UK	1	-	Central Beds	11-25 years and wider family	Troubled family triage	Central Bedfordshire Council	2014	2100 clients seen by early intervention project (April 2011 – March 2013) 150 families 2013/14
Mentoring	4YP UK	1	-	Central Beds	-	-	Central Bedfordshire Council	2015	85 group mentoring for those at risk of school exclusion
Young people at risk of teenage pregnancy	Brook	2	20 per quarter	Central Beds	15+	Schools, Agencies, Services	Central Bedfordshire Council	2015	Not available as contract has been re-focused on more

									vulnerable from 1/4/13
Early intervention – children affected by parental drug/alcohol abuse	Plan B/CAN	2	Not available	Central Beds	5-18	Schools, LA, CAMHS, voluntary sector, self; infrequently school nurse or primary care	Central Bedfordshire Council	01/09/2014	121 clients seen by risky behaviours partnership
Tier 2 Drug and Alcohol Service	Plan B/ CAN	2	100 young people per annum offered one to one programme. Group work meets demand (approx 150 per annum)	Central Beds	12-18	Schools, social care, voluntary sector, self.	Central Bedfordshire Council	31/03/2015	30 YP seen in Q1 in one to one sessions, 25 seen in group work. Awaiting Q2 data.
Prevention and Treatment for young people with emerging substance misuse issues	Plan B/CAN	2/3	Not available	Central Bedfordshire and Bedford Borough	<18 years	Not available	Public Health (Pooled Treatment Budget)	Not available	Not available
Early Intervention Looked After Children's Service	South Essex Partnership Trust	2	Not available	Central Beds and Bedford Borough	0-21	CAMHS, LA, primary care, school nurse, education	Jointly commissioned by BB Council & CB Council	31/03/2014	61 direct contacts and total caseload of 18 (Q1 2013 -

									service has not operated for whole year)
Talktime Early intervention Counselling Service	Relate Bedfordshire and Luton	2	-	Central Beds	10-21	Usually self, also voluntary sector, LA, primary care, education	Central Bedfordshire Council	31/03/2014	515 (Total clients) 440 (Talktime clients)
Talktime – Leighton Buzzard	Relate	2	6 hours per week	Leighton Buzzard	10-21	GPs, Self	Bedfordshire CCG	30/09/2014	-
Talktime in schools	Relate	2	2-6 hours per week	8 middle/Upper schools	Middle-upper school age		Schools		
Family counselling	Relate Bedfordshire and Luton	2	-	Central Beds		Usually self, also voluntary sector, LA, primary care, education	-	-	75 (Family Counselling clients)
Tier 1 EWB Awareness	CHUMS	1	-	Central Beds	3-18	-	Central Bedfordshire Council	31/03/2014	-

Tier 2 EWB Service	CHUMS	2	66 referrals per month (across Bedford Borough and Central Bedfordshire)	Central Beds and Bedford Borough	3-18	Usually self, also includes voluntary sector, LA, primary care including GPs, education, social care, youth Workers	Bedfordshire CCG (tier 2)	30/09/2014	(903 in total) 595 in CBC
Bereavement service	CHUMS	2	n/a	Central Beds and Bedford Borough	3-18	Self, parents/carers, education, social care, primary care, CAF, CDC	Bedfordshire CCG (tier 2)	30/09/2014	423 in total 262 in CBC
Open Door	Open Door	1+2	Not available	Ivel Valley	13-25	GP	Ivel Valley BCCG GP Group, grants	30/09/2014	97 clients seen in the community from Ivel Valley in Central Bedfordshire and Bedford Borough combined. Numbers of clients not analysed separately by local authority area.

Early intervention and wellbeing	SORTED	2	244 hours	Central Bedfordshire	18-25 (core service)	Early help (CAF), primary care including GPs, self, education, other young people's services	Bedfordshire CCG,	30/09/2014	234 clients seen in 11/12
Work with children affected by domestic abuse	SORTED	2	-	Central Beds	5-13	Early help (CAF)	Central Bedfordshire Council	31/12/2014	-
Hear 2 Listen	Hear 2 Listen	2	N/A	Central Beds	11-25	Education, primary care, self	Trusts, grants etc.	Ongoing	50-100

CBC+ Central Bedfordshire Council, BBC= Bedford Borough Council, LA=local authority; IFSS = Intensive family support service; Early help CAF= Common assessment framework, CDC= Child development centre

4.3. Stakeholder Information

4.3.1. Where Services Could be Improved

Through questionnaires and in-depth interviews with service providers and commissioners, a number of gaps in services and areas for improvements for tiers 1 and 2 mental health services in Central Bedfordshire were highlighted Areas identified were:

Awareness of Services

Several providers in Central Bedfordshire felt that there was a lack of awareness locally of available services for young people's mental health and wellbeing among families and young people. This is supported by research undertaken by Relate in 2011 (across Bedfordshire and Luton), which reported that young people were largely unaware of mental health services available locally and were therefore likely to go to a friend or family member for mental health support.

There was a general perception that it is also difficult for health professionals to keep track of what services are available for child mental health and wellbeing locally. This was particularly the case as services provided change often (largely due to short term commissioning arrangements). There is currently no, one directory or place locally where young people or families can go to find out what services are available for mental health support. Such a directory was thought to be useful; however this should include all local organisations, not just those commissioned by the organisation compiling the directory.

Some Tier 2 providers were not aware of Tier 1 provision available locally. CHUMS however, felt there was good awareness of their services locally.

Communication between Mental Health Service Providers

It was perceived that improved networking between local mental health services would be useful to improve communication. However, the time-consuming nature of this was acknowledged. 4YP UK, for example, felt that it would be useful if there were opportunities for tier 1 organisations to feedback information to tier 2 providers about their work with young people and mental health problems at the early intervention stage.

The Tier 2 SEPT mental health service for looked after children felt there are more opportunities for communication and joint working with organisations such as the local authority. For example, being more involved/informed about looked after children reviews, children in need cases and child protection plans could help to identify children at an earlier stage who could be supported by the looked after children mental health service. This could also include ensuring minutes from relevant meetings relating to looked after children (e.g. looked after children's reviews) are shared in a timely fashion. The looked after children's mental health team also perceive they could be more involved in the planning of children's care, for example out of area placement moves that may impact a child's health and wellbeing.

Some providers said communication, information sharing and joint working is stronger between some local mental health organisations than others and that there are areas for improvement.
SORTED, for example, felt that it would be useful as part of improved communication/networking if there was one organisation locally which took responsibility for disseminating e.g. legislation regarding mental health. A good example of this already taking place locally for another service was given as Central Bedfordshire's Family Network, which helps share information about local services for families etc.
A number of examples of good communication were, however, provided. For example, CHUMS felt they had good communication with SEPT CAMHS Tier 3 services and meet with them regularly to discuss clients.

Referrals/Access to Services
At present there are a number of referral routes, and this plethora causes some confusion.

1. Early Help (CAF referrals)
   Referrals are received by the CAF team for a range of tier 2 services including those offered by Sorted, Relate and CHUMS. For such referrals, an early help (CAF) form with consent is completed. This ensures that the case is logged as participating in Early Help.
2. Tier 2 referrals can also be made directly to CHUMS and to other Tier 2 services e.g. SORTED and Relate. In such circumstances, a CAF form is not completed.
3. Tier 3 referrals are also directly made to CAMHS (SEPT).

Referring through Early Help (CAF) allows a holistic assessment of a young person's needs to be carried out so that referrals can be made to other services where required in additional to mental health/wellbeing services. Additionally, referrals through the Early Help (CAF) allow tracking of needs information so that trends in need can be identified. Outcomes are also able to be tracked through the Early Help (CAF) process.

Anecdotally, there was some confusion among professionals (e.g. GPs) and among young people themselves about which organisation to contact/refer to when a young person has a mental health need. This sometimes resulted in families not knowing which organisation they had been referred to. In addition to this, for some of the Tier 2 organisations, if a young person is referred to them and they need to then be referred on elsewhere, they have to refer back to the GP to refer them on to SEPT Tier 3 services rather than being able to refer them directly to this service, which could create delays in supporting young people.

For example, SORTED stated that a central referral route would be useful as if an individual has been referred to SORTED but they are found to have a Tier 3 need, they have to be referred back to the GP for onwards referral to SEPT Tier 3 services as SORTED are not able to refer directly to SEPT Tier 3 services.
It was also reported anecdotally there may be case of some referrals being made to CHUMS as there is a perception that this may be a way of gaining speedier access to CAMHS.

The CAMHS Tier 2 looked after children team are currently looking at piloting a one-point of referral scheme to address this difficulty. This would mean that all referrals were made to one place which would then assess referrals and ensure they were signposted to the correct organisation. This could then mean that self-referrals may be able to be made (self-referral to tier 2 or 3 CAMHS is not currently available). A number of stakeholders felt that having one point of referral would be useful. However, it was acknowledged that having one point of referral would be a big commitment and that the team responsible for referrals would have to have a very good understanding of and communication with different local mental health services to be able to effectively channel the referrals to the most appropriate place.

Some service providers felt that sometimes young people may not wish to go through an organisation (e.g. school, doctors) due to a difficulty with perceived authority figures and would benefit from the ability to self-refer.

Hear 2 Listen perceived that sometimes 'red tape' can prevent quick responses e.g. with assessment forms needing to be completed and processed in their work with schools in Central Bedfordshire. They felt that sometimes young people need more immediate support.

Continuity of Care

Looked after children who are accessing Tier 2 CAMHS services in Bedfordshire may be moved to out of area placements, sometimes at short notice. As not all neighbouring locations have a Tier 2 CAMHS service, this may result in interruption or discontinuation of their care. Improved communication between the CAMHS looked after children Tier 2 service and social services may help teams to plan continuity of service at an earlier stage.

Criteria for accessing support from children's mental health services are different from criteria for eligibility for adult mental health services. Therefore there is a gap as some young people with Tier 2 needs may not meet the criteria to continue receiving support once they become an adult at age 18.

Talking Therapy Strategy

It is currently unclear how improving access to psychological therapies and talking therapies for children are integrated into other CAMHS services.

4.3.2. Potential Areas of Unmet Need

Feedback from stakeholders has highlighted the following areas as gaps in the current service provision for children in Central Bedfordshire:

- **Tier 2 demand and longer term Tier 2 support:**
  Anecdotally, a number of service providers identified a gap between Tier 2 and Tier 3 services in Central Bedfordshire for those that need longer term Tier 2 interventions. Most of the current providers offer only short Term Tier 2 interventions (e.g. CHUMS on average offer 4 sessions). This may not be a sufficiently long enough intervention to resolve Tier 2 mental health issues. Anecdotally, CHUMS stated that around 80% of their clients improve within 4 sessions of treatment, however this leaves a proportion who may need longer

term support. A number of service providers felt that they are seeing an increasing number of complex cases, with a high level Tier 2 demand (just below the threshold for Tier 3 services). For example, some individuals who had experienced issues such as sexual abuse or sexualised behaviour had been referred to Tier 2 services as they had not met the criteria for Tier 3 services.

CHUMS stated that demand for their Tier 2 bereavement and emotional health and wellbeing services are greater than the service they are commissioned to provide. This results in capacity difficulties and may result in waits of up to 3 months between being referred and receiving treatment. For example, CHUMS are commissioned to deliver emotional health and wellbeing support to 720 young people across Central Bedfordshire and Bedford Borough. However, in 2012/13, this service was delivered to approximately 595 young people in Central Bedfordshire. A number of other service providers felt that there was a need for further Tier 2 services locally.

- **Family based mental health and wellbeing support**
  CHUMS data suggests that 50% of children referred to their emotional health and wellbeing service also have a parent with a mental health issue. Therefore, it was suggested that there is a gap relating to integrated family mental health services. Currently, it was felt that adult and child mental health services operate independently and there is little work involving the family unit as a whole. This type of work may support a young person to ensure they maintain emotional wellbeing in the home environment after Tier 1 or Tier 2 interventions.

- **Pathway for children with autism**
  A number of Tier 1 and 2 mental health service providers felt that a better pathway for children with autism is needed (both those with and without mental health issues as well as autism). CHUMS provide some Tier 2 support for children with both autism and mental health needs but were not aware of any services young people with autism could be referred on to if they did not have the mental health needs to meet CHUMS criteria.

- **Increased early prevention/Tier 1 work**
  A number of organisations anecdotally felt that there was a need for further early intervention/Tier 1 work locally. For example, SORTED said further work promoting resilience, self-esteem and coping skills would be helpful locally. 4YP UK also stated anecdotally that more services for early intervention were needed. However, there are already a number of existing Tier 1 services in Central Bedfordshire including CHUMS, 4YPUK and Open Door (in Ivel Valley). Anecdotally it was also felt that more preventative work with younger clients who are experimenting with self harm was needed (e.g. Open Door and 4YP UK).

- **Service use by males**
  One service provider stated that anecdotally, although the number of males presenting to Tier 2 services is increasing, a much greater proportion of service users are female. This is despite mental health issues being common

among males. Therefore further work may be needed to encourage young men to present to mental health services at Tiers 1 and 2.

- **Self-harm support services**
  Several service providers expressed concern that there is little support for young people who are self-harming.

- **Addiction prevention**
  Hear 2 Listen perceive there to be little provision for addiction prevention in Central Bedfordshire. For example, young people can only access CAN/Plan B after a substance misuse issue has been identified. There is little provision from a preventative point of view that can work with the underlying issues before young people find routes into addiction to cope. Hear 2 Listen are doing some work in this area in Central Bedfordshire schools however, and would potentially have capacity to be able to deliver this to additional schools.

- **Domestic violence support for parents of children experiencing domestic violence**
  Although SORTED provide a domestic violence support service for young people, anecdotally they have identified a gap in services supporting parents of these young people who have experienced domestic violence.

- **Group based Tier 1 and 2 support**
  CHUMS stated there would be enough demand to run support groups for children affected by divorce or separation and low mood but currently these are not provided due to capacity. Other providers felt that group sessions supporting young carers would be beneficial. SORTED felt there is little group based Tier 1 and 2 support for young people in Central Bedfordshire.

- **Communication of secondary care referral pathways**
  Not all service providers were aware of referral routes from secondary care e.g. there was a lack of clarity about where children who have had an overdose might be referred to now that emergency services at Bedford Hospital have changed. Services were unclear if young people who have had such overdoses could still be referred to Tier 2 mental health services in Central Bedfordshire following treatment/discharge or if they would be referred to other services at another hospital.

- **Support for those who have experienced sexual abuse or who have shown sexualised behaviour**
  Sexualised behaviour services/sexual abuse was identified as a gap in service provision as some individuals with these issues are currently being referred to Tier 2 services where they do not meet Tier 3 criteria.

- **Funding for travel to appointments**
  4YP UK stated that mental health services in Central Bedfordshire could be improved by providing funding for people with mental health issues to get to appointments. CHUMS was the only organisation who stated that they have volunteer drivers etc. to support young people in attending appointments.

- **Waiting times for Tier 2 services**
  CHUMS stated that demand for Tier 2 services is greater than that which they are commissioned to provide and subsequently, there are often long waiting times to see young people.

- **Services for under 5s**
  Plan B stated anecdotally that they are aware of few services that can be referred onto for children who are aged under 5 years who may have mental health needs that cannot be addressed by Plan B

4.3.3. Emerging Trends
Anecdotally, the following issues about why young people present to mental health and wellbeing services were raised:

- It was felt that young people are becoming more aware of mental health issues and are more willing to discuss them than in the past.
- It was felt that there is an increasing demand for Tier 2 mental health support among young people.
- One provider stated that anger is becoming more common as a reason for presenting to some Tier 2 services.
- A number of providers felt that more complex cases are more commonly presenting to Tier 2 services e.g. presenting with anxiety, but also having e.g. an eating disorder or self-harming.
- Anecdotally, SORTED predict that demand for their domestic violence support service for young people in Central Bedfordshire is likely to increase.

4.3.4. Tier 1 and 2 Child and adolescent mental health and wellbeing services in Central Bedfordshire schools
A health in schools review is carried out biennially in Central Bedfordshire to help schools to self-assess the health and wellbeing in their school. This was most recently carried out in 2013. Key findings are outlined below, and include findings relevant to Tiers 1 and 2 services (although the survey was not specific to these tiers):

Referring to specialist services for advice

Schools referred to a wide range of specialist services for advice. Services most commonly referred to were:

- CAMHS
- CHUMs
- Educational psychologists
- Child protection
- School nurse

- Jigsaw (behaviour support)

Referrals were often made through the Special Educational Needs Co-ordinator or the Common Assessment Framework (CAF).

Services less commonly identified by schools included: Cruse (bereavement support), SMILE (supporting minds in a learning environment), learning mentor, family justice, intensive family support, education support panel, parent partnership advisor and child development centre (helps children with disabilities and special needs), behaviour support team, Connexions, Relate and Plan B, pastoral carers, 2 can counselling and other counselling services, play therapy, action for children, Chilterns' outreach team, the Edwin Lobo centre and the Red Bear Multi-Agency support tram.

Schools identified a number of school policies which may relate to wellbeing, such as safeguarding policies and anti-bullying policies. One of the schools had a stress management policy. However none of the schools identified a specific mental health/health and wellbeing policy.

Signposting

The most common ways schools sign-posted young people to mental health and wellbeing services were using display boards, newsletters, websites and leaflets. The Special Educational Needs Co-ordinator also signposted to relevant services in some schools.

Identifying and providing support for children facing challenging circumstances

The most common ways in which children facing challenging circumstances were identified included using individual education plans to identify need, monitoring and tracking pupils (e.g. monitoring school attendance), staff meetings to review pupil progress and identify children who may be facing difficulties, meetings with parents, circle time activities and having worry/suggestion boxes.

In addition to the above services that may be referred to, there were a number of services within schools identified to support young people's health and wellbeing. Schools frequently identified the SEAL programme (social and emotional aspects of learning programme). Other services included were mentoring, support from the Family Support Worker (for example for children in need or child protection issues), buddy systems and intervention groups. SMILE (supporting minds in a learning environment) was commonly talked about by schools in Central Bedfordshire. Smile aims to promote positive mental health and wellbeing e.g. by raising awareness, building capacity and providing access to Counsellors.

