This meeting may be filmed.*

Central Bedfordshire Health and Wellbeing Board

Agenda

Meeting Title:	Central Bedfordshire Health and Wellbeing Board
Date:	Wednesday, 20 January 2016
Time:	**3.00 p.m.**
Location:	**Ouse Room, Jordan's Mill, Holme Mills, Langford Rd, Biggleswade, SG18 9JY**

Please note that it is a different start time and venue.

1. **Apologies for Absence**

   Apologies for absence and notification of substitute members.

2. **Election of Vice-Chairman**

   To elect the Vice-Chairman of the Central Bedfordshire Health and Wellbeing Board for the remainder of the municipal year 2015/16.

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

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

4. **Minutes**

   To approve as a correct record the Minutes of the last meeting held on 7 October 2015 and note actions taken since that meeting.

5. **Members' Interests**

   To receive from Members any declarations of interest.

6. **Public Participation**

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

HEALTH AND WELLBEING STRATEGY

Item	Subject	Page Nos.	Lead
7.	**Enabling People to Stay Healthy for Longer - Reducing Premature Mortality from Cardiovascular Disease** To outline the roadmap to enable people to stay healthy for longer, specifically to reduce premature mortality from cardiovascular disease, one of the priorities within the Health and Wellbeing Strategy.	11 - 28	MS
8.	**Better Care Fund - Update** To update the Board on progress to date with the delivery of the Better Care Fund Plan and performance against key delivery targets.	29 - 98	JO

OTHER BUSINESS

Item	Subject	Page Nos.	Lead
9.	**Community Health Services Review** To receive a verbal update on the Community Health Services Review.	Verbal Update	MT

To: Members of the Central Bedfordshire Health and Wellbeing Board

Dr J Baxter	Director, Bedfordshire Clinical Commissioning Group
Mr R Carr	Chief Executive, Central Bedfordshire Council
Mr C Ford	Director of Finance, NHS Commissioning Board Area for Hertfordshire & South Midlands
Mr M Coiffait	Director of Community Services
Mrs S Harrison	Director of Children's Services, Central Bedfordshire Council
Cllr C Hegley	Executive Member for Social Care and Housing, Central Bedfordshire Council
Cllr M Jones	Deputy Leader and Executive Member for Health, Central Bedfordshire Council
Mrs A Lathwell	Interim Director of Strategy and Redesign, Bedfordshire Clinical Commissioning Group
Mrs J Ogley	Director of Social Care, Health and Housing, Central Bedfordshire Council
Mrs M Scott	Director of Public Health
Mr R Smith	Interim Chairman, Healthwatch Central Bedfordshire
Mr M Tait	Chief Accountable Officer, Bedfordshire Clinical Commissioning Group
Cllr M A G Versallion	Executive Member for Education and Skills, Central Bedfordshire Council

please ask for	Sandra Hobbs
direct line	0300 300 5257
date published	8 January 2016

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CENTRAL BEDFORDSHIRE COUNCIL

At a meeting of the **HEALTH AND WELLBEING BOARD** held in Council Chamber, Priory House, Monks Walk, Shefford on Wednesday, 7 October 2015

PRESENT

Cllr M R Jones (Chairman)
Dr J Baxter (Vice-Chairman)

Mrs D Blackmun	Chief Executive Officer, Healthwatch Central Bedfordshire
Mr M Coiffait	Director of Community Services
Mrs S Harrison	Director of Children's Services
Mrs A Lathwell	Head of Strategy & Corporate Planning, Bedfordshire Clinical Commissioning Group
Mr A Moore	Interim Chief Operating Officer, Bedfordshire Clinical Commissioning Group
Mrs J Ogley	Director of Social Care, Health and Housing
Mrs M Scott	Director of Public Health
Cllr M A G Versallion	Executive Member for Education and skills

Apologies for Absence:
Mr R Carr
Mr C Ford
Cllr C Hegley
Mr N Robinson
Mr R Smith