Opportunities for children and young people to develop responsibility, build confidence and self-esteem

Schools offered a number of ways for young people to build confidence and self-esteem, such as peer mentoring, extra-curricular clubs and being able to take on responsibilities e.g. as form representative or on a school council. One school has a lunchtime club for children with emotional needs, and another school holds a health and happiness week.

4.3.5. Outcomes Data

The table in Appendix 4 gives an overview of the outcomes data that is available from mental health and wellbeing services locally, identifies gaps in information and highlights trends where these can be identified from the data.

RECOMMENDATIONS

Recommendations:

Recommendations made by the CAMHS Tier 1 and 2 project team as a result of the review are:

Recommendation	*Lead Organisation:*
1. **Develop a pathway for child and adolescent mental health services (including talking therapies), with a single referral route where appropriate (e.g. through the early help CAF service).**	Central Bedfordshire Council, Bedfordshire Clinical Commissioning Group
2. **As part of the development of a pathway, consider integration/pooling budgets to streamline the pathway and reduce duplication of services**	Central Bedfordshire Council, Bedfordshire Clinical Commissioning Group
3. **Ensure that provision of current Tier 1 specific services (school based support/training in early identification for mental health) continues in future.**	Children's Services,, Central Bedfordshire Council
4. **Embed the enhanced School Nurse (SN) Service Tier 1/2 Emotional and Behaviour Management Pathway (pathway currently in draft form).**	Public health, Central Bedfordshire Council
5. **As part of action 3 above, undertake stakeholder work with GPs, schools and health visitors to identify early intervention (Tier 1) actions that could be taken to prevent young people developing more serious mental health and wellbeing issues.**	Central Bedfordshire Council, Public Health
6. **Develop a standard template to be used for monitoring/evaluation of child mental health and wellbeing services to include information about outcomes, quality, client feedback and breaking down service use information by local authority area.**	Children's Services, Central Bedfordshire Council
7. **Develop an emotional health and wellbeing (CAMHS) strategy for Central Bedfordshire, to be reported to the Children's Trust Board**	Central Bedfordshire Council, Bedfordshire Clinical Commissioning Group

	Action	Lead
8.	**Raise awareness of existing Tier 1 and 2 child mental health and wellbeing services locally.** As part of this develop a directory of services (e.g. on a webpage) for child mental health and wellbeing and identify an agency to keep it up to date. This could include having information on the GP ref system and as part of early help (CAF) work training GPs	Central Bedfordshire Council, Bedfordshire Clinical Commissioning Group
9.	**Work with service providers on further analysis to map Tier 1 and 2 child mental health need on a geographic basis (localities).**	Central Bedfordshire Council, Public Health Public health
10.	**Revise and update the service specification for all Tier 1 and 2 provision, to implement the recommendations of the review and ensure outcome focus**	Central Bedfordshire Council, Bedfordshire Clinical Commissioning Group

APPENDICES AND REFERENCES

Appendix 1: Detailed Needs Information: Need for CAMHS services in Central Bedfordshire

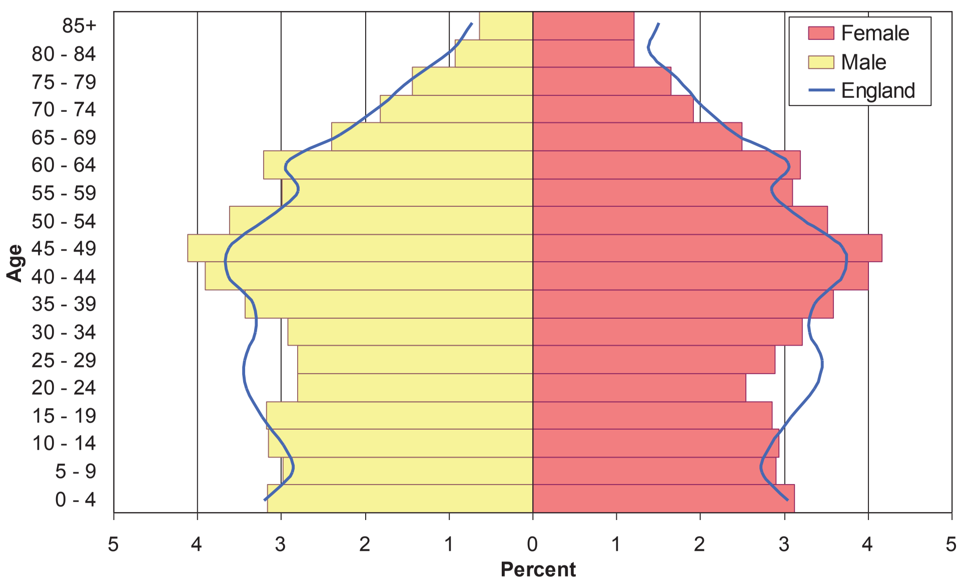
Population in Central Bedfordshire

Age (Years)	0-4	5-10	11-16	17-18	16*-19	Total 0-18	Total population (all ages)
Central Bedfordshire	16,643	18,505	18,813	6,372	12,059	60,333	259,969

Source: ONS Mid 2012 estimates

*16 year olds counted again to match age bands used in subsequent report

Age profile by sex 2011, Central Bedfordshire compared to England



(***Source:*** *Office for National Statistics, 2011 Census)*

Projected changes in population

Central Bedfordshire's total population is estimated to grow by between 1.2-1.3%% each year for the next 10 years, with a total population increase of 13.7% estimated between 2011 and 2021. For the 0-19 year olds the estimated growth over the next 5 and 10 years is shown below:

Age	% Growth 2011-2016	% Growth 2011-2021
0-4	9.4%	11.6%
5-9	12.4%	23.9%
10-14	-1.0%	11.3%
15-19	-6.9%	-7.0%

Source: ONS Interim 2011-based population projections

Within this age range, by 2016 there will be an increase in the 0-9 year olds and a decrease in the 10-19 year olds. There will be an overall decrease in the 15-19 year olds. Over the next 10 years it is estimated that there will be a significant increase in the 5-9 year olds of nearly 24%. Numbers of 0-4 and 10-14 year olds are also predicted to increase by around 11%. The number of 15-19 year olds will decrease by 7%.

Key facts

A report by Green et al (2004) estimated the prevalence of mental disorders in children:

- **It is estimated that 1 in 10 children and adolescents has a mental disorder**
- **Boys are more likely to experience mental health problems than girls (11.4% compared to 7.8%)**
- **Children aged 11-16 years are more likely (11.5%) than 5 to 10 year olds (7.7%) to have mental health problems**
- **For Looked After Children the rates are significantly higher**

The local picture

A CAMHS Needs Assessment Report has been produced by CHIMAT and provides prevalence and need data for the Central Bedfordshire population.

Pre-school children

There are relatively little data about prevalence rates for mental health disorders in pre-school age children.

A literature review of four studies looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6% (Egger, H et al, 2006). Applying this average prevalence rate to the Office for National Statistics (ONS) mid-year population estimates for 2012, gives a figure of 2,595 children aged 2 to 5 years inclusive living in Central Bedfordshire who have a mental health disorder.

School-age children

Estimated prevalence for each mental health disorder

The following tables show the estimated number of children with conduct, emotional, hyperkinetic and less common disorders in Central Bedfordshire by applying the prevalence rates to the 2012 population (the numbers in this table do not add up to the numbers in the previous table because some children have more than one disorder).

Estimated number of children with mental health disorders by age group and gender

	Estimated number of children aged 5-10 yrs (2012)	Estimated number of children aged 11-16 yrs (2012)	Estimated number of boys aged 5-10 yrs (2012)	Estimated number of boys aged 11-16 yrs (2012)	Estimated number of girls aged 5-10 yrs (2012)	Estimated number of girls aged 11-16 yrs (2012)
Conduct Disorders	910	1245	655	785	255	470
Emotional disorders	445	945	210	390	230	560

	Estimated number of children aged 5-10 yrs (2012)	Estimated number of children aged 11-16 yrs (2012)	Estimated number of boys aged 5-10 yrs (2012)	Estimated number of boys aged 11-16 yrs (2012)	Estimated number of girls aged 5-10 yrs (2012)	Estimated number of girls aged 11-16 yrs (2012)
Hyperkinetic disorders	300	265	260	235	40	40
Less common disorders	245	265	210	155	40	105

Source: Office for National Statistics mid-year population estimates for 2012. Green, H. et al (2004).

Across all children aged 5-16 years conduct disorders are the most common mental health disorder with the highest numbers seen in the 11-16 year olds. Amongst boys conduct disorders is the most prevalent disorder in both the younger and older age group. Girls are more likely to experience a disorder between the ages of 11-16 and emotional disorders account for the highest rates.

Older children aged 16-19 years

A study conducted by Singleton et al (2001) has estimated prevalence rates for neurotic disorders in young people aged 16 to 19 inclusive living in private households. The tables below show how many 16 to 19 year olds would be expected to have a neurotic disorder if these prevalence rates were applied to the population of Central Bedfordshire.

Estimated number of males aged 16 to 19 with neurotic disorders in Central Bedfordshire

Mixed anxiety and depressive disorder (males 16-19 yrs) (2012)	Generalised anxiety disorder (males 16-19 yrs) (2012)	Depressive episode (males 16-19 yrs) (2012)	All phobias (males 16-19 yrs) (2012)	Obsessive compulsive disorder (males 16-19 yrs) (2012)	Panic disorder (males 16-19 yrs) (2012)	Any neurotic disorder (males 16-19 yrs) (2012)
325	105	60	40	60	35	545

Source: Office for National Statistics *mid-year population estimates for 2012*. Singleton, N. et al (2001).

Estimated number of females aged 16 to 19 with neurotic disorders

Mixed anxiety and depressive disorder (females 16-19 yrs) (2012)	Generalised anxiety disorder (females 16-19 yrs) (2012)	Depressive episode (females 16-19 yrs) (2012)	All phobias (females 16-19 yrs) (2012)	Obsessive compulsive disorder (females 16-19 yrs) (2012)	Panic disorder (females 16-19 yrs) (2012)	Any neurotic disorder (females 16-19 yrs) (2012)
715	65	155	125	55	35	1105

Source: Office for National Statistics *mid-year population estimates for* 2012. Singleton, N. et al (2001).

In the older age group of 16-19 year olds mixed anxiety and depressive disorder is the most prevalent mental health disorder with the number of females affected more than double that of males.

Appendix 2: Service Descriptions – Tier 1 and 2 Child and Adolescent Mental Health Programmes

TIER 1 SERVICES

The Healthy Child Programme (HCP)

The Healthy Child Programme (DH, 2009) is an early intervention and prevention programme. It is a single programme divided into two life stages: pregnancy and first five years of life (0-5) and 5-19 years.

The SEPT 0-19 Children's Service incorporates Health Visitors and School Nurses and they are commissioned to provide key elements of the HCP 0-5 and 5-19 programmes (other partners include GPS, Schools, Children's Centres). The universal offer is key to early identification of need and risk. The Universal Plus and Partnership Plus programmes can then be implemented appropriate to need and should ensure the most vulnerable are identified and supported.

Current provision

An evaluation of the 0-5 HCP (2010) found that full universal offer was not available in Central Bedfordshire. However with increased numbers of health visitors being recruited the following improvements are planned in the next 2 years as part of the universal provision:

- Increase in number of women seen antenatally by the health visitor
- 95% of mothers to receive face to face postnatal contact by 10 weeks to include assessment of maternal mood by end of 2014/15
- All children/parents to attend 1 year and 2-2½ year Health and Development Review.

The 0-19 Team are also working to ensure those families identified as Universal Plus and Universal Partnership Plus receives appropriate early interventions or referrals.

Reduced numbers of school nurses in recent years has affected implementation of the 5-19 HCP which has also been patchy in Central Bedfordshire with the following implications:

- There is inconsistency around content and follow-up of the School Entry Review
- There is no health review provided at transition year (Year 6/8) – a key time to identify emerging health and wellbeing issues
- Weekly school Nurse drop-ins are being rolled out to 5 Upper Schools in Central Bedfordshire and their 13 Middle schools, all in areas of higher deprivation during 2013/14. These will be rolled out to all remaining Upper and Middle schools and special schools in Central Bedfordshire during 2014/15.

- Opportunities for public health education/promotion to improve emotional health and wellbeing are very limited.

There is planned expansion of the School Nurse Service to deliver the full HCP 5-19 in Central Bedfordshire. The service specification has been redeveloped recently to ensure full delivery of the 5-19 Healthy Child Programme by the end of the 2014/2015 academic year. This will include Solihull and CAMHS training for School Nurses to enable them to assess and provide support at Tier 1 and 2.

Aspire

The Aspire Programme is an early intervention workshop and coaching programme for vulnerable children susceptible to poor outcomes. The programme aims to help them reach their potential and addresses the risk factors that may lead to teenage pregnancy. It is delivered over 14 weeks, with 6 weekly workshops, followed by 6 weeks' telephone coaching and 2 further workshops. This is followed up by quarterly tracking over 12 months. Schools nominate children to join the programme. In Central Bedfordshire the programme runs in 11 targeted schools for 20 children per school (10 boys and 10 girls).

CHUMS – Emotional Health and Wellbeing School Based Training and Support

CHUMS provide Tier 1 early intervention and prevention service for schools promoting emotional health and wellbeing school based training for all schools in Central Bedfordshire. An emotional health and wellbeing lead will be trained in each school, and training involves being able to support young people, identify early signs of emotional distress and being able to signpost to appropriate Tier 2 services where appropriate. This is also being expanded to include work with school nurses and drop in sessions.

CHUMS offers supervision and consultation to the emotional wellbeing lead from those schools that sign up. Each locality has its own cluster enabling those trained to network and gain support from peers as well as working alongside the CHUMS Family Care Practitioners.

4YP UK

4YPUK are a Tier 1 and 2 service offering guidance, support and mentoring to young people aged 11 to 25 years. These are delivered by drop in sessions in Leighton Buzzard, Houghton Regis, and Dunstable, however sessions are also held at youth centres across Central Bedfordshire by appointment. 4YP also provide support and mentoring for young people in schools in Central Bedfordshire.

Referrals to 4YP are made for a range of mental health issues and frequently include referrals for anxiety, depression, attention deficit hyperactivity disorder (ADHD), conduct disorders, emotional disorders, anger management, self-harm and sexual

exploitation. Other common reasons for presentation to the service include homelessness, benefit issues, to encourage community and peer involvement, for intensive support and mentoring.

Sources of 4YP referrals are outlined in table 1 but are rarely received from primary or secondary care.

In Central Bedfordshire 4YP UK are commissioned to provide:

- Intensive support project – referral to this is only via early help (CAF) and can be made by any professional working in Central Bedfordshire
- Troubled families programmes – commissioned from Sep 2013 – 2014, working with families identified as requiring High and Medium levels of support – referral to this is via the Troubled families triage
- Group mentoring - 85 school pupils in Central Bedfordshire receiving group mentoring (for those at risk of school exclusion) in 2012/13
- Early intervention project, 2100 clients seen by early intervention project (April 2011 – March 2013)

Open Door

Open Door deliver both Tier 1 and Tier 2 services to young people aged 13-25 but only in the Ivel Valley area of Central Bedfordshire. Open Door offers short term counselling, support and treatment (usually up to 12 sessions).

Main reasons for presentations to Open Door include anxiety, difficulties with family relationships and self-esteem and self-harm.

In Ivel Valley, Open Door referrals are only accepted from GPs. There is currently a waiting list to be seen and this may fluctuate seasonally (e.g. demand peaks after Christmas and before the school summer holidays). Services are delivered by volunteer counsellors with the exception of two paid counsellors working in schools.

TIER 2 SERVICES

CHUMS – Emotional Health and Wellbeing Service and Bereavement Service

CHUMS offer a short term (on average 4 sessions) emotional health and wellbeing service for young people across Central Bedfordshire delivered by a multi - disciplinary team using evidence based interventions. This is for young people with mild to moderate mental health issues, with common presenting issues being anxiety, family relationships, autism, behavioural issues and some self-harm.

In addition to this, CHUMS offer a number of Tier 2 group support sessions across Central Bedfordshire, for example support with anxiety, behaviour issues, self-

esteem, and for those on the autistic spectrum. CHUMS also run parents' support groups alongside the children's groups.

CHUMS also deliver a Tier 2 bereavement and trauma service across Central Bedfordshire. This service is commissioned to support children who have experienced bereavement relating to specific types of traumatic event (suicide, murder or road traffic accidents). The service is delivered by a consultant trauma psychologist and a principal psychologist two trauma psychiatrists and a number of trainees.

CHUMS have volunteer drivers and are sometimes able to pay for taxis to support young people to make appointments as well as offering appointments in a range of locations including community based settings and individual's homes.

Plan B/CAN

Plan B is a Tier 2 service which offers support, information and advice to a young people aged 5 to 18 who use drugs or alcohol or who are affected by someone using these substances. Outreach services are delivered across Central Bedfordshire Monday to Friday 9am to 4:30pm, with late appointments offered to those in crisis in the week.

The main reason why young people present to Plan B is because either themselves or someone close to them (mainly parent/carer) is affected by drugs and/or alcohol (experimental drug users through to problematic drug users in the Tier 3 service). Support is also available for those with complex trauma, historical abuse, sexual abuse or sexual exploitation when these issues have led them into drugs/alcohol. Depression, personality disorders, anxiety and other emotional disorders are common among those presenting to the service.

Sources of referrals to Plan B are outlined in table 1, but are rarely or never received from primary or secondary care. If referrals do not have Tier 2 needs that can be addressed by Plan B, they may be referred on to CHUMS, Open Door (in Ivel Valley only), Relate, MIND or SEPT. There is currently no waiting list for the Plan B service.

The service is commissioned by Central Bedfordshire Council and Public Health until 2014.

SEPT – Early Intervention Looked After Children's Service

The only Tier 1 or 2 service delivered by SEPT is the early intervention looked after children's service (all other CAMHS services are tier 3).

This is a Tier 2 service for young people aged 0-18 years delivered by South Essex Partnership Trust (SEPT) and which operates across Central Bedfordshire. Support is provided to families and children for up to 16 weeks (although timescales are flexible). Services provided include art therapy, nursing support and play therapy. It

is planned that Improving Access to Psychological Therapies (IAPT) services will be introduced to this service later this year.

The service frequently receives referrals from organisations such as the local authority, school nurses and primary care. Referrals are rarely or never received from secondary care or the voluntary sector. Individuals are not currently able to self-refer into this service; however self-referrals may be introduced later in the year as part of the introduction of IAPT. There is currently no waiting list for the service.

Placement breakdown is a common reason why young people present to this service, as well as issues such as anxiety, depression, ADHD and conduct disorders. Many of the children using this service are complex cases and risky and anti-social behaviours are common.

The service is commissioned jointly between Bedford Borough and Central Bedfordshire Councils until 2014. There were 61 direct contacts in Central Bedfordshire in quarter 1 of 2013, with a total caseload of 18 young people in this period. The service is new and has only been in operation since April 2013.

As this is a new service that commenced in 2013, no outcomes data will be available until late 2013 (October onwards).

Relate Bedfordshire and Luton

Relate offer Tier 2 short term counselling services to young people and families across Central Bedfordshire. Services are provided by trained counsellors. These are:

- Talktime young people's counselling

This is one to one counselling for 10-21 year olds which is delivered face to face in a number of venues across Central Bedfordshire, free of charge to the young person. Up to 6 sessions are delivered and common mental health issues dealt with include anxiety and anger. Additional sessions can be delivered if a clinical decision is recommended. The majority of referrals to Relate are self-referrals however referrals to the service can also be made by professionals (e.g. teacher, local authority worker etc.) by ringing Relate.

Talktime is commissioned by Central Bedfordshire Council until April 2014. Bedfordshire Clinical Commissioning Group (CCG) also commission Talktime in Leighton Buzzard. This service is primarily for Leighton Buzzard residents (90%) and GPs can refer to this service, or self referrals can be received. The Leighton Buzzard service is commissioned for 6 hours per week by BCCG.

8 middle/upper schools in Central Bedfordshire also commission Talktime directly, which means the service is accessible to pupils at those schools for between 2 to 6 hours per week at the school location. In 2012/13, 440 clients were seen by Talktime in Central Bedfordshire.

Young people are referred on to Tier 3 Child and Adolescent Mental Health Services if they have more severe mental health needs or to safeguarding services if there are safeguarding issues. No areas for improvement in the referrals process were identified.

- Family counselling

This service is commissioned by Central Bedfordshire Council until April 2014 and consists of short term counselling sessions for young people together with their families to address the family and young person's tier 2 mental health issues.

Referrals for family counselling and Talktime are via the early help (CAF) process. Clients can self-refer and a early help (CAF) form will be completed with the permission of the client(s). 75 families received family counselling in 2012/13 in Central Bedfordshire.

Relate nationally also offer a range of online support and on-line chat resources to support young people and families

- Education and learning services

Commissioned directly by schools and organisations and previous workshops have included delivering e.g. anti-bullying training to staff.

SORTED

Sorted is a Tier 2 service for young people aged 18-25, which operates across Central Bedfordshire. SORTED deliver emotional health and wellbeing support, which may include object therapy or cognitive behavioural therapy.

Referrals can be from a range of sources including primary care, self-referral or education. The most common method of referral is from a GP.

SORTED also deliver a service for young people aged 5-13 in Central Bedfordshire who have been affected by Domestic Violence. Referral to this service is via the early help (CAF).

In addition to this, SORTED deliver an early intervention and wellbeing service across Central Bedfordshire. Referrals to this service are through the early help (Common Assessment Framework - CAF). Relate and SORTED deliver 900 hours annually of this service in Central Bedfordshire (450 of these delivered by SORTED).

Common presenting issues to SORTED's mental health service include Obsessive Compulsive Disorder, anxiety/panic attacks, depression, eating disorders, self-harm, bullying/domestic violence and anger.

SORTED's domestic violence service and early intervention service deliver 12 weeks of support. In addition to this, SORTED's mental health service delivers on average 9 weeks of support to an individual however the number of sessions is open ended (e.g. no cut-off after a specific number of sessions).

SORTED are commissioned by Bedfordshire CCG. The domestic violence service is commissioned by Central Bedfordshire Council.

Hear 2 Listen

Hear 2 Listen is a Tier 2 service, for 11-25 year olds across Central Bedfordshire, which provides a young people's counselling service. Anxiety, depression, ADHD, conduct disorder and emotional disorders are all common reasons for people presenting to Hear 2 Listen. Other common presenting issues include low self-esteem, difficulty with relationships (personal and educational), eating disorders, self-harm, abuse, lack of confidence and substance misuse. Hear 2 Listen also run workshops and support groups for young people to help raise awareness and increase support on a variety of issues including addiction, understanding addiction within the home, self-esteem, confidence and relationships.

Hear 2 Listen operates mostly 9am to 5pm during the week, but is able to offer some services during the evenings and at weekends. The service is based in Biggleswade, but also operates from some schools in Central Bedfordshire.

Referrals to Hear 2 Listen are most commonly received by education; however self-referrals and school nurse referrals are also common. Referrals are uncommon or rare from CAMHS, the local authority, voluntary sector, primary or secondary care. There is a waiting list for the service of no more than 6 weeks. Hear 2 Listen have not yet needed to refer on to other organisations as they operate across multiple tiers.

Hear 2 Listen is currently funded on an on-going basis from a variety of sources e.g. trusts, grants and local contributions, however there are currently no local commissions. Between 50 and 100 referrals were received in Central Bedfordshire during 2012/13.

Brook

Brook delivers a planned programme of 4-6 one-to-one interventions for young people who have been identified as exhibiting potentially risky sexual behaviours.

Service aims:

- To provide information, support and opportunities to young people
- To provide appropriate evidence strategies for reducing unintended teenage pregnancies
- To identify the societal, community and family level factors that may influence the young person's routes to early parenthood and supporting them to overcome individual barriers
- To provide accurate , up-to-date, objective information about personal and lifestyle issues, learning and career opportunities, progression routes, choices, where to find help and advice and how to access it

- To develop young people's resilience as a means of reducing the risk factors associated with early parenthood
- For the provider to work collaboratively with local services to address the multiple factors associated with teenage pregnancy

Appendix 3: Evidence base

NICE Best Practice for social and emotional wellbeing in children and adolescents

Social and emotional wellbeing provides the building block for healthy behaviours and educational attainment. It also helps prevent behavioural problems and mental illness. The following tables summarise NICE recommendations about emotional health and wellbeing and specific mental health conditions.

Table taken from the NHS Bedfordshire Mental Health Assessment (2012)

Promoting social and emotional wellbeing in schools (NICE)

Social and emotional wellbeing: early years NICE PHG 40 (October 2012) 1. Ensure social and emotional wellbeing of vulnerable children features in the Health and Wellbeing Strategy and JSNA and informs integrated commissioning of universal and targeted services for children under 5 – including GP's, maternity, health visiting and early years providers 2. Early years and health professionals should identify vulnerable children and assess need by building trusting relationships with vulnerable families and identify risk factors e.g. using the early years foundation stage assessment process 3. Health visitors and midwives should offer a series of intensive home visits for vulnerable children and families 4. Children's services should ensure all vulnerable children can benefit from high quality childcare and take up their entitlement to early childhood education where appropriate 5. Health and early years providers should pit systems in place to deliver integrated universal and targeted services to support vulnerable children, involving parents and encouraging vulnerable parents to use early years services	Universal/Tier 1
Promoting children's social and emotional wellbeing in primary education NICE PHG12 (2008) 1. Ensure all primary schools adopt a whole school approach and work with local CAMHS to support a "stepped care" approach to prevent and manage mental health problems 2. Develop a programme to develop children's social and emotional skills including: • a curriculum that develops	Universal/Tier 1

social and emotional skills across all subject areas and integrated activities to support development of skills e.g. assemblies, homework • Training and development for teachers to deliver curriculum and manage behaviour • Support for parents to develop parenting skills 3. Ensure teachers/practitioners are trained to identify and assess early signs of anxiety, emotional distress and behavioural problems and use the CAF process where appropriate 4. Provide a range of interventions including problem-focused group sessions delivered by specialists and parenting sessions alongside.	Tier 1-2
Social and emotion wellbeing in secondary education NICE PHG 20 (2009) 1. Secondary education settings to take an organisation-wide approach to promote the social and emotional wellbeing of young people 2. Schools to ensure social and emotional wellbeing features within plans, policies, activities and an ethos of mutual respect is promoted. 3. Ensure young people have access to pastoral support and specialist services 4. Integrate social and emotional skills across the curriculum to promote positive behaviours and successful relationships and reduce bullying etc. Reinforce learning through extra curricular activities e.g. homework, voluntary work 5. Work in partnership with parents/carers and help develop parenting skills where appropriate 6. Work in partnership with young people to give them to the opportunity to contribute to decision making and build relationships e.g. through peer education 7. Integrate social and emotional	Universal/Tier 1

wellbeing within the training and continual professional development of practitioners and governors	

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 last 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 4: Outcomes data

Provider	Outcomes data	Trends in Outcomes/Referral data	Information Gaps/Comments
CHUMS	**Outcomes:** • Change in SDQ score, annual audit • Not currently analysed by BB/CBC **Need(Referrals/presenting issue):** • Monthly reporting of referral data/presenting issue etc. • Referrals stepped up/down to CAMHS Tier 3 reported but not by BB/CB	**Outcomes: (September 2012-March 2013)** **EMS Service** • Mean SDQ scores for the emotional wellbeing (EMS) service (pre/post intervention)decreased from 18 to 15 (cohort 1) and 18 to 16 (cohort 2) • The mean pre SDQ score is in the ‘abnormal’ range (17-40), while the mean post SDQ score is classified in the ‘raised’ range (14-17) • The majority of reduction made on the SDQ was for those who received between 2 and 6 sessions • Older individuals showed greater improvements following treatment, although this may be due to better perception of the difficulties • Relationships showed the most improvement on SDQ scores following treatment, with autism and low mood making the least improvement • Individual support resulted in larger decreases in SDQ scores than group support • In group sessions, behaviour difficulties followed by anxiety showed the biggest reductions in SDQ score • When comparing the scores in the SDQ audit with the September 2012 Audit, the Total Difficulties Score has increased from 16 to 18. This suggests that CHUMS is now dealing with children more significant presenting issues than in the previous year	• Outcomes data not currently reported monthly with performance report • Outcomes data spilt by BB/CB is not currently available/reported • Only no of referrals accepted is reported by BB/CBC • All other referral/presenting issue information is reported monthly but not broken down by BB/CBC • Postcode level data is collected for referral data so it would be possible to report this by BB/CBC in future • Provider keen to collaborate in future to further develop reporting of information

	Need(Referrals/presenting issue): • Monthly reporting of referral data/presenting issue etc. • Referrals stepped up/down to CAMHS Tier 3 reported but not by BB/CB	**Referrals (January-July 2013):** **EMS Service** • Number of monthly referrals received ranged from 64 to 135, with very few inappropriate referrals (where eligibility criteria are not met) • Approximately two thirds (56% to 84.6%) of the monthly referrals accepted to the EMS service were from CB and one third from BB • Behaviour issues (including anger, aggression and conduct) and anxiety were the most common presenting issues, with depression also being common • GPs, parent/carer and school are the most common sources of referral • Those using the EMS were most commonly aged 5-15 years • There was an approximate 50:50 split of males/females using the EMS service • The majority of service users were White British • Wait time average for 1:1 appointments ranged between 8 and 12 weeks during this period (waiting list of 74-103 young people) • In 2013, CHUMS received more service demand (referrals) than they were commissioned to provide (across CB+BB combined). E.g. Jan-April 2013 CHUMS were commissioned to provide the EWS service for 264 people, but the actual number delivered was 358 **Bereavement service:** **Referrals (January-July 2013):**	to identify need etc. • For 20% of clients post intervention SDQ score was not available (e.g. non return of questionnaire) • Outcome of therapy not reported on monthly performance report • Data not available by

		• Number of monthly referrals received ranged from 27 to 46, with between a quarter and a third of these being Central Bedfordshire children (approximately 70 in the period) • The majority of referrals were from schools • A small number of referrals were from GPs and health professionals, but a very small number of referrals were from CAMHS or social services • Between 83% and 96% of children were contacted within 3 days	BB/CB apart from number of referrals
CAMHS Tier 2 Looked after children service	**Outcomes:** • Not available • Will include IAPT outcomes including SDQ score **Need(Referrals/presenting issue):** • Monthly reporting of referral data/presenting issue etc. • Referral data broken down by Bedford Borough and Central Beds and includes referral source, age, ethnicity, discharge destination etc.	**Outcomes: Not available** **Referrals:** • Total caseload numbers in Q1 2013 were 18 in Central Bedfordshire (61 direct contacts) • Social services was by far the largest referrer to this service • 75% (Central Bedfordshire) of first contact to clients was within 4 weeks of initial contact • Postcode level data collected on number of referrals	• No outcomes data will be available for this service until after quarter 2 later in 2013 (post October) as it is a new service • Only 1 quarter's referral data available so far, so too early to identify trends • Presenting issue not recorded on performance reports
Relate	**Outcomes:** • Outcomes not reported for BB/CB separately except for on specific projects	**Outcomes:** • Talktime and Family counselling client feedback in Central Bedfordshire showed an increase in the wellbeing of clients following their counselling sessions	• Presenting issue or outcomes data not currently collated/analysed by

	where e.g. commissioned only by CB **Need(Referrals/presenting issue):** • No of referrals available by BB/CB separately • Presenting issue and other info not generally reported separately for BB/CB • Talktime/family counselling funded by CBC: main presenting issues were: ability to cope with problems, stress/worry/anxiety and relationships	• Before counselling 42% felt bad about issues such as relationships, stress and anger whereas 1% felt bad about these issues following counselling **Need(Referrals/presenting issue):** • Figures for Central Bedfordshire funded work (one contract family counselling and talktime) suggest ability to cope with problems followed by stress/worry/anxiety and relationships are the most frequent presenting issues • Higher numbers of families use Talktime and family counselling in Central Bedfordshire than Bedford Borough	CB/BB as contracts/funding are from a number of sources
4YP UK	**Outcomes:** • Improvement in scores on an "opportunity wheel" and on specific soft skills e.g. self-esteem, confidence and motivation are captured for specific services/projects delivered **Need(Referrals/presenting issue):** • Not provided	**Outcomes:** • The intensive support service in Central Bedfordshire (19 of 21 clients completed evaluation) showed a 52.6% increase in areas such as feelings, motivation, confidence and feelings following completion of counselling • Group mentoring in Central Bedfordshire in January – May 2013 (7 attendees) showed increase in soft skills following counselling sessions such as an 80% increase in self-esteem and a 147% increase in motivation	• Performance info provided did not include data on presenting issue, referral source, discharge destination, age or gender

		• Qualitative outcomes were collected for counselling for those at risk of school exclusion (provided in one school) in Central Bedfordshire and reported positive outcomes e.g. "It helped me, I'm less angry and I talk to people more"	
Hear 2 Listen	**Outcomes:** • Exact outcome figures not available **Need(Referrals/presenting issue):** • Exact figures not available but all referrals due to problem behaviour at school	**Outcomes:** • Exact figures not available but approximately 95% of those who accessed the service showed improvements e.g. improved social relationships, increases in self-esteem, emotional awareness, communication and educational engagement **Need:** • All referrals were for disruptive behaviour e.g. difficulty with emotional management (anger), difficulty maintaining healthy relationships or for isolation e.g. anxiety, lack of confidence and low self-esteem	• Outcomes data, breakdown of referrals data by presenting issue, figures of referral source and destination
Open Door	**Outcomes:** • Improvement in traits such as happiness, self-confidence and ability to solve problems recorded before and after counselling and can be analysed by BB/CB **Need(Referrals/presenting issue):** • Analysis is by CB/BB combined in e.g. annual	• In Central Bedfordshire, self-confidence, dealing with problems and happiness showed the biggest improvement after counselling, but all areas measured (including looking to the future, attitude to others ability to cope with life and feelings about yourself) all showed improvements after counselling	• Referral numbers and presenting issue by BB/CB

	report		
Plan B	**Outcomes:** • Various depending on individual project but include increased knowledge, feeling safer, better relationships and quality measures **Need(Referrals/presenting issue):** • Split by BB/CB	**CAN young people's team: Tier 2 support** • The CAN young people's team in Central Bedfordshire saw 30 young people in Q1 2013 • Cannabis followed by alcohol were the most common reasons for young people presenting to CAN (in Q1) • Service users were most likely to be male and White British • Universal education followed by a relative were the most common referral sources • Between 40 and 45% of service users improved after service use in areas such as health and wellbeing, social functioning and quality of life. However, • Many of the projects see very small numbers of young people quarterly, making it difficult to identify trends • Data provided separately for BB/CB	• Good data and split by CB/BB • Good qualitative feedback captured • No annual analysis/compilation of data for trend analysis available as far as commissioner aware (data collection quarterly)

Appendix 5: References

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Bedfordshire Clinical Commissioning Group

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Review of Tier 3 Child and Adolescent Mental Health Services (CAMHS)

1. Introduction, Background, Aim and Review Methodology

Acknowledgement

Bedfordshire Clinical Commissioning Group (BCCG) would like to take the opportunity to thank all those who took part in this process and the time invested to make this happen.

Introduction:

Definitions of the Tiers of Community adolescent mental health services (CAMHS) services can be found below.

Definitions of Tiers of Child and Adolescent Mental Health Services: Tier 1: Social, emotional and developmental support from professionals outside specialist CAMHS, as part of their everyday work that generates resilience and prevents mental health problems (e.g. teachers, social workers, SEN workers, Health visitors, school nurses and GPs). Tier 2: Any specialist CAMHS workers using individual professional skills with children and families (e.g. primary mental health workers, psychologists and counsellors working in community and primary care settings. **Tier 3: Specialist CAMHS workers working in specialist therapeutic teams in community mental health clinics or child psychiatry outpatient service (known as Core CAMHS)** Tier 4: Highly specialist teams working in day and in-patient units providing services to children and young people with the most serious problems (this is commissioned by National Commissioning Board, specialised commissioning team (SCT). The tiers are based on the CAMHS four-tier strategic framework, which was laid out in 1995 Health Administration System (HAS) and is widely used.