Officers in Attendance:	Mrs M Bradley	–	Head of Mental Health and Wellbeing, Bedfordshire CCG
	Dr S Chakrabarti	–	Assistant Director of Public Health
	Mrs P Coker	–	Head of Service, Partnerships - Social Care, Health & Housing
	Mrs S Hobbs	–	Committee Services Officer
	Mrs B Rooney	–	Head of Public Health
	Mrs C Shohet	–	Assistant Director of Public Health
	Mrs S Tyler	–	Head of Child Poverty and Early Intervention
	Ms E White	–	Safeguarding Vulnerable Adults Manager
Others in Attendance:	Mr A Caton	–	Chairman of the Central Bedfordshire Children Safeguarding Board
	Dr H Jopling	–	Public Health Registrar
	Mr A Scanton	–	Public Health Analyst
	Ms J Syme	–	SEPT Community Health Services

HWB/15/13. **Chairman's Announcements and Communications**

The Chairman announced that the date of the next meeting would be 20 January 2016 and not the 6 January 2016 as originally scheduled. This would include a visit to Biggleswade Hospital with the Board meeting at an alternative venue in the area.

The Chairman proposed that the Board invite the Local Government Association to facilitate a self assessment. This was agreed and would enable the Board to develop its future work programme to improve the health and wellbeing of the community in Central Bedfordshire.

HWB/15/14. **Minutes**

RESOLVED

that the minutes of the meeting of the Central Bedfordshire Health and Wellbeing Board held on 1 July 2015 be confirmed as a correct record and signed by the Chairman.

HWB/15/15. **Members' Interests**

None were declared.

HWB/15/16. **Public Participation**

There were no members of the public registered to speak.

HWB/15/17. **Giving Every Child the Best Start in Life**

The Board received a presentation on the Joint Health and Wellbeing Strategy priority of giving every child the best start in life and school readiness. In previous years Central Bedfordshire was behind the national average for achieving a good level of development at the end of Year R. Following research and group discussions the Children's Trust found that three key areas emerged which were considered important to improving outcomes:-

- Communication with parents and professionals.
- Assessment and observation.
- Pathways.

Health Visitors were now helping to lead the delivery of the Health Child Programme 0-5 years and would also focus on school readiness. Further work was being carried out to improve communications with parents and embed a 'whole education' approach, including data sharing and developing clear pathways to support children.

RESOLVED

to report back to the Health and Wellbeing Board at their next meeting on 20 January 2016 on the progress being made on school readiness.

HWB/15/18. **Ensuring Good Mental Health and Wellbeing at Every Age**

The Board considered a report that provided an update on progress towards the Joint Health and Wellbeing Strategy priority of ensuring good mental health and wellbeing at every age.

The East London Foundation Trust were working on a number of priorities, including improving the crisis pathway, reducing the number of out of area placements for people and improving the environments within acute in-patient settings. Also work had been established to improve recovery outcomes locally and to implement national guidance on permitting GPs to make diagnosis of dementia for people in care and nursing homes.

A draft Child and Adolescent Mental Health Services (CAMHS) Transformation Plan for Bedfordshire and Luton had been developed following the Government's Taskforce report, Future in Mind. The key priorities were:-

- Eating disorders.
- Perinatal mental health.
- Early intervention/crisis prevention.
- Embedding the children and young people's Improving Access to Psychological Therapies principles.
- Schools/CAMHS training pilot.

In response to a question, it was noted that the Bedfordshire Clinical Commissioning Group had received additional funding to help clear the waiting list for Improving Access to Psychological services.

RESOLVED

1. **that the proposed steps to develop the CAMHS Transformation Plans for Bedfordshire be endorsed;**

2. **to authorise the Chairman, in consultation with the Directors of Public Health and Children's Services to sign off the CAMHS Transformation Plan for submission;**

3. **that the Board supports the five ways to wellbeing campaign;**

4. **that the progress to date in promoting mental wellbeing be noted and the next steps be endorsed, including the Board receiving an update on progress in six months time.**

HWB/15/19. **Better Care Fund**

The Board considered a report that provided an update on the performance against the delivery targets of the Better Care Fund (BCF) Plan. The report also set out the Section 75 agreement between Central Bedfordshire Council and the Clinical Commissioning Group to allow for the BCF to be transferred into a pooled fund.

Work was progressing to create a shift to out of hospital care and early intervention and prevention through multidisciplinary working as this remained fundamental to the BCF Plan, especially as non-elective admission rates remained high and were rising. Under each of the overarching priorities there were key work streams taking place. It was agreed to report back to the next meeting on 20 January, setting out the areas where delivery was proving difficult to achieve.