NB From 1st April 2013, the responsibility for commissioning tier 4 services lies with the National Commissioning Board, specialised commissioning team.

CAMHS are a comprehensive range of services that provide help, assessment and treatment to children and young people experiencing emotional or behavioural difficulties, or mental health problems, disorders and illnesses. Referral is through professionals such as GPs, social workers and educational psychologists. More details about CAMHS services can be found elsewhere in this report. CAMHS services are described in tiers, and used to explain the nature of the presenting condition and the service received. There are four tiers, tier 1 is described as a universal service for children and young people with low level need – tier 4 is used to describe very specialist services used by a small number of children and young people.

BCCG commission tiers 2 and 3 CAMHS services, local authority's commission services generally at tiers 1 and 2, whilst NHS England is responsible for commissioning specialist services at tier 4.

In order to inform the development of a revised service specification and model of services delivery for tier 3 CAMHS, Bedfordshire Clinical Commissioning Group (BCCG) has undertaken a review of tier 3 CAMHS as currently provided. This report sets out the scope and methodology used to complete the review, and highlights findings and recommendations.

A separate review of Tiers 1 and 2 has been completed by Public Health for both local authority areas. The aim of which was to examine and evaluate the Tier 1 and Tier 2 CAMHS service provision in Bedfordshire and identify information to inform future commissioning of services. This included collecting service providers and local stakeholder's views on local services, gaps and areas for improvement. The review produced a final report and recommendations presented to the Commissioning Officers Group at Bedford Borough Council (BBC) and the Acting Early Group in Central Bedfordshire Council (CBC). A full copy of the findings and recommendations from this review are attached in Appendix 1 and 2 of this report. The BCCG are members of the review project team in each local authority area.

This report of the tier 3 review does not intend to repeat the findings and issues raised within the Public Health Review but considers appropriate recommendations for Tier 3 commissioning and issues to be addressed as part of a potential overall strategy for CAMHS across Bedfordshire.

NATIONAL PERSPECTIVE

Health outcomes matter to patients and the public. The White Paper: 'Liberating the NHS' outlined the Coalition Government's intention to move the NHS away from focusing on process targets to measuring health outcomes. The annual NHS Outcomes Framework reflects the White Paper vision and contains a range of indicators to provide a balanced coverage of NHS activity. Its purpose is to:

- provide a national level overview of how well the NHS is performing;

- provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board for the effective spend of some £95 bn of public money; and
- act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.

LOCAL PERSPECTIVE

Bedfordshire CCG is developing its vision for Children's services. This will be based on an integrated partnership multi-disciplinary approach to all community based services. This work will reflect NHS England's and Operating Framework 14/15 vision of integrated working between health and social care. Children's services both in and outside our hospitals are also being reviewed and a model will be developed to support the vision, which will include the integration of community and hospital services. With this in mind it is expected that CAMHS model will be developed in line with this approach over the coming months and years to ensure a strategic fit within this vision.

Aims:

The aim of the review was to ensure that Bedfordshire Clinical Commissioning Group:-

- Looks at the needs and intervention required to meet the needs of children and young people rather than diagnosis.
- Looks at the current gaps in service and issues within the delivery of Tier 3 CAMHS in Bedfordshire and makes recommendations for improvements which support the tier 1 and 2 pathway.
- Focuses on BCCG responsibilities as the lead commissioners of Tier 3 services.
- Focuses on availability, location, waiting time, flexibility and staffing of the service to children and young people and their family.
- Enables an effective, seamless patient journey through clear pathway/tiers.
- Provides continuous improvement and outcome based service specification, specifying functions which meet the needs of children and young people with a mental health issue in Bedfordshire.

As Commissioners, to deliver outcomes, we need to ensure that these points are embedded within our service specifications, quality/performance monitoring and management arrangements.

Background:

In Bedfordshire, the responsibility for providing tier 3 services is with Bedfordshire Clinical Commissioning Group (BCCG), who has commissioned South Essex

Partnership Trust (SEPT) to deliver these services; working in partnership with local authorities and other providers (who deliver tier 1 & 2). The budget for the tier 3 CAMHS services commissioned by BCCG is approximately £4.1m for 2013/14

The Benchmarking Network data released in November 2013 allows us to compare data and statistics with other CAMHS provided across England. The data produced makes comparisons across a range of indicators per 100,000 population, Bedfordshire has a 0-17 year old population of approximately 100,000.

Through this comparison, we can directly compare the level of funding the local CAMHS services gets with other providers. The tier 3 CAMHS service commissioned in Bedfordshire falls in the top quartile for investment for 0-17yrs for 100,000 population, i.e. Bedfordshire is in the top 25 %

The CGG has made this comparison on tier 3 services only – the national benchmarking data could include tiers 1 and 2 if covered by the same provider. This means that the budget provided to SEPT for tier 3 services per 100,000 could in fact be more in comparison than other areas if they have includes other tiers in their submission.

Therefore at this stage, it is not envisaged that there will be any further financial investment as a result of completing the review, and any changes to services will be met within the resource envelope held.

For 2013/14 SEPT, has been commissioned to deliver 13,233 direct contacts (e.g. face-to-face contact or significant consultation with service users/parent) and 1,045 in-direct contacts (such as consultation with professionals) for tier 3 CAMHS.

SEPT has included an indicative figure of £40,000 savings in the Cost Improvement Plan for 2013/14.

The BCCG currently commission the following Tier 3 services from SEPT with each team/functions having a separate service specification. These teams are as follows:-

Core CAMHS Team (Tier 3 / Specialist CAMHS)

The objective of this service is to address the needs of children, young people their families and carers presenting with moderate to severe mental health problems by:-

- Supporting them to develop problem solving skills.
- Developing parents' and carers' ability to manage existing psychological problems more effectively.
- Enhancing children and young people's coping abilities.
- Having a positive impact on the child or young person's resilience to assist them manage negative stress more effectively.

- Providing evidence based clinical interventions to treat diagnosed Mental Health disorders/illnesses, where appropriate.

The service operates from **9am** to **5pm** and there are three teams based at the **Bedford Borough, South and Mid Bedfordshire.**

Learning Disability Team

The objective of this service is to provide an integrated service to children up to the age of 18 years, who have a learning disability, complex neuropsychiatric needs associated with challenging behavioural problems and moderate to severe mental health problems. The service operates from **9am** to **5 pm** and the team is based in Bedford, but covers Bedfordshire.

Home Treatment Team (HTT)

The objective of this service is to ensure that young people with a high level of mental health needs have access to appropriate and effective treatment and in particular to reduce pressure and increase capacity in the current Tier 3 services to undertake planned work and reducing the number of CAMHS inpatient bed days (Tier 4). It does this by providing a local highly specialist alternative to inpatient service for children and young people up to the age of 18. This includes a focus on:

- Maintaining young people with severe mental health needs safely within their community focusing on a service around the individual and family.
- Providing intensive evidence-based treatment on an outreach basis and an extended service including evenings, weekends and 24 hour on call for crisis resolution.
- Assessing all children and young people who potentially require inpatient admission.
- Facilitating planned early discharge where appropriate.
- Working closely with other services including the Core specialist CAMHS team and education and social care teams using a care pathway approach.
- Ensuring that high intensive treatment and support is as short term as possible with the transfer of services back to the Core specialist services as soon as is medically appropriate.

The service operates from:-

During weekday normal office hours all elements of the service to be available

During weekdays 5pm to 10pm provision of home support and an on call service

During weekends 9am to 10pm provision of home support and on call service

There is 24/7 support via a telephone helpline and adult CR/HT

Tier 2 Services:

In addition, BCCG also commissions Tier 2 services from a range of providers - CHUMS, Relate, Open Door and Sorted. CHUMS are the largest tier 2 provider commissioned by BCCG (they are commissioned to provide interventions to 66 new referrals per month). Further details of all the Tier 2 services commissioned by BCCG along with all commissioned services across both tiers 1 and 2, can be found in the Public Health report on the findings and recommendations of the review of CAMHS Tiers 1 and 2 – at Appendix 1 and 2.

Review Methodology

There has been input from a range of stakeholders to identify issues with current service provision, gaps and areas for improvement. Key steps in the project included:

- An initial scoping meeting with appropriate key stakeholders which included local authorities and SEPT.
- Initial feedback from the Children Young People and Maternity Services Programme Board.
- Summary of information on estimated local need for CAMHS services provided by Public Health.
- Data from service providers including SEPT and CHUMS.
- Consultation meetings with service providers (SEPT and CHUMS), including clinicians, Team and Senior Managers.
- Discussions with local authority senior managers from Bedford Borough and Central Bedfordshire Councils.
- Benchmarking of other reviews of CAMHS undertaken elsewhere.
- NHS Benchmarking network information data, November 2013.
- NICE guidance and recommendations in relation to Tier 3 Mental Health Services Guideline - **Referral, Assessment and coordination of care and Treatment considerations in all settings to include** Psychological therapies used in the treatment of children and young people should be provided by therapists who are also trained child and adolescent mental healthcare professionals.
- Results of a questionnaire circulated to all GPs and Local Authority Social Workers/Children's Services staff. (See Appendix 3)

It is intended that as part of the next phase of the project, service users, parents and carers will be consulted on the finding of this report.

2. Summary of Findings

2.1 Access

Needs of the Bedfordshire population:

Mental Health:-The prevalence estimates for different mental health disorders, broken down by age for Bedfordshire are detailed below. Please note that any child may have more than one disorder. (Source ONS 2001.)

National and Estimated Local Prevalence of Emotional Disorders by Age Bands

Age band (years)	Bedfordshire Population Estimate (2010-11)	National Prevalence in 2004		Estimated local absolute number* (BCCG)	
		Anxiety Disorders	Depressive Disorder	Anxiety Disorders	Depressive Disorders
5-10 yrs old	29500	2.20%	0.20%	649	59
11-16 yrs old	30,680	4.40%	1.40%	1350	429
5-16 yrs old	60,180	3.30%	0.90%	1986	541

National and Estimated Local Prevalence of Conduct Disorders by Age Bands

Age band (years)	Bedfordshire Population Estimate (2010-11)	National Prevalence in 2004	Estimated local absolute number* (Bedford Borough)	Estimated local absolute number* (Central Bedfordshire)	Estimated local absolute number*(BCCG)
5-10 yrs old	29,500	4.90%	549	897	1446
11-16 yrs old	30,680	6.60%	803	1,222	2025
5-16 yrs old	60,180	5.80%	1355	2136	3490

National and Estimated Local Prevalence of Hyperkinetic Disorders by Age Bands

Age band (years)	Bedfordshire Population Estimate (2010-11)	National Prevalence in 2004	Estimated local absolute numbers *

5-10 yrs old	29,500	1.60%	472
11-16 yrs old	30,680	1.40%	429
5-16 yrs old	60,180	1.50%	902

National and Estimated Local Prevalence of Eating Disorders by Age Bands

Age band (years)	National Prevalence in 2004	Estimated local absolute number* (Bedford Borough)	Estimated local absolute number* (Central Bedfordshire)	Estimated local absolute number (BCCG)*
5-10 yrs old	0.30%	34	55	89
11-16 yrs old	0.40%	49	74	123
5-16 yrs old	0.30%	70	110	180

National and Estimated Local Prevalence of Autism Spectrum Disorders by Age Bands

Age band (years)	National Prevalence in 2004	Bedfordshire Population Estimate (2010-2011)	Estimated local absolute number (BCCG)*
5-10 yrs old	1.00%	29500	295
11-16 yrs old	0.80%	30680	245
5-16 yrs old	0.90%	60180	541

National and Estimated Local Prevalence of Psychotic Disorders

Age band (years)	National Prevalence	Bedfordshire Population Estimate (2010-2011)	Estimated local absolute number (BCCG)*
5-18 years	70,460	0.40%	282

Source: National estimate from NICE, applied to local population estimate

Source: Child and Maternity Health Observatory (CHIMAT) Data: Self-harm for 0-17

Year	CHIMAT Self-harm for 0-17 year
2010-2011	154
2011-2012	74

Local Self-harm Data: Numbers of Emergency Admissions for Intentional Self-harm for 10-17 year olds (2008-2011) in BCCG

Year	Intentional Self-harm for 10-17 year olds within BCCG
2008-2009	71
2009-2010	70
2010-2011	100

* Estimates are based on local population numbers (rounded figures). National Estimate from Mental Health of Children and Young People in Great Britain 2004

Source: NHS Bedfordshire (Bedfordshire Clinical Commission Group) Mental Health Assessment

Learning Disabilities: The prevalence estimates for learning disabilities in Bedfordshire are detailed below. Please note that any child may have more than one disorder.

The known prevalence rate of a learning disability as defined above is 3% of children. Of these 0.3% have a severe learning disability, with a high likeliness of complex health needs. There are 700,000 children with disabilities, under the age of 16, in the UK – this data includes children with physical disabilities who do not have a learning disability. (Family Resources Survey, 2002-2003). Of these up to 6,000 children living at home are dependent on assistive technology (including ventilators

Age band (years)	National Prevalence	Bedfordshire Population Estimate	Estimated local absolute number (BCCG)*
0-18 years	3%	120,360	3611

Prevalence of complex health needs in the population of children with learning disabilities is increasing, with an expected increase in levels of severe learning disabilities of about 1% per annum, with an overall increase of 10% by 2020.

Data from SEPT contract management informs us that in April 2012 to March 2013 SEPT received 2568 referrals, 2030 of these were accepted.

Currently there is no data outlining the needs of those receiving SEPT services, or other Tier 2 services which we provide such as the nature of diagnosis or the reasons for receiving CAMHS treatment.

It is anticipated that the future introduction of Payment By Results and the clustering (of needs) processes could be used to identify the number of service users treated, allocating each patient to a classification system and agreeing what should be provided for people in each cluster. This information could be used to help identify the appropriate number of cases within each CAMHS tier.

From data provided by SEPT – Funding for Core CAMHS is £2.583m and the number of contacts per annum for Core CAMHS is 12,440 (2013/14 data).The estimated cost per contact is £208 per contact. However the national average is £220 per contact.

The cost of tier 2 per contact in Bedfordshire is £95.

Eligibility Criteria:

Feedback from SEPT clinicians and senior Managers identified the following as gaps within the current commissioning arrangements. This will need continuous service development and will be included within the new service specification:

- Sexualised behaviour (psychosocial assessments and treatment reducing harm to others and the community).
- Eating disorders (early referrals with up to date record of weight, BMI also indication if weight lost how much and how quickly also any physical investigation and the results thereof etc.).
- Forensic Service (to address the needs of young people who display anti-social, high risk and/or offending behaviour e.g. arson etc.).
- A need for family based interventions and support especially as research indicates that many children with a mental health disorder will also have parents with mental health issues. For example, CHUMS data suggests that 50% of children referred to their emotional health and wellbeing service also have a parent with a mental health issue.
- Paediatric psychology – currently there is only 1 post based at the Luton and Dunstable Hospital. However, it is anticipated that this issue will be picked up as part of the review of paediatric services.
- SEPT(Tier 3) and other Tier 2 providers have also highlighted a rise in the number of complex cases, leading to an increase in-direct work such as liaising with social workers. Although the recent withdrawal of Social worker posts in SEPT (Bedford Borough) may also be a factor in this issue. In April 12 to March 13, there was 2042 in-direct contacts with SEPT (16%) compared to 12440 (84%) direct contacts.
- Moving between tiers - this has been consistently raised as an issue. Feedback from professionals and stakeholders have emphasised that when users do not meet criteria for tier 3 but they need more than 4 sessions, where do they go? There are a significant number of cases referred from tier 3 to tier 2, which indicates that the pathway is not very clear to those referring and those using the services. This is further supported by the recent CAMHS Benchmark data.
- The results of a questionnaire circulated to GPs and Social Workers/Children's Services professionals in both Bedford Borough and Central Bedfordshire Council found that referrals are being rejected as patients do not meet the threshold for Tier 3 services; this was an important issue for professionals.
- From the recent NHS CAMHS benchmarking data it was apparent that there are disproportional national average numbers of medical, clinical psychologist,

operational managers, administrational and support workers compared to other Trust average.

The above information tells us that in order to ensure that the needs of children and young people are met quickly and smoothly we need to redefine the pathway, review the composition and grading of the workforce and possibly reduce the number of teams from 3 to 2, supported by up skilled-staff and administration to take on and support cases with complex needs. There is also a need to integrate the 3 functions in tier 3 into a single service specification, ensuring that services are based on intervention required to meet the needs of individuals and not diagnosis. Discussions with local authorities suggests that there could be better integration of the CAMHS LD team with local authorities and development of a prioritisation model to manage crisis and prevention as well as high cost placements. These would enable evidence based outcomes for young people. The creation of two teams on local authority boundaries will enable this.

Recommendations:

- In order to ensure that this need is met and people receive appropriate referral and treatment, more work was required by all partners (including local authorities) to identify the actual numbers of cases required for commissioning across all CAMHS tiers (1-3) to meet local need.
- Develop a new outcome based single service specification for SEPT based on meeting the needs identified and not diagnosis including parental support, sexualised behaviour, eating disorders, forensic services etc.
- Redefine Tier 3 and ensure seamless service specification between tiers to avoid any gaps.
- SEPT to review and act upon their workforce, skill mix profile and professional training.
- Need to set the contacts/ activities to reflect the spending, ready for the contract variation.
- Reduce the numbers of Core CAMHS teams from three to two to realign with local authority boundaries and integrate CAMH Tier 3 services with provide a seamless service for children and young people which reflects their health and social care needs.

2.2 Patient Journey:

BCCG commission tiers 2 and 3 and Local Authorities have responsibility for commissioning 1 and 2. The tier 1and 2 review was not able to establish how many children and young people fall in tier 1 and 2, therefore we need to look at how many cases are and should be should be within the tiers, and this will need to be done by working with partners, including local authorities and providers.

At present there are many CAMHS providers in tier 2, this can make the journey very complicated resulting in users and professionals making referrals to all services, including Tier 3. Therefore for referrers and for service users we need to ensure that there is a single entry point into CAMHS to allow streamlining, and better co-ordination in the service users journey. This is supported by the findings of the questionnaires circulated to GPs and Social Workers/Children's Services. Common themes identified through the responses were focused on:

- the importance of earlier access to services (such as a reduction in the current waiting times);
- earlier intervention; and
- a joined up approach across all relevant services (health, social work and education/schools) including better communication between agencies at different tiers to meet the mental health needs of children and young people.

It would be beneficial to benchmark service areas looking at a whole tier approach to CAMHS as part of developing a strategic and holistic patient journey and developing pathways with partners to ensure children and young people get the right treatment at the right time. This needs to be embedded into an overall CAMHS strategy for Bedfordshire.

Recommendations:

- Develop a pathway of care across all tiers to ensure coherent patient journey across providers and tiers. This should include Tier 4 specialist commissioning.
- Develop a CAMHS strategy across Bedfordshire.

2.3 Referrals:

Against their commissioned target, SEPT is currently over performing. Data provided by SEPT clearly identifies that the number of referrals accepted is the same as the number of referrals received. Anecdotal evidence (letters from the service to commissioners, findings of tier 3 review and conversations with clinicians) suggests that there are a number of inappropriate referrals to the service (perhaps as much as a third of referrals are more appropriate for tier 1 and tier 2 services).

Anecdotally there is evidence that GPs and other professionals make more than one referral and make inappropriate referrals as there is limited knowledge about the providers with clear criteria about what should be referred under which tier. Across the children's workforce, there is a lack of knowledge about where to refer to and how across different tiers.

Stepping up and down between tiers 2 and 3 has issues too – e.g. between CHUMS and SEPT. There is a need to ensure that people enter the system at the correct tier and therefore get timely appropriate treatment.

These points were supported by the findings of the questionnaire circulated to GPs and Social Workers/Children's Services where a number of challenges to making referrals were raised. This included the lack of a single point of access, absence of clarity and knowledge about referral criteria and services available locally and the high number of rejections received due to the current Tier 3 criteria. However, a small number of respondents also mentioned that the process of making referrals to SEPT had improved or that it was positive or good.

From the national benchmark data it is indicated that over 60% of SEPT services do not use prioritisation criteria. Data from the national benchmarking exercise also highlighted that in 2012/13 SEPT received 2,005 referrals per 100,000 population – and accepted 1,357 of these referrals

Recommendations:

- Develop a Single Point of Access and communicate to users and professionals how it works. Ensure that they can refer in an appropriate manner. It was reported that for a Single Point of Access to operate effectively, the professional would have to be appropriately trained, skilled and knowledgeable.
- There are currently too many CAMHS providers resulting in duplication, and confusion for those entering the system and those referring. Therefore we need to stream line, redefine clear pathways and pool the money for better outcomes and VFM.
- Improve monitoring of rejected referrals including obtaining more consistent data is required from SEPT to understand and monitor these as on-going issues.

2.4 Waiting Times

The results of the questionnaire outlined that the ability of the tier 2 and 3 CAMHS to assess and treat the service user quickly is highly desired by professionals and commissioners.

It was notable that this was not considered to be the case at present, with many respondents highlighting instances of significant waiting times for CAMHS. 73% of

GPs and 69% of Social Workers/Children's Services professionals who responded did not feel that the current waiting time was appropriate with a significant theme throughout the responses on the need to reduce waiting times. However, it was felt by some that there needs to be a flexible response which should be based on need/urgency of the child presenting with mental health problems.

What did become apparent was that the waiting time as indicated by SEPT, is from referral to assessment **but** there is further waiting time from assessment to treatment. On average the waiting time from referral to assessment is 10 weeks and a further 20 weeks from assessment to treatment, which equals 30 weeks.

The BCCG have stated that it is their intention that by 2015, we expect that 100% of children and young people referred to tier 3 CAMHS will be seen and where appropriate treatment started within 6 weeks.

Data from SEPT analysed at the end of quarter 2, 2013/14 indicates that the average length of treatment is 30.5 weeks. However it was apparent that length of treatment varied from team to team, Dunstable averaging 55 weeks compared to North Bedfordshire averaging at 16 weeks.

Recommendations:

- Explore reducing waiting times from referral to assessment and assessment to treatment as part of CQUIN, along with reducing repeat referrals.
- To monitor referral to assessment and assessment to treatment as part of SEPT contract monitoring.
- Clinicians from SEPT should be supported by their organisation to discharge cases back to GPs or back to referees at the end of their treatment, thus creating a throughput and reducing waiting times.
- The length of treatment should be reduced thus allowing new referrals to be assessed, treated and discharged quickly.

2.5 Providing Choice and Flexibility (Location and appointment times):

- Currently, the SEPT Core CAMHS Teams work across three locations, two sites in Bedford and one in Dunstable. SEPT offer some flexibility on where appointments are held e.g. outreach work, and clinics, however, they should build on this further.
- The accessibility of Beech Close site in Dunstable can be a challenge particularly for those coming from Leighton Buzzard as it can be 50 minutes on a bus and children and their families may have weekly or fortnightly sessions. Accessibility increased as an issue for this team when they moved to Beech Close from a more central location in Dunstable. There could be merit in exploring a move to a more central location and/or undertake more outreach work.

- The Mid Bedfordshire team are based in Bedford rather than in Mid Bedfordshire.
- There was a notable difference in responses to our questionnaire, showing that half the respondents wanted different times for both non-urgent assessment and treatment, across the 3 teams in Bedfordshire and half thought that current arrangements were adequate.
- The availability of services outside of working hours would be beneficial for those service users who have to attend school, college, or work during the hours of 9:00am to 5:00pm on weekdays. This was a theme within the responses to the questionnaire circulated to professionals.
- From the GP and Social work questionnaire, when asked *where should the most appropriate location for specialist CAMHS services for non-urgent treatment be?*, the location which received the most votes was for a local and accessible CAMHS unit/clinic. There was also broad support for other locations including GP Practice/Health Centre, School, home and community venue (e.g. local Children's Centre).
- Professionals believed that it should be possible for a level of flexibility to be built into the service, based on the need of the child. This would allow service users to be seen when and where they choose.
- There is a need for consultation with children, young people and their parents/carers on access to services.

Recommendation:

- More outreach work is required based on consultation with children and their families/carers, as well as asking questions at the beginning of their initial assessment about what their needs are in terms of location and timings. This should include exploring options of using alternative venues e.g. GPs surgeries/Health Centre, School, home and community venue (e.g. local Children's Centre) etc.

2.6. Providing a High Quality Service:

- Findings from the questionnaire circulated to professionals highlighted that **SEPT Tier 3 provide a quality service** to the children and young people who meet their criteria.
- **Appointment booking and Did Not Attend (DNA)** – From the current local data, DNA rate for Quarter 2 in 2013 is 13% for the CAMHS Core Team, in comparison with benchmarking average is also 13%. This places us in the top quartile, however the bottom quartile is 9%. Therefore, reducing DNAs (particularly within the Core Teams) would create additional capacity within the current service. More work could be undertaken to benchmark with other areas, the possible use of text messaging reminders etc. it is recommended that SEPT undertake an audit in this area and identify solutions.

- **Case Co-ordinator/communication with children, young people teams** - Feedback from SEPT suggests that there is a need for a case co-ordinator to work alongside therapists to provide consistency and communication. Often extra time is being spent on in-direct work and does not maximise the effective use of resources.
- **Implementation of an IT system** – There is still a great emphasis on paper work and duplication in relation to information gathering, completion of the CAF, and assessment by tiers repeating the same question.
- **Home Treatment Team** – At present the response time is 4 hours from referral to assessment. Often this is too long for children and young people and their families, commissioners may need to consider reducing the response time to 2 hours. The questionnaire for professionals raised the importance of easy access to the crisis support (delivered by the Home Treatment Team) including over a weekend or evening/night.
- **Transitions to adult services** – Some cases are held by clinicians after their 18th birthday. Clinicians inform us that this is due to lack of appropriate treatment or not meeting the adult criteria/ threshold for services. Data provided by SEPT from the Care Plus System in early October 2013 outlined that there were 98 transition cases of 18 year olds plus being held by Core CAMHS, HTT and Looked After Children's Teams. 16 of these cases had no plan to close/or identified transition arrangements. Commissioners need to ensure that SEPT continues to undertake an annual audit of transitions to ensure on-going discharge or transfer to adult services.
- **Workforce to meet present and future needs** -from the recent NHS benchmarking data which is for SEPT CAMHS including Essex and Luton, Workforce makeup/pay band is unclear for Bedfordshire, however it was apparent that there are discrepancies :-

High numbers of the following:

- ✓ Medical staffing on average with other NHS providers is 8.86 fte compared to SEPT which was 11.43 fte
- ✓ Clinical psychologists on average is 11.58fte compared to SEPT 19.92fte
- ✓ Operational Mangers on average 2.6fte compared to SEPT 4.60fte
- ✓ Mental health therapist on average is11.68fte compared to SEPT at 17.69fte

Low numbers of the following:

- ✓ Administration staff on average 19.30fte compared to SEPT 6.56fte
- ✓ Support worker on average at 2.17fte compared to Zero employed by SEPT

- Training of other health, social care, education, patient and carers was on average is 80% compared to 10 % by SEPT

- In general the workforce skill mix in relation to Bandings was limited.

Recommendations:

- Explore the nature of DNA through undertaking an audit and looking at possible ways to reduce these.
- Jointly develop an integrated multidisciplinary working to deliver tiers 1, 2, 3 services.
- Reduce the HTT 4 hour target from referral to assessment to 2 hours in the service specification to ensure easy access to crisis support.
- Explore integrated IT systems to reduce duplication and increase efficiency.
- Ensure that SEPT undertake an annual transitions audit this should include ensuring that post 17 years cases are smoothly discharged or transferred to adults as per transition protocol.
- Review the workforce and realign with CAMHS benchmarking profile, reconfiguration of teams and up skill staff.

3. Service Specification for Tier 3 CAMHS

BCCG currently commission Tier 3 CAMHS services from SEPT with three separate service specifications for each individual team, Core CAMHS, Home Treatment and Learning Disability teams.

To deliver the Government's vision of outcome based commissioning set out the White Paper: Liberating the NHS and the NHS Outcomes Framework, the BCCG need to develop an outcome based service specification which reflects both the NHS Outcomes Framework and the development of outcome measures being developed as part of the implementation of Children and Young Peoples' IAPT. Detailed outcome measures need to be included within the new service specification.

The development of a single specification for the Tier 3 CAMHS service would reduce any potential for silo working and help focus on the delivery of outcomes which commissioners would like the service to deliver. Respondents to the professional questionnaire raised communication between SEPT teams as an issue, which could have an impact on referrals and treatment.

Although BCCG commission Tier 3 services for significant mental health issues, there is anecdotal evidence that referrals are made to both tier 3 and tier 2 providers (such as CHUMS, Relate) simultaneously to ensure quick and timely access into assessment and treatment. Therefore there may be double counting.

An amended draft service specification will incorporate the relevant recommendations from this review with clear outcomes.

The recommendations below are combination of recommendations from tier 1, 2 and 3 reviews. This will help us to develop the seamless and robust CAMHS Strategy.

Recommendations for the CAMHS Service.	*Tiers*
1. Develop a pathway for child and adolescent mental health services, with a single referral route where appropriate (e.g. through the early help CAF service) – for all tiers.	All
2. There are too many providers and it is confusing for the child and their family to move through the system. Need to consider pooling the budget together, streamline the pathway and reducing duplication in the services.	All
3. Develop a standard template to be used for monitoring/evaluation of child mental health and wellbeing services to include information about outcomes, quality, client feedback and breaking down service user information by local authority area.	All
4. Raise awareness of existing Tier 1 and 2 child mental health and wellbeing services locally.	All
5. Develop an emotional health and wellbeing (CAMHS) strategy for Bedfordshire, to be reported to the Children's Partnership Board and CYP and maternity services programme board.	All
6. Develop a pathway of care across all tiers – coherent patient journey across providers and tiers. This should include Tier 4 specialist commissioning.	All
7. In order to ensure that this need is met and people receive appropriate referral and treatment, more work was required by all partners (including local authorities) to identify the numbers contacts required for commissioning across all CAMHS tiers (1-3) to meet local need.	All
8. Develop a new outcome based single service specification for SEPT Tier 3 service based on meeting the needs identified and not diagnosis including parental support, sexualised behaviour, eating disorders, forensic services etc.	3
9. Redefine/Redesign Tier 3 and ensure seamless service specification between tiers to avoid any gaps.	2&3
10. Need to set the contacts/ activities to reflect the spending, ready for the contract variation.	3
11. Ensure that GPs can refer in an appropriate manner, it was reported that for a Single Point of Access to operate effectively, the staff would have to be appropriately trained, skilled and knowledgeable.	All
12. Improve monitoring of rejected referrals.	2 & 3
13. Monitor the referral to assessment and the assessment to treatment and repeat referrals as part of contract monitoring	2&3
14. Explore monitoring and reduce waiting times from referral to assessment and assessment to treatment as part of CQUIN.	2&3
15. Clinicians should be support by the organisation to reduce length of treatment and discharge cases back to GPs or back to referrals at the end of their treatment, thus creating a throughput and reducing waiting time.	3
16. More outreach work based on consultation with children, as well as asking question at the beginning of their initial assessment about what	2&3

their needs are in terms of location and timings– explore options of using alternative venues e.g. GPs surgeries, Library etc.	
17. Explore nature of DNA through undertaking an audit and looking at possible ways to reduce these.	2&3
18. Reduce the HTT[1] 4 hour target from referral to assessment to 2 hours in the service specification.	3
19. Jointly develop an integrated multidisciplinary working to deliver tiers 1,2,3	All
20. Explore integrated IT system to reduce duplication and increase efficiency.	All
21. Ensure that SEPT undertake an annual transitions audit this should include ensuring that post 18 years cases are smoothly discharged or transferred to adults as per transition protocol.	3
22. Further work needed in relation to capacity, effectiveness of the tier 3 workforce and around a need to up-skill staff to meet the new challenging demands.	3
23. Reduce the number of Core CAMHS team (Tier 3) from three to two to ensure better consistency and throughput. This will realign CAMHS Tier 3 services with local authority boundaries to provide an integrated and seamless service for children and young people which reflects their health and social care needs.	3

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Meeting: **Social Care, Health and Housing Overview and Scrutiny Committee**

Date: **7 April 2014**

Subject: Tenant's Scrutiny Panel

Report of: **Cllr Mrs Carole Hegley, Executive Member for Social Care Health and Housing**

Summary: The report proposes the adoption of a Tenant's Scrutiny Panel investigation on improving the way Anti Social Behaviour is dealt with for the Council's Landlord Service as identified through their role in co regulation.

Advising Officer: Julie Ogley, Director of Social Care, Health and Housing

Contact Officer: Carol Rooker, Head of Housing Management

Public/Exempt: Public

Wards Affected: South of Central Bedfordshire

Function of: Council

CORPORATE IMPLICATIONS

Council Priorities:

1. As a landlord, the Council is responsible for providing good quality homes and services to the Council's tenants. Many of these tenants are vulnerable. Tenant scrutiny provides a means of ensuring that the Council has sound financial and service management and this will contribute to the Council providing value for money, and enabling the Council to successfully deliver its priorities.

Financial:

2. The costs involved in developing and supporting the Tenant's Scrutiny Panel can be covered within the existing Landlord Service Business Plan.

Legal:

3. The Council, as part of the new revised regulatory framework for social housing providers, is expected to give tenants a wide range of opportunities to influence, and be involved, in the following areas:
   - Formulating their landlord's housing related policies and priorities
   - Making decisions about how housing related services are delivered, including setting service standards
   - Scrutinising their landlord's performance and recommending how performance might be improved

   The Tenant's Scrutiny Panel provides the formal scrutiny role for tenants, who will, if necessary, hold the Council to account for any concerns they have with the services that they receive.

Risk Management:

4. There is a reputational risk to the Council if there are inadequate arrangements in place to ensure that tenants are supported in being able to hold the Council as their landlord to account.

   There is also a risk of intervention by the Homes and Communities Agency (Regulation Committee) if they consider that the Council is not complying with the regulatory arrangements, in terms of co-regulation.

   There is a governance risk of the Panel failing to act in the best interests of the tenants and community. The above risks have been mitigated by the introduction of clear terms of reference and a robust Code of Conduct for the Tenants Scrutiny Panel and this mechanism for reporting the Panel's findings back to the Overview and Scrutiny Committee.

Staffing (including Trades Unions):

5. Not Applicable.

Equalities/Human Rights:

6. The Council, as a public body, must act to eliminate unlawful discrimination, victimization and harassment against people on the grounds of race, religion or belief, age, sex, pregnancy and maternity, gender reassignment, sexual orientation and disability. Further, the duty requires the Council to advance equality of opportunity between different groups, and foster good relationships between different groups.

   The National Standard for Housing Providers on Tenant Involvement and Empowerment – requires that the Council understands and responds to the diverse needs of tenants. The new Tenants Scrutiny Panel assists in progress on meeting this aim.

Public Health

7. Good quality housing and services have a positive impact on public health and well being.

Community Safety:

8. Not Applicable.

Sustainability:

9. Not Applicable.

Procurement:

10. Not applicable.

RECOMMENDATION(S):

The Committee is asked to:-

1. **The Committee is asked consider the recommendations detailed in the report and where applicable to the Council, and recommend that they be implemented at the earliest opportunity and within the timescales outlined in the Tenant's Scrutiny Panel report on Anti Social Behaviour.**

2. That the Tenant's Scrutiny Panel be invited to monitor the implementation of the recommendations and report to the Overview and Scrutiny Committee in the future, on an exception basis, any recommendations not appropriately implemented within the timescales outlined in the report.