RESOLVED

1. **that the quarterly report, submitted to NHS England on 28 August 2015, be noted;**

2. **that the financial details of the BCF Plan, as set out in the Section 75 agreement, be approved; and**

3. **that the governance structure to support the delivery of the BCF Plan through the Section 75 pooled budget arrangements be approved.**

HWB/15/20. **Board Development and Work Plan 2015/2016**

The Board considered the updated work programme of items for the Health and Wellbeing Board for 2015-2016.

RESOLVED

that the work plan be approved, subject to the inclusion of a report on Giving Every Child the Best Start in Life – School Readiness for the meeting on 20 January 2016.

HWB/15/21. **Local Safeguarding Children's Board Annual Report 2014-2015**

The Board considered a report that set out the annual report of the Central Bedfordshire Safeguarding Children Board that provided evidence of the commitment and determination among agencies and professionals to keep children and young people across Central Bedfordshire safe.

The Chairman of the Safeguarding Children Board highlighted the key challenges:-

- Ensuring that the voice of children was heard and that their views were taken into account in all aspects of safeguarding.
- Ensuring that lessons learned from local and national case reviews and audits were embedded in local practice and improve the quality of the provision of services to children and young people.
- Ensuring the effectiveness of safeguarding support for children living with the consequences of domestic abuse, parental mental ill health and parental substance misuse.
- To continue to monitor and evaluate the impact of early help.
- Ensuring the Central Bedfordshire response to child sexual exploitation (CSE) was identifying those children at risk of CSE at the earliest opportunity and evaluating the multi-agency response to keep children safe.

RESOLVED

1. that the Central Bedfordshire Safeguarding Children Board Annual Report be noted; and

2. that key messages for stakeholders be considered and to communicate the relevant messages back to their organisation and staff.

HWB/15/22. **Bedford Borough and Central Bedfordshire Safeguarding Adults Board Annual Report 2014-2015**

The Board considered a report that set out the Bedford Borough and Central Bedfordshire Safeguarding Adults Board (SAB) Annual Report. The SAB had continued with strong strategic leadership and operational arrangements which had enabled standards to improve, evidence robust safeguarding arrangements and deliver sustained professional improvement. The main areas the SAB had focused on were:-

- Preparation for the new duties under the Care Act 2014 for adult safeguarding and for managing quality and safety in care provision.
- Ensuring the implications of the Supreme Court ruling on Deprivation of Liberty Safeguards (known as “Cheshire West”) were robustly managed.
- Making safeguarding personal, ensuring that person centred outcomes were at the forefront of safeguarding work.

RESOLVED

that the Bedford Borough and Central Bedfordshire Safeguarding Adults Board Annual Report 2014-2015 be noted.

HWB/15/23. **Exclusion of the Press and Public**

RESOLVED

that in accordance with Section 100A (4) of the Local Government Act 1972 the public be excluded from the meeting for the following item of business on the grounds that it involved the likely disclosure of exempt information as defined in paragraph 3 of Part I of Schedule 12A of the Act.

HWB/15/24. **Outcomes of Data Sharing and Analysis between BCCG and CBC**

The Board received a presentation on what was driving unplanned hospital admissions in Central Bedfordshire. Joint working to identify high risk patients was taking place between the Bedfordshire Clinical Commissioning Group and Central Bedfordshire Council as well as integrated care teams.

RESOLVED

to consider the results of the risk profiling work at the next meeting as part of the Better Care Fund update.

(Note: The meeting commenced at 2.00 p.m. and concluded at 4.25 p.m.)

Chairman ……

Dated ……..

Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	**Enabling People to Stay Healthy for Longer – reducing premature mortality from cardiovascular disease**
Meeting Date:	20 January 2016
Responsible Officer(s)	Muriel Scott
Presented by:	Muriel Scott, Director of Public Health

Recommendation

1. **That the Board considers the roadmap to reducing premature mortality from Cardio Vascular Disease and identifies any further actions that either the Board or partners should be taking.**

Purpose of Report	
1.	To outline the roadmap to enable people to stay healthy for longer, specifically to reduce premature mortality from cardiovascular disease, one of the priorities within the Health and Wellbeing Strategy. To identify the areas where action is required of the Health and Wellbeing Board and others that will have the greatest impact in improving outcomes.