Background

1. Members will recall that as part of the Government's revised regulatory framework for social housing, housing providers are expected to support tenants in enabling them to monitor and shape the housing services that are provided, and to hold their landlords to account.

2. As part of this requirement for co-regulation, the Council's tenants, following consultation, agreed to set up a formal Tenants Scrutiny Panel, which was formed in 2013, and has now completed its first enquiry into the way that the Landlord Service deals and responds to complaints about anti social behaviour.

3. The initial report of the Tenant's Scrutiny Panel was prepared by four members of the panel. See Appendix A – The Tenant's Scrutiny Panel Report on Anti Social Behaviour, and please see Appendix B the Tenant's Scrutiny Panel's action plan.

Presentation

1. The Tenant's Scrutiny Panel has prepared a presentation to showcase the report, its recommendations and the Action Plan which has been produced.

   The second part of the presentation has been produced by the Landlord Service in response, to identify the actions it will take to implement the recommendations, and the learning from this first report.

   Appendix C – The Tenants Scrutiny Panel Presentation on Anti Social Behaviour, and the Landlord Services response.

Appendices:
Appendix A – The Tenant's Scrutiny Panel Report on Anti Social Behaviour
Appendix B – The Tenant's Scrutiny Panel Action Plan on Anti Social Behaviour
Appendix C – The Tenants Scrutiny Panel Presentation on Anti Social Behaviour.

Background papers and their location: (open to public inspection)
Tenant's Scrutiny Panel and Designated Persons and Tenant's Complaints Panel from Social Care, Health and Housing Overview and Scrutiny Committee 21 January 2013.

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Appendix A

Central Bedfordshire Council

Tenant Scrutiny Panel

Final Report

Anti-Social Behaviour

Contact Details: Julie Harnett, TSP Chair,

c/o Brett Douglas Tenant Involvement Manager

Executive Summary

This report was undertaken for the Housing Service at Central Bedfordshire Council (CBC) to examine why the target of resolving Anti-Social Behaviour (ASB) cases within 28 days is not being achieved, and to recommend long term sustainable solutions.

As a result, this report covers all aspects of the ASB service including how to access and report ASB, as well as how CBC responds and then deals with it.

On scrutinising ASB service we found that the way that workload is split between CBC management and staff is good as shown by the division of case load based on officers capacity. However, we found the system does not work when key members of the team are on leave.

There is a positive relationship between CBC and its partners. Partners told us they undertake joint visits and share information when dealing with cases. Partners were complimentary about the skill and ability of CBC staff that deal with ASB.

More systematic communication between staff, partners and victims is needed when responding to ASB, including when contacting ASB victims whether by phone or letter which appears to be inconsistent. In particular some tenants advised that CBC failed to respond to telephone messages.

It was difficult to draw any conclusions about whether the ASB service provides value for money as performance and satisfaction information is not collected and reported in a way that enables it to be analysed against costs.

We have made a number of recommendations. Some of these include that CBC should work with its tenants to review its customer facing information about how to report ASB. Another is that when staff receive reports of ASB cases that more priority should be given to assessing vulnerability and where the vulnerable are identified that these victims are given the correct priority.

1. Introduction

1.1 The TSP was set up in March 2013, recruited by Central Bedfordshire Council, following work completed by an independently facilitated Tenant Scrutiny Steering Group made up of involved tenants, staff and elected Members. Our main role is to scrutinise the council to ensure that they run their services and procedures to their own standards. The panel currently consists of four members: Julie (Chair), Mal, Maggie and Ron.

1.2 Our first project was to undertake a review of the ASB service. We decided this would be our first project by looking at the Key Performance Indicators (KPIs). By studying the data from the KPIs, we were able to see that the target in relation to resolving all ASB cases within 28 days was not being met.

1.3 The first thing we decided to do was to read the ASB procedure to try and find out what their standards are, as well as to check for any flaws in the procedure, therefore allowing us to make recommendations. We had interviews with senior management and we also had focus groups with tenants, staff and partners. We also did some mystery shopping, bench marking and reviewed some current cases. All of these activities enabled us to finish the report and make our final recommendations.

2. Methodology

2.1 The scrutiny project was undertaken using the following methodology:

- Document review, including the ASB Housing Services Procedure Manual
- A series of interviews were held with housing staff responsible for dealing with ASB, and managing relevant staff
- Three focus groups; with frontline staff, with customers that had experienced ASB and with partners of the housing service.
- Telephone calls to customers that had experienced ASB.
- Examining case files.
- Analysing benchmarking information and other data.

3. Findings

3.1 Access to the service

3.1.1 There is a lack of information about the ASB service available to customers. We checked in CBC reception, some other places where it would be reasonable to expect to find information and could not find any information such as leaflets. Staff that we met were unclear about the location of information leaflets and could not state with certainty where they could be found. Failing to provide information in a variety of places could mean that people experiencing ASB may not know how to report it.

3.1.2 ASB Service Standards are not well-promoted. Tenants that we met who had reported ASB had no knowledge of the ASB Service Standards, and so had no understanding of what service to expect and how to hold CBC to account if it failed to meet the stated level of service. Failing to promote effectively the Service Standards also increases the risk of tenants having unrealistic expectations of what CBC can, and can't, do to resolve ASB.

3.1.3 CBC has stated that there are a number of ways to report ASB; in person, by phone, by email and through an online reporting system. However, contact information about how to report ASB is in reality not easy to find. Tenants that we met said that they found it hard to obtain the phone numbers of the relevant staff and had resorted to using e mail. This means that residents without access to email may find it hard to report ASB and will therefore be less likely to do so.

3.1.4 It is not easy to report ASB outside of office hours. A mystery shopping exercise was undertaken using the following phone numbers: Police Service Neighbourhood

team – 01234 841212; Community Safety Team – 0300 300 8302 / 8098; Well Being Lifeline – 0800 0740263. Results were disappointing and it was found that most calls made were not answered, and for those that were answered staff were either unable to give effective advice or to make contact with an on duty specialist member of staff. This means that some instances of ASB go un-recorded, some tenants may be unable to obtain appropriate advice and incidents of ASB will be unresolved.

3.2 Response to first reports of ASB

3.2.1 While the ASB Procedure Manual is comprehensive, the section 'receiving a complaint' does not set out clear instructions to staff about assessing the seriousness of the case, or vulnerability of the person making the complaint. In addition there are no set timescales within which the Tenancy Management Officer (TMO) must respond, although we understand that a response within 48 hours is usual (this contradicts the ASB service standards which state that reports of ASB will be acknowledged within 1 working day). This means that serious cases or cases involving vulnerable people may not be given a high priority.

3.2.2 Reports of ASB are not responded to in a consistent manner. Tenants that we met had experienced an inconsistent service when reporting ASB, this included CBC failing to respond to telephone messages left and different approaches to keeping complainants informed.

3.2.3 Not all members of staff undertake vulnerability risk assessments when reports of ASB are made. For example, during the out of hours mystery shopping exercise the only member of staff responding to the one call answered did not ask whether the caller had any needs that may have made them vulnerable. Failing to ask relevant questions of people reporting ASB could mean that the situation could become volatile.

3.3 Dealing with ASB

3.3.1 There is no real or clear definition in the procedure between ASB and nuisance, for both staff and tenants/residents alike. Staff have told us that CBC tends to deal more with nuisance, but the procedure takes the same approach regardless of the type of complaint. This means that CBC is missing an opportunity to look for different solutions to different types of problems.

3.3.2 The procedure does not make it clear how the workload is split between the Estate Management Officers (EMOs) and the Tenancy Enforcement Officer (TEO). The TEO

is responsible for more serious cases but it is not clear at what point cases are referred on. This means that staff may not be clear where their own responsibility lies.

3.3.3 The procedure does not place sufficient emphasis on acting quickly when cases are urgent and it is not clear who takes responsibility for identifying whether a case is urgent and what timescales should be kept to. This means that victims may be put at risk.

3.3.4 The procedure includes various solutions to resolving ASB, including restorative justice, parenting contracts, written and verbal warnings and abatement notices but it does not include clear instructions and advice for staff on how to use these solutions. As a result it is not clear whether for example, restorative justice or community payback schemes have been regularly used, despite it being made clear in the procedure that these are usually very effective solutions even when ASB is first reported.

3.3.5 Victims of ASB are not regularly kept informed of the progress of their case, and although the procedure does require staff to do this, it relies heavily on letters and does not specify that staff must agree acceptable timescales to provide updates with the victim. As a result, victims that we met reported that they had to chase staff for information. This makes victims feel frustrated and extremely isolated.

3.3.6 Not all aspects of the procedure are being followed. The procedure includes guidance to staff on the use of diary sheets as way of collecting evidence. Victims that we met reported that although they had completed diary sheets, the sheets were not collected and did not seem to be required; and staff did not provide ongoing support and guidance in relation to the completion of the diary sheets. This means that victims may not feel it is worth completing the diary sheets which may affect the quality of evidence.

3.3.7 It does not appear that staff routinely complete the case management file pro forma. The pro forma prompts staff to ask relevant questions and to make a record of the responses, as well as setting out what action has been agreed with the victim. Tenants that we met could not recall having been asked questions from the pro forma and had not seen or signed an action plan. This contributes to some tenants feeling that they didn't know what was happening to resolve their case.

3.3.8 The procedure does not encourage staff to provide a responsive service. Tenants that we met felt that CBC was not proactive in resolving cases and as a result the ASB had persisted for unacceptable periods of time. In one instance, CBC had told

the victim that the ASB pre-dated her tenancy and had existed for 12 years. This approach has resulted in victims having to repeatedly contact CBC, and its partners including the local MP, to achieve some level of improvement.

3.3.9 The procedure does not include any reference to working with the community to resolve ASB. Tenants are unaware of any community or diversionary activities that CBC participates in. Neither are they aware of any Good Neighbour Agreements (GNAs) – with one tenant that we met suggesting that such a scheme would be beneficial in agreeing local behaviour standards. This could affect the likelihood of achieving a sustainable solution and such agreements could encourage the community to come forward when experiencing ASB which will assist CBC in understanding issues on its estates.

3.3.10 It is not clear what diversionary activities CBC uses to prevent or reduce ASB, as some partners that we met were not able to describe how they had been involved or what activities had taken place.

3.3.11 CBC and its partners work together to respond to ASB in hotspot areas that are identified by the police through collecting and analysing data received from residents.

3.3.12 Partners that we met had not been involved in the development of CBC's ASB procedure or policy, some of them also stated that they were unaware of the procedure but knew about CBC's methods used to prevent ASB and that an appropriate approach to enforcement is taken.

3.3.13 Exchange of some information between CBC and some partners may need to be revisited to ensure that it is wholly appropriate and necessary. Information sharing should be limited to any potential breach of tenancy.

3.3.14 There is a positive relationship between CBC and its partners. The partners that we met spoke very highly of CBC and felt linked in, invited and involved. They referred to undertaking joint visits and sharing information and making clear plans through partnership meetings to identify the right partner to support victims. They felt that CBC was willing to work together, come up with ideas, always positive, open and supportive as well as taking in to account the needs of the individual.

3.4 Staff

3.4.1 The division of cases between the EMOs is working to support their capacity. ASB cases are dealt with on a patch basis where each EMO is responsible for the same number of properties in a geographical area. Workload is monitored by the manager to understand how many cases each has. If one area becomes overloaded then the workload would be redistributed; this hasn't happened yet.

3.4.2 Staff are adequately kept up-to-date with new issues, for example the ASB Bill, new Tools and Powers and the Community Harm Statement. Regulatory updates come from The Social Landlords Crime and Nuisance Group (SLCNG) by email, through attendance at conferences and workshops; with further advice provided by the internal CBC legal team.

3.4.3 Staff find that training is easy to access. Staff that we met reported that they had undergone many training courses and were able to confirm that funding is sufficient to allow for this. Courses attended include seminars and conferences, as well as free briefing sessions on the ASB Bill.

3.4.4 However, staff training needs are not assessed sufficiently to be sure that their needs are being met. Training is identified through feedback from staff dealing with ASB and ideas from the manager. In addition, training undertaken is not assessed for impact and whether it has improved the service.

3.4.5 Staff training is not as effective as it could be in terms of assisting staff when there are long term absences. We came to this conclusion though talking to staff and found that when a key member of the team is on leave for a long time the system does not work as well. We also had a look at some cases which supported our findings. This means that the system is under more pressure when there is long term absence and by giving staff more training there will be more flexibility so members of staff can cover each other when there are staff on leave for a long time.

3.4.6 IT systems are not fully supporting staff to carry out their roles. At present the main IT system – QL – acts as a receptacle for all ASB data, which is not ideal as this cannot track costs of action or flag up required actions, for example. Consideration is currently being given to working more closely with the Police and use a shared system to more quickly exchange data and up to date information.

3.4.7 The effectiveness of partnership working has been affected by some of CBC partners finding it difficult to keep up with staff changes at CBC and in particular the long term absence of some staff.

3.5 Tenant involvement

3.5.1 Tenants were involved in agreeing the ASB procedure. The Way Forward Panel was invited to approve it, as well as a small independent group of residents who reviewed it.

3.5.2 Tenant involvement has not continued as a way of monitoring performance of the service and obtaining useful feedback. Tenants are also not included in any of the partnerships. This means that the service may not be as responsive as it could be.

3.6 Satisfaction with the ASB service

3.6.1 CBC has acknowledged that it has not been successful in understanding satisfaction with its ASB service. This is because it has relied on written surveys being returned by victims and it has not taken the opportunity yet to explore other options. Without customer feedback, CBC cannot be sure that it is providing the right service.

3.7 Performance

3.7.1 Although CBC had, prior to this project, already identified that it wished to review the ASB service, it had not taken advantage of the Respect Standard (now replaced by Charter) to carry out a gap analysis. This means that it has missed a valuable opportunity to improve and update the service in line with the Charter and good practice and as a result tenants have not had access to the best service available.

3.7.2 The target of resolving cases in 28 days is not realistic and does not help staff to do their job effectively. The types of ASB cases reported to CBC Housing Department vary from low level neighbourhood nuisance to long standing serious cases involving threats of, and actual, violence. Tenants we met cited cases that had been on-going for months, even years, without satisfactory resolution. Staff that we met also stated that they felt that the 28 day target is not appropriate for all cases, especially multi-agency cases. Giving examples of cases being closed due to the target and subsequently being re-opened as a sustainable solution had not been found. Our review of cases files supported this. Staff interview evidence suggested that the indicator was not based on good practice or guidance and it is unclear why this target was chosen, especially when annual benchmarking results from

HouseMark show that on average, cases nationally are resolved after 75 days. The impact of stating that cases will be resolved in 28 days raises the expectations of the victim when in reality it sometimes cannot be achieved.

3.7.3 The procedure sets out clear guidelines for how the performance of staff should be monitored. However, with the long term absence of the TEO it is clear that these guidelines have not been kept to. This means that victims of ASB may not be receiving the service that they require, and that staff may be experiencing lack of support.

3.7.4 We already know CBC is not meeting its own performance target of resolving cases within 28 days, but we were unable to draw any other conclusions about other aspects of its performance as these are not reported, including performance against ASB service standards.

3.7.5 Not all partnerships are governed by Service Level Agreements (SLAs). This means that there can be misunderstandings and differing expectations around roles, responsibilities and timescales which may impact on performance.

3.7.6 There is an over reliance on using complaints and satisfaction data to understand whether the team is performing, and less attention to spot checks on cases undertaken by the manager. This is not effective as insufficient satisfaction data is being received and it is not clear how many complaints have been received about the service.

3.8 Value for money

3.8.1 It has been difficult to draw any value for money conclusions as CBC does not routinely collect satisfaction data, although it does have information about costs and performance. Benchmarking information relating to cost that was made available was from 2009/10 and 2010/11 (CBC is currently working to submit more recent data) and so it is not based on current circumstances. However the information showed that staffing costs had decreased over that period, which was not in line with CBC's peer group which showed an increase (and CBC could not explain why this had happened) and it also showed that the number of employees per 1,000 properties was higher than peers.

3.8.2 Although staff that we met could not identify any value for money examples, there was a clear emphasis on being encouraged to consider costs when deciding on solutions. However, without staff understanding the concept of VFM, this could

mean that staff always choose what they think is the least expensive option which may not be the most effective.

4. Conclusion

4.1 We have been able to undertake an in-depth investigation on CBCs' behalf. As the newly formed TSP, we hope that you find all our research and information of great importance to CBC, along with providing you with a very useful analysis of the ASB service that you otherwise would have had to undertake yourselves.

4.2 We hope that our recommendations will be accepted and implemented within our suggested timescales, as we would like to see CBC excel in the way it delivers this service; using a creative approach and to be innovative, especially given the pressure on resources and changing expectations of customers.

4.3 We would like to thank everyone who took part, Brett Douglas for all his organisational skills enabling us to take part in a very steep learning curve, supported by our external mentor Anna O'Halloran. Carol Rooker and Richard Farrow for taking time out of their busy schedule, along with the staff who attended our focus group, the customers willing to take part who had experienced ASB and all the partner agencies that provide invaluable support to the whole of CBCs' Housing Team.