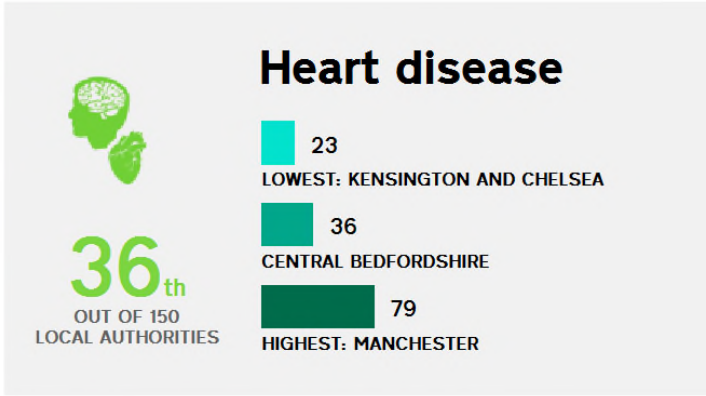
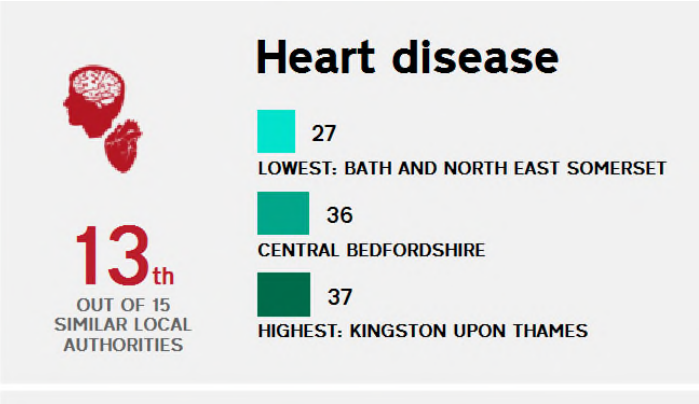
Background	
2.	Cardiovascular Disease (CVD) in practice represents a single family of diseases and conditions linked by common risk factors and the direct effect they have on CVD mortality and morbidity. These include coronary heart disease, stroke, hypertension, hypercholesterolemia, diabetes, chronic kidney disease, peripheral arterial disease and vascular dementia. Many people who have one CVD condition commonly suffer from another and yet opportunities to identify and manage these are often missed (Cardiovascular Disease Outcomes Strategy 2013) therefore it is critical that services are integrated around the person rather than one component of their medical condition. Unfortunately each year over 100 people in Central Bedfordshire die prematurely (defined as before the age of 75 years) from preventable CVD and for women this is higher than other similar local authorities. The infographics below show that although premature death rates in CBC compare well to the England average, when the same rates are compared to statistical neighbours there is significantly more that needs to be achieved. **Figure 1: Premature Mortality compared to the England average** 

Figure 2: Premature Mortality compared to Statistical Neighbours



Deaths from CVD are the biggest single contributor to the inequality gap in health within Central Bedfordshire.

As part of the review of Non Elective Admissions (NELs) in Central Bedfordshire, Heart Failure and Angina were identified as the 3rd and 4th highest causes of avoidable admissions in 2014-15. The commissioning for value packs published in 2015 (used to identify priority programmes to improve outcomes and value) also showed a higher spend on circulatory disease compared with similar CCGs. Therefore improving outcomes will also have a significant impact upon costs to the local public sector