5. Recommendations

Number	Recommendation	Priority	Timescale
1	CBC should work with its tenants to review its customer facing information about how to report ASB so that it is easy to find and encourages reports of ASB.	High	6 months
2	CBC should work with customers to take steps to ensure that the ASB Service Standards are well promoted using methods that customers use.	Medium	3 months
3	An effective system to report ASB outside of office hours should be made available, with clear guidance for staff operating the service as well as clear information for customers needing to use it, and that is easy to access.	Low	4 months
4	Ensure that serious cases or those involving vulnerable people are given the correct priority through proper assessment of the situation when the complaint is first made. Issue guidance to staff receiving first complaints including timescales, and monitor that these timescales are being kept to. Work with customers to agree target timescales.	High	1 month
5	When reviewing the procedure ensure that it clearly states how urgent cases must be identified and managed, with clear timescales that staff can be held accountable to and that are used to reassure victims.	High	6 months
6	Take steps to more effectively monitor and report staff compliance with the procedure and ASB service standards to ensure that a consistent service is being offered and tenants know what to expect.	High	3 months
7	Work with all staff to raise the importance of undertaking risk assessments each time a report of ASB is made and that the procedure is being complied with.	High	Immediately
8	Ensure that staff are aware of, and use, the variety of solutions available to resolve ASB through providing a comprehensive procedure, effective monitoring and training.	High	12 months
9	Work with customers, using best practice and learning from others to develop appropriate procedures for dealing with nuisance. Take steps to more clearly define the difference between ASB and nuisance, to assist staff and customers understand the different solutions.	Medium	6 months

10	Involve partners in the development of all new policies and procedures to ensure that all activities are coordinated, reduce the likelihood of duplication and that all targets are reasonable and agreed	Medium	6 months
11	CBC needs to issue clear guidance for staff to ensure that roles within the team are understood – particularly the difference responsibilities held by the EMO and the TEO.	Medium	6 months
12	Improve communication with victims through agreeing frequency and method of contact during the action planning process, ensure that staff compliance with this is recorded on the case file and the CRM and monitored by the manager.	Medium	Immediately
13	Provide staff with training and guidance on the use of diary sheets to ensure that they are only issued in appropriate circumstances and that victims feel supported to complete them. Offer alternative methods of collecting evidence to victims – such as tape recorders and cameras.	Medium	3 months
14	CBC should ensure that it takes all necessary action to ensure that it is creative in achieving long term sustainable solutions to ASB. To help it do this it needs to analyse the different potential solutions available to it and understand what's most likely to work through learning from others and previous cases, as well it being clear in the procedure about how to escalate cases to either senior or expert staff.	Medium	6 months
15	CBC should revise the procedure with partners to include information about diversionary activities as a potential solution to ASB and it should also consider working with tenants to resolve issues in the local area, for example by signing a Good Neighbour Agreement (GNA). CBC should work with residents to agree the best methods of publicising this.	Low	6 months
16	Work with tenants to develop a way that tenants can regularly be involved in the service to shape, monitor and provide feedback.	High	3 months
17	Training needs of staff should be individually assessed using a training needs analysis (or similar) against the needs of the service to ensure there are no gaps in knowledge. The impact of training should be assessed as well to ensure that the training is of a high quality.	Low	3 months

18	CBC should ensure that the team is able to operate properly at all times, even when there are long term absences, by training staff on all aspects of the role and taking steps to ensure that long term absences are filled, particularly in key posts.	High	6 months
19	Using best practice and learning from other organisations generally, take steps to set up a successful method of achieving satisfaction data.	High	4 months
20	Set a clear deadline for finalising the work with the Police to explore the likely effectiveness of Safety Net, or another system, and implement within a clear timeframe.	Medium	6 months
21	CBC should review its ASB performance indicators; including consulting with a diverse group of residents, learning from best practice and from high performing peers. Challenging and achievable targets will assist victims of ASB to understand what to expect, as well as leading to service improvements and support a victim centred approach.	High	6 months
22	CBC should put in to place more effective ways to monitor service delivery. The procedure sets out the current system – but it is clear that this is not being kept to. CBC should learn from best practice how high performing organisations monitor casework.	High	1 month
23	CBC should work with regular partners to review the success of those partnerships and decide whether implementing SLAs would improve accountability and performance.	Medium	12 months
24	Take steps to record, understand and analyse the true cost of the ASB service, including the costs of particular solutions (for example the cost of home visits, letters, warnings, legal action, partner interactions etc.) and use this information, along with satisfaction and performance data to be sure that VFM solutions are being used to their full potential.	High	12 months
25	CBC should regularly assess its ASB service, including the procedure and policy against the Respect Charter, and good practice widely available, to ensure that its tenants are provided with an excellent service.	High	12 months
26	Increase staff awareness of VFM through regular training and awareness-raising sessions, for example at team meetings and 121s.	High	1 month

27	Continue to provide current data to HouseMark to ensure that any decisions made relating to VFM are based on recent information. Take steps to analyse satisfaction and performance against costs to draw VFM conclusions about the service and use the conclusions to inform service development.	High	12 months
28	Keep partners up to date with staff changes to ensure that they are aware of who does what and to ensure that handovers happen where ever possible when staff leave.	High	Immediately

6. Appendices

6.1 Partners that attended the focus group:

- Bromford Support
- Luton Mediation Service
- Domestic Abuse Coordinator
- Bedfordshire Police

6.2 Staff interviews:

- Carol Rooker
- Richard Farrow

6.3 Staff Focus Group:
(Housing Management plus Community Safety)

6.4 Documents examined:

- Housing Services Scorecard @ December 2012
- HouseMark benchmarking data
- ASB Procedure Manual
- ASB Information Pack
- Information leaflets
- Staff job descriptions

Appendix B

Task No	Task / recommendation	Outputs / evidence	Resources	Start Date	Target Date	Actual Completion Date	Outcome	Progress to date (RAG)	Status (started / completed)	Narrative (if R or A)
1	Review Customer facing information	Information accessible via web and leaflets	Front line staff/Resident input	Mar-14	Apr-14		Improved Customer Experience		Not started	This will be part of the new SEO's responsibility to lead on
2	Ensure ASB standards are well promoted and accessible for customers	Procedure to be put on website and leaflets distributed to varied locations		Nov-13	Apr-14		Improved access for residents to information on ASB	A	Started	EMO Team have been asked to produce an advice leaflet by end of Feb 14 for approval.
3	System to report ASB out of hours	Information readily available on how to report ASB out of hours	Resident Involvement Team/Communications	Nov-13	Mar-14		Improved information for residents	A	Started	Information will be part of leaflet produced at point 2.
4	Ensure all cases are correctly risk assessed and prioritised accordingly and monitored. Agree timescales with residents for serious cases	Risk assessments and action plans are documented in case files and on QL system	Staff	Nov-13	Feb-14		Improved Customer Experience	G	Completed	HEM has carried out recent reviews of cases where risk assessments have been evidenced.
5	When reviewing the procedure ensure that it clearly states how urgent cases must be identified and managed, with clear timescales	New procedure clearly defining process for identifying urgent cases and timescales for dealing with the case	Staff/Resident Input to procedure review	Apr-14	Apr-15		Up to date procedures with defined processes and timescales		Not started	The ASB procedure is to be reviewed in 2014 taking into account the corporate and government guidance plus the new powers that will be available later in 2014.
6	Take steps to more effectively monitor and report staff compliance with the procedure and ASB service standards	The new Estates Management Team Leader will monitor via 121 meetings and document these accordingly	EMTL/EMO	Mar-14	Oct-14		Improved performance data	A	Started	1-1s meetings already take place with individual.
7	Work with all staff to raise the importance of undertaking risk assessments	Risk assessments and action plans are documented in case files and on QL system	EMTL/EMO	Nov-13	Feb-14		Improved case prioritisation	G	Completed	staff have been reminded of the use of Risk Assessments at the first contact stage to correctly prioritise each case at 1-2-1's.

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8	Ensure that staff are trained in the variety of solutions available to resolve ASB	Learning & Development plans in place for staff that deal with ASB/Nuisance	EMTL/HEM	Nov-13	Sep-14		Better trained staff and consistent case management	A	Started	A training plan will be developed for each member of the team following the restructure.
9	Work with customers to develop appropriate procedures for dealing with nuisance. Clearly define the difference between ASB and nuisance	Nuisance procedure developed with staff and residents	Residents/Staff	Apr-14	Nov-14				Not Started	Nuisance procedures will be written alongside the ASB procedures when reviewed.
10	Involve partners in the development of all new policies and procedures	Partnership involvement	Partners/Staff	Apr-14	Oct-14		New Procedure		Not Started	Partners will be fully involved in the review of ASB and Nuisance procedures.
11	CBC needs to issue clear uidance for staff to ensure that roles within the team are understood – particularly the different responsibilities held by the EMO and the TEO	Restructure implemented and communicated to relevant partners any changes	HEM/HOHM	Mar-14	May-14		Clear structure and roles understood	G	Started	Under the restructure the TEO position has been deleted and a new Team Leader will take responsibility for leading on ASB issues.
12	Improve communication with victims through agreeing frequency and method of contact during the action planning process and monitored by the manager	Risk assessments and action plans are documented in case files and on QL system	EMTL/EMO	Nov-13	Feb-14		Clear action plans that have been agreed with victims of ASB	A	Started	Staff have been reminded of the importance of the involvement and agreement of victims in the action plan and that agreement is made with the victim about regularity and method of feedback and updates.

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13	Provide staff with training and guidance on the use of diary sheets to ensure that they are only issued in appropriate circumstances and that victims feel supported to complete them. Offer alternative methods of collecting evidence to victims – such as tape recorders and cameras	Diary sheets are given to all victims of nuisance/ASB to record incidents and log persistency of incidents	EMO	Nov-13	Nov-14		Improved Customer Experience	G	Completed	Options such as tape recorders and cameras for use by residents are not as yet available and research needs to be undertaken to establish the validity of such evidence in court.
14	CBC should ensure that it takes all necessary action to ensure that it is creative in achieving long term sustainable solutions to ASB	Risk assessments and action plans are documented in case files and on QL system	EMTL/EMO	Mar-14	Sep-14		Tenancies are sustained and court action avoided where possible	A	Started	I believe that the procedure is clear in this respect, but that training for staff is needed to ensure they understand the procedures.
15	CBC should revise the procedure with partners to include information about diversionary activities as a potential solution to ASB and it should also consider working with tenants to resolve issues in the local area, for example by signing a GNA	Learning & Development plans in place for staff that deal with ASB/Nuisance		Mar-14	Sep-14		Tenancies are sustained and court action avoided where possible	A	Started	Officers are aware of and consider all options available to them to resolve any case, with the emphasis being on avoiding legal action if possible. Further training will reiterate this approach.
16	Work with tenants to develop a way that tenants can regularly be involved in the service to shape, monitor and provide feedback	Improved customer contact and feedback regarding the service	EMO/HA	Mar-14	Sep-14		Improved performance data	A	Started	Learning & Development Plans will be put in place for each individual officer dealing with ASB/Nuisance and processes to improve customer feedback from Victims will be implemented.

17	Training needs of staff should be individually assessed using a training needs analysis	Learning & Development plans in place for staff that deal with ASB/Nuisance	HEM/EMTL	Mar-14	Sep-14		Better trained staff and consistent case management	A	Started	Learning & Development Plans will be put in place for each individual officer dealing with ASB/Nuisance.
18	CBC should ensure that the team is able to operate properly at all times, even when there are long term absences, by training staff on all aspects of the role	Learning & Development plans in place for staff that deal with ASB/Nuisance	HEM/EMTL	Mar-14	Sep-14		Better trained staff and consistent case management	A	Started	Learning & Development Plans to be implemented for individual staff based upon role competencies.
19	Using best practice and learning from other organisations generally, take steps to set up a successful method of achieving satisfaction data	Visits to high performing Authorities/Associations to establish best practice	HEM/EMTL	Mar-14	Nov-14		Improved performance & customer satisfaction	A	Started	This work will need to be don e alongside the procedure reviews.
20	Set a clear deadline for finalising the work with the Police to explore the likely effectiveness of Safety Net, or another system, and implement within a clear timeframe	Safety Net is to be used for ASBRAC cases only as discussed at meeting on 4th February 2014	Police/ CS	Nov-13	Apr-14			G	Completed	It has been agreed by the partnership that Safety Net will be used for ASBRAC cases only. Officers will have access to the system and be able to input those high priority cases.
21	CBC should review its ASB performance indicators; including consulting with a diverse group of residents, learning from best practice and from high performing peers	Housemark PI's to be implemented	HEM	Nov-13	Apr-14		Performance data available to be used for benchmarking the service against others.	G	Completed	Agreed that with effect 1st April 2014 performance data will be reported as per the housemark definitions.

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22	CBC should put in to place more effective ways to monitor service delivery	Documented monitoring of Case Reviews readily available	EMTL	Mar-13	Apr-14		Improved performance data and case management	A	Started	The addition of a SEO post within the restructure will enable this to work to be undertaken more effectively.
23	Work with Partners to review success of partnership working	Housing attend regular joint meetings with partners to discuss cases	EMTL/EMO	Feb-14	Mar-14		Improved undertsanding and partnership working between agencies	G	Completed	Joint meeting between the Police, Community Safety and Housing have been reinstated.
24	Analyse the cost of the ASB service including the cost of different solutions		HEM/FO	Apr-14	Nov-14		Better understanding of VFM		Not Started	A review of the value for money aspect of the service needs to be undertaken when the other priority points of the action plan are implemented.
25	Review service against Respect Charter	Procedure review implemented	HEM/EMTL/EMO	Nov-13	Nov-14				Not Started	This done in line with policy and procedure reviews as well as policy/law changes.
26	Increase staff awareness of VFM		HEM/EMTL	Mar-14	Nov-14		Better understanding of VFM		Not Started	Will be implemented as part of the on-going development plan and training requirements for staff.
27	Benchmark against Housemark Data	TSP View the Housemark report	HEM/JM	Mar-14	Apr-14		improved outcomes	A	Started	This is already done but will be more beneficial when the reported data is in line with housemark definitions.
28	Communicate staff changes to partners	Partners updated in respect of restructure	HEM	Apr-14	May-14		Better partnership Working	A	Started	partners are aware of who deals with ASB and updates will be given when needed.

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Appendix C

Tenant Scrutiny Panel

Final Report
Anti-Social Behaviour

Tenant's Scrutiny Panel &
Carol Rooker, Head of Housing Management

Introduction

- Who is the TSP?
- Why we got involved
- Interview & selection
- Why we chose ASB

Where we started

- Checked performance information
- Did our homework
- Received further training and support

Method

- Held focus groups
- Benchmarked and compared
- Met with staff, partners and tenants affected by ASB
- Compiled evidence
- Kept tenant & Council issues private & confidential
- Wrote report

Recommendations

- Made 28 recommendations
- Allocated a proposed timescale to each
- Initial response from Housing service was positive
- Asked them to develop recommendations into an action plan

Outcomes

- Outputs & evidence on the action plan
- Open dialogue with Housing management
- Regular monthly meetings to review action plan
- Some changes already introduced

Housing Service Response

- Welcomed the report : comprehensive, well written, balanced and fair
- Embraced the perspective from the tenants view
- Informed restructure of the Housing management Team with additional resources
- Set up regular meetings
- Produced an action plan

Actions include

- Improve communication and information
- Reviewing procedure
- Differentiation between nuisance and anti social behaviour
- Improving monitoring of cases
- Learning and development plan
- Identify best practice
- Review performance indicators

Future

- Develop relationship with Tenant's Scrutiny Panel
- Embrace the "added value" the Panel can bring
- Develop managers and staff buy-in
- Work together on improvement opportunities
- Ensure the Panel is properly resourced and supported
- Ensure co-regulation is a reality

Learning

- What worked well
- What could improve
- On-going training
- Results

What next

- Promoting the report and findings to tenants
- Next Enquiry

Questions?

Meeting: **Social Care, Health and Housing Overview and Scrutiny Committee**

Date: **7 April 2014**

Subject: Quarter Three Performance Monitoring Report

Report of: **Cllr Mrs Carole Hegley, Executive Member for Social Care, Health and Housing**

Summary: The report highlights the performance for the Social Care, Health and Housing Directorate for Quarter 3 of 2013/14

Advising Officer: Julie Ogley, Director of Social Care, Health and Housing
Muriel Scott, Director of Public Health

Contact Officer: Nick Murley, Assistant Director, Resources
Celia Shohet, Assistant Director, Public Health

Public/Exempt: Public

Wards Affected: All

Function of: Council

CORPORATE IMPLICATIONS

Council Priorities:

1. The quarterly performance report underpins the delivery of the Council's priorities, more specifically in the area of promoting health and well being and protecting the vulnerable.

Financial:

2. There are no direct financial implications.

Legal:

3. There are no direct legal implications.

Risk Management:

4. Areas of ongoing underperformance are a risk to both service delivery and the reputation of the Council.

Staffing (including Trades Unions):

5. Not Applicable.

Equalities/Human Rights:

6. This report highlights performance against performance indicators which seek to measure how the Council and its services impact across all communities within Central Bedfordshire, so that specific areas of underperformance can be highlighted for further analysis/drilling down as necessary.

7. As such, it does not include detailed performance information relating to the Council's stated intention to tackle inequalities and deliver services so that people whose circumstances make them vulnerable are not disadvantaged. The interrogation of performance data across vulnerable groups is a legal requirement and is an integral part of the Council's equalities and performance culture, which seeks to ensure that, through a programme of ongoing impact assessments, underlying patterns and trends for different sections of the community identify areas whether further action is required to improve outcomes for vulnerable groups.

Public Health

8. The report highlights performance against a range of Adult Social Care, Housing and Public Health indicators that are currently in the corporate indicator set.

Community Safety:

9. Not Applicable.

Sustainability:

10. Not Applicable.

Procurement:

11. Not applicable.

RECOMMENDATION:

The Committee is asked to consider and note the report

Introduction

12. This report provides information on how the Social Care, Health and Housing Directorate and Public Health contribution to the Medium Term Plan is being met.

Overview

13. Both continue to perform well against the Medium Term Plan priority of “Promote health and wellbeing and protecting the vulnerable”.

14. Four of the measures are under performing. Two are Red: Number of Additional “Extra Care” flats provided (C2 MTP) and Clients receiving self directed support (C6 MTP) and two are Amber, Percentage of decent homes (Council stock) (C3 MTP) and coverage by Village Care scheme (C 4a MTP).

15. C2 MTP, Number of additional “Extra Care” flats is Red as the new likely delivery date of Summer 2015 for Priory View (formerly Dukeminster) exceeds the MTP target of 2014. The building contract for Priory View was awarded in December 2013.

16. The performance of C6 MTP, the number of social care clients receiving self directed support remains red against the local stretch target of 100%. This indicator however continues to perform well against the national target of 70%.

17. The Percentage of decent homes (Council stock) is Amber. As previously reported, the MTP target of 100% decent homes may not be achieved because replacement of elements within Council properties (e.g. kitchens, bathrooms, etc) are no longer be based on failure of the Decent Homes Standard, but on the life expectancy of the element.

18. The proportion of Central Bedfordshire covered by a Village Care Scheme remained at 87% and is scored amber, as the Sandy scheme was not up and running in December as originally planned.

19. The remaining indicators are performing in line with the milestones set.

20. Performance against C1 MTP, Protecting vulnerable adults, continues to progress. The audit of Safeguarding cases is now being carried out on a rolling monthly basis, using a combination of “peer audit” and safeguarding team case file audit. In total 25% of safeguarding cases will be audited by the safeguarding team.

21. Good progress is being made on Council commissioned dementia care rated as good or excellent (C 5a MTP). Using the ADASS quality workbook, 61% of dementia care providers are rated as Good or Excellent.

22. Good progress continues to be made on the number of Health Checks offered (C 7 MTP) with the target being exceeded and in line to deliver the Medium Term Plan target.

Director’s Summary – Social Care, Health and Housing

23. The Directorate continues to perform well against the Medium Term Plan priority of "Promote health and wellbeing and protecting the vulnerable".

24. The proportion of people receiving self-directed support continues to increase overall. Performance against the national target is good and remains strong in comparison to neighbouring authorities and the Eastern Region. There is a continuing focus to achieve the local aspirational target of 100%.

25. The build contract for Priory View, formerly Dukeminster, was awarded in December 2013, with a start on site in early 2014.

26. The target for the Village Care Scheme was missed in December due to a delay in the "go live" date for the Sandy Scheme in December 2013. A revised launch date for March 2014 has been set. Development of the Leighton Buzzard Scheme is continuing and we remain on course to achieve the 100% ward coverage MTP target.

27. Progress has been maintained in the other targets.

Director's Summary – Public Health

28. The number of Health Checks offered again exceeded target in Quarter 3, and work continues to maximise their uptake. Now that the local programme is well established there is an increased focus on looking at the difference that Health Checks can make to those patients who are identified as being at risk, and making sure that Health Checks are effective in supporting local people to live longer, healthier lives.

29. In the first 6 months of the 2013-14, Health Checks resulted in 81 newly diagnosed case of hypertension. They were also responsible for diagnosing type 2 diabetes in 22 Central Bedfordshire residents who did not know that they were suffering from this serious condition. In cases like these, Health Checks provide the opportunity for pharmacological intervention; during this period 132 people who had Health Checks were identified as needing to be prescribed statins for the first time.

30. But not everyone needs this type of help; patients who are identified to be at risk of poor cardio vascular health can often benefit from improvements in their lifestyle, before there is the need to prescribe medicines. Providing access to effective prevention and early intervention has been proven to reduce the need for expensive drugs required to treat health condition, before it becomes established.

31. Between April and September 2013, 111 Central Bedfordshire residents who had a Health Check were referred to the Stop Smoking Service, and 139 were referred to a weight management programme.

Appendices:
Appendix A – Quarter Performance Report Q3 2013/14

Background papers and their location: (open to public inspection)
None

Appendix A - Quarterly Performance Report (For CMT only)

Medium Term Plan Indicators and CMT Appendix A indicators

Quarter 3 2013/14

Report comparison - Depends on the nature of the indicator			**Performance Judgement**			
			Direction of travel (DoT)		RAG score (Standard scoring rules unless the indicator specifies alternative scoring arrangements)	
Seasonal	Compared to the same time period in the previous year			Performance is reducing	**R**	RED - target missed / off target - Performance at least 10% below the required level of improvement
Quarter on quarter	Compared to the previous quarter			Performance remains unchanged	**A**	AMBER - target missed / off target - Performance less than 10% below the required level of improvement
Annual	Compared to one fixed point in the previous year		æ	Performance is improving	**G**	GREEN - Target achieved or performance on track to achieve target

Overview of performance

Ref	Indicator	Performance will be reported:	Performance information being reported this quarter		
			Time period	**Performance**	
Promote health and wellbeing and protect the vulnerable					
C 1 MTP	Protecting Vulnerable Adults	Quarterly	Quarter 3 2013/14		**G**
C 2 MTP	Number of additional ‘Extra Care’ flats provided	Quarterly	Quarter 3 2013/14		**R**
C 3 MTP	Percentage of decent homes (Council stock)	Quarterly	Quarter 3 2013/14	æ	**A**
C 4a MTP	Number of Village Care schemes in operation	Quarterly	Quarter 3 2013/14		**A**
C 5a MTP	Percentage of council commissioned dementia care classed as ‘good’ or ‘excellent’.	Quarterly	Quarter 3 2013/14		**G**
C 6 MTP	Clients receiving self directed support	Quarterly	Quarter 3 2013/14		**R**
C7 MTP	Percentage of 40 to 74 year olds offered a health check	Quarterly	Quarter 3 2013/14	æ	**G**

Promote health and wellbeing and protect the vulnerable

C 1 MTP	Protecting Vulnerable Adults

Milestones:

1. Independent audits of safeguarding case files - Annual
2. Annual Safeguarding Report - Annual
3. Develop & implement new safeguarding performance framework – September 2013

Latest comparator group average		Report comparison		Performance Judgement		
	-		-			G

Comment:

The monthly audit of Safeguarding cases continues to take place, with action taking place where required. Examples of excellent cases are shared as good practice with the Adult Social Care staff through the practice workshops run by the Safeguarding Team.

The necessary changes to the Adult Social Care database (Swift) for the new reporting framework have been implemented and a data quality framework has been developed.

Monthly performance reports are presented to the Executive and Deputy Executive members for SCHH.

C 2 MTP	Number of additional 'Extra Care' flats provided

Milestones:

1. Secure Planning Permission; agree s106 – July 2013
2. Procure contractor - tbc
3. Commence Construction – January 2014
4. Open New Provision – by December 2014

Latest comparator group average		Report comparison		Performance Judgement		
						R

Comment:

Following consultation the site formerly known as Dukeminster scheme has been named Priory View and the build contract was awarded

C 3 MTP	Percentage of decent homes (Council stock)

Unit	Good is	2012/13				2012/13			
%	Low	Qu 1	Qu 2	Qu 3	Qu 4	Qu 1	Qu 2	Qu 3	Qu 4 / Outturn
Target		98.20	98.20	99.00	100	100	100	100	100
Actual		99.3	99.4	99.35	99.35	99.6	99.7	99.7	

Latest comparator group average		Report comparison		Performance Judgement		
	-		Seasonal		æ	A

Comment:

As previously reported, following the adoption of the Housing Asset Management Strategy, replacement of elements within Council properties

C 4a MTP	Number of Village Care schemes in operation											
Unit	Good is	2013/14					Latest comparator group average	-	Report comparison	-	Performance Judgement	A
%	High	Qu 1	Qu 2	Qu 3	Qu 4	Outturn						
Target		NA	87.1	90.3	100	100						
Actual		NA	87.1	87.1								

Comment:

87% of Central Bedfordshire is covered by a Village Care scheme, which represents 27 out of 31 wards. The Village Care scheme in Sandy is finalising their volunteer packs and banking arrangements and it is anticipated that they will be up and running in January. Meetings are scheduled with Leighton/Linslade Town Council to develop a scheme to cover the three wards in Leighton Buzzard and Linslade.

C 5a MTP	Percentage of Council commissioned dementia care classed as 'good' or 'excellent'											
Unit	Good is	2013/14					Latest comparator group average	-	Report comparison	-	Performance Judgement	G
%	High	Qu 1	Qu 2	Qu 3	Qu 4	Outturn						
Target		60	60	60	60	60						
Actual		NA	61.2	61.2								

Comment:

Using the ADASS quality workbook, 61% of dementia care providers are rated as Good or Excellent.

C 6 MTP	Clients receiving self directed support (ASCOF1c)																				
Unit	Good is	2011/12	2012/13						2013/14						Latest comparator group average	44.1 CIPFA 2011/12	Report comparison	Quarter on Quarter	Performance Judgement	R
		Outturn	Target (Outturn)	Qu 1	Qu 2	Qu 3	Qu 4	Outturn	Target (Outturn)	Qu 1	Qu 2	Qu 3	Qu 4	Outturn						
%	High	52.9	100	54.7	66.2	71.7	75.9	75.9	100	77.1	77.5	75.3								

Comment:

The number of people receiving self-directed support continues to rise with a slight decrease in Quarter 3. Between January and December 2013, 3,328 people received self-directed support, with 1,465 customers taking that support as a direct payment. Whilst the proportion of customer receiving self-directed support over the last 12 months has decreased, the year to date position, from April continues to show an increasing number of customers with self-directed support.

As previously reported, the target of 100% for 2013/14 is still a challenging one and accounting for the identified exceptions, if performance reaches 86%, it will be deemed that the target will have been met. Progress to meeting this target continues, with a concerted effort being made to reach the target by March 2014.

C 7 MTP	NHS Health checks (percentage of people aged 40 to 74 years of age offered a health check).													
Unit	Good is								Latest comparator group average		Report comparison	Quarter on Quarter	Performance Judgement	æ G
%	High		2010/11	2011/12	2012/13					2013/14				
			Outturn	Outturn	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Outturn	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Outturn
Percentage offered a health check	Target	Number	12,999	20,822	6,014	6,014	6,014	6,016	24,058	3,979	3,979	3,997	3,979	15,916
	Actual	Number	14,923	21,466	5,057	4,978	9,083	6,651	25,769	6,091	4,312	5,129		
		%	115	103	84	83	151	111	107	153	108	128		
Number of Health checks delivered	Target	Number	6,500	10,411	3,007	3,007	3,007	3,008	12,029	2,767	2,767	2,767		11,068
	Actual	Number	7,547	10,499	1,992	2,398	2,949	3,148	10,487	2,714	2,328	2,767		
		%	116	101	66	80	98	105	87	98	84	82		

Comment:

The number of Health Check invitations offered continues to exceed the revised target set and is in line to deliver as stated in the Medium Term Plan. The Quarter 3 performance was at 128% of target, giving a cumulative performance of 130% of the 9 monthly target achieved by the end of December.

The trend at Quarter 3 shows a similar level of performance against target from 2012/13 and stable against activity in Quarter 2.

In addition to the figures relating to those having been offered Health Checks, the cumulative percentage of Health Checks delivered is at 88% for the first three quarters of 201/14, a slight drop from the previous quarter. Work to identify the reasons for not achieving either quarterly or nine-monthly targets indicates that there remain some providers significantly under-performing. Work is underway to support these under-performing Primary Care providers with remedial action in the second half of the year to ensure the target is met. High-performing providers are being encouraged with revised targets, where they can up any 'slack' in their locality. Horizon Health Choices are contracted to increase capacity, both in supporting under-performing providers and ensuring supplementary delivery of the NHS Health Check service in a range of community settings.

The following data relates to direct outcomes for CBC residents having a Health Check, during the period April to September 2013 (Health Checks delivered 11,871):

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Meeting: **Social Care Health and Housing Overview & Scrutiny Committee**

Date: **07 April 2014**

Subject: Work Programme & Executive Forward Plan

Report of: **Chief Executive**

Summary: The report provides Members with details of the currently drafted Committee work programme and the latest Executive Forward Plan in addition to details of a recent work programming session with partners.

Contact Officer: Paula Everitt, Scrutiny Officer

Public/Exempt: Public

Wards Affected: All

Function of: Council

CORPORATE IMPLICATIONS
Council Priorities: The work programme of the Social Care Health and Housing Overview & Scrutiny Committee (SCHHOSC) will contribute indirectly to all 5 Council priorities. Whilst there are no direct implications arising from this report the implications of proposals will be details in full in each report submitted to the Committee

RECOMMENDATION(S):

1. that the Social Care Health and Housing Overview & Scrutiny Committee

1.1 considers and comments on the proposals to enhance the health scrutiny functions;

1.2 considers and approves the work programme attached, subject to any further amendments it may wish to make;

1.3 considers the Executive Forward Plan; and

1.4 considers whether it wishes to add any further items to the work programme and/or establish any Task Forces to assist it in reviewing specific items.

Overview and Scrutiny Work Programme and proposals for health scrutiny

1. The currently drafted work programme for the Committee is attached at **Appendix A**.
2. Throughout 2012 Central Bedfordshire Council was one of 14 Scrutiny Development Areas (SDAs) working with the Centre for Public Scrutiny (CfPS) and the Department of Health to develop more effective scrutiny of health and social care. Members were engaged in discussions regarding the most effective way of undertaking robust health scrutiny. In 2013 the final report of the enquiry into Mid-Staffordshire NHS Trust (the Francis Report) was also

published, which highlighted the importance of seeking the engagement of the public and professionals in setting the work programme and prioritising items accordingly.

3. In light of the outcomes of the CfPS programme and the Francis report it was recommended by the Overview and Scrutiny Coordination Panel that:-

   3.1 Health scrutiny has its own visible section on the agenda of the SCHHOSC that incorporates matters relating to the health of children. The Chairman of Children's Services OSC has also been appointed as a Member of SCHHOSC to promote collaboration. This will ensure that scrutiny of health and wellbeing has a clear and visible focus within the SCHHOSC agenda. These changes to the agenda will be trialled in April 2014.

   3.2 Work programming will be undertaken more proactively with a range of partners including the Care Quality Commission, the Health and Wellbeing Board, Healthwatch and the Tenant Scrutiny Panel. Information will be included in the work programme report to identify opportunities for collaboration and to prevent duplication.

4. The Chairman met with partners on 20 January 2014 and the relevant items that were highlighted by others are attached at **Appendix B**. Comparing Appendix A and B Members are asked to consider whether any of these items that are not already on the work programme should be added or if a collaborative approach could be considered. It is suggested that a more detailed work programming session be held with Members prior to their meeting in May 2014 to discuss the key issues for scrutiny during 2014/15.

Overview and Scrutiny Task Forces

5. In addition to consideration of the work programme, Members may also wish to consider how each item will be reviewed i.e. by the Committee itself (over one or a number of Committee meetings) or by establishing a Member Task Force to review an item in greater depth and report back its findings.

Executive Forward Plan

6. Listed below are those items relating specifically to this Committee's terms of reference contained in the latest version of the Executive's Forward Plan to ensure Members are fully aware of the key issues Executive Members will be taking decisions upon in the coming months. The full Executive Forward Plan can be viewed on the Council's website at the link at the end of this report.

Issue	Indicative Exec Meeting date
Revenue. Capital and Housing Revenue Account (HRA) Quarter 3 Budget Monitoring Report *	18 March 2014
Central Bedfordshire Council's Residential Care Homes for Older People	22 April 2014
Housing Allocations Policy for Central Bedfordshire	22 April 2014
Quarter 3 Performance Report *	18 March 2014

Those marked (*) are not presently on the Committee work programme

Conclusion

7. Members are requested to consider and agree the attached work programme, subject to any further amendment/additions they may wish to make in light of Appendix B and highlight those items within it where they may wish to establish a Task Force to assist the Committee in its work. 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.

Appendix A Social Care Health and Housing Overview and Scrutiny Work Programme

Appendix B Outcomes of recent work programming session

Background reports

Executive Forward Plan (can be viewed at any time on the Council's website) at the following link:-

http://www.centralbedfordshire.gov.uk/modgov/mgListPlans.aspx?RPId=577&RD=0

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Work Programme for Social Care, Health and Housing Overview & Scrutiny Committee 2014 - 2015

Ref	Indicative Overview & Scrutiny Meeting Date	Report Title	Report Description	Comment
1.	12 May 2014	Better Care Fund Report	To receive and comment on the final Better Care Fund plan.	
2.	12 May 2014	BCCG: Bedfordshire Plan for Patients 2015/16	To receive and comment on the proposals	
3.	12 May 2014	Allocations Policy	To receive and comment on the Allocations Policy for Central Bedfordshire.	
4.	12 May 2014	Housing Investment Plan to deliver a new homes programme and regeneration.	To receive a report on the proposed scope for investment by the Council's Housing Service.	
5.	12 May 2014	Domiciliary Care Retender	First year progress report on the implementation and operation of the Domiciliary Care Framework Agreement.	Requested by the Committee in January 2014
6.	12 May 2014	Quality Account	To receive the Quality Account from Bedford Hospital, The Luton and Dunstable Hospital and SEPT Services	

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Ref	Indicative Overview & Scrutiny Meeting Date	Report Title	Report Description	Comment
7.	23 June 2014	Homelessness Review and Homelessness Strategy	Initial consideration of the Homelessness Review, prior to development of the Homelessness Strategy, which is a statutory obligation.	Executive December 2014
8.	23 June 2014	Park Homes Strategy Contact: Nick Costin	The strategy is an overarching document that sets out the approach for all Park Home issues in Central Bedfordshire including standards, fees, advice, assistance and licensing	Executive August 2014
9.	23 June 2014	Review of Disabled Facilities Grant (DFG) benchmarking following independent DFG review outcomes.	Review of performance	
10.	23 June 2014	Discretionary Housing Payments Policy Contact: Gary Muskett	To receive an update and provide feedback on the Discretionary Housing Policy consultation	Exec 15 July 2014

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Appendix B

The table below demonstrates the outcomes of a work programming session with partners from several organisations held in January 2014 relating specifically to 'health' items. Also included are issues raised by colleagues in Children's Services, Public Health and Social Care. In light of the below Members are asked to consider whether any of these items should be added where they are not already on the work programme:-

Items identified as a priority:

- Recommissioning of mental and community health services (incorporating Child and Adolescent Mental Health)*
- Homelessness *
- The Better Care Fund and its implementation *
- Strategic Review of Bedfordshire Health Services *

Other issues under consideration by **Healthwatch**	Other issues under consideration by the **Health & Wellbeing Board**	**Other** issues identified
1. Stroke services 2. Visual Impairment Service 3. Housing matters, including housing for the elderly	1. Joint approach to integration 2. Health and Social Care self assessment framework 3. Joint Strategic Needs Assessment (JSNA) review 4. Health and Wellbeing Strategy	1. Monitoring of Budgets, performance and emerging policies * 2. Performance of Hospitals and CCG (ie Hospital discharge) * 3. Approach to integration 4. Supporting Aspirations for Children's Health

(Items marked (*) are already on the Committees work programme)

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