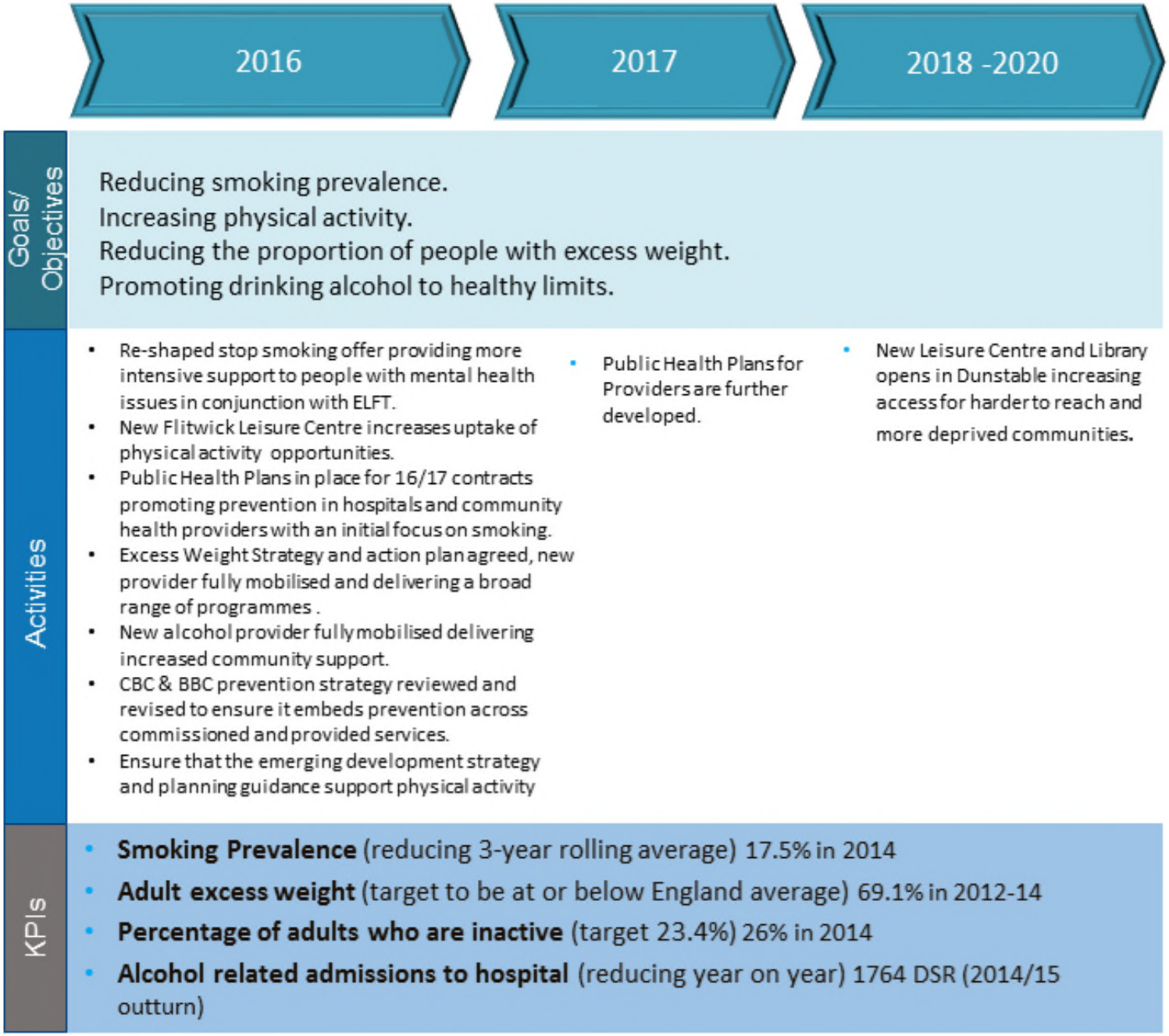
We know that most premature deaths from CVD are preventable and relate to 9 modifiable risk factors: diabetes, high blood cholesterol, high blood pressure, psychological stress, overweight/ obesity, smoking and tobacco use, unhealthy diet, excess alcohol consumption and insufficient physical activity. There is also evidence to suggest that maternal nutrition and air pollution may also be linked (Longer Lives 2014).

The good news is that if people adopt healthy lifestyles, in most instances, CVD can be prevented or its onset delayed. If someone does develop CVD and it is identified early and managed well, then outcomes can be improved for both those affected and their families.

What do we need to do to reduce early deaths from CVD?	
3.	We need to take action on the modifiable risk factors outlined above and prioritise the following: **Preventing people from developing CVD by:** • Reducing smoking prevalence. • Increasing physical activity. • Reducing the proportion of people with excess weight. • Encouraging people to stick to safe drinking limits. **Identify people at high risk of developing CVD by:** • Increasing the uptake of Healthchecks in the areas of higher deprivation and to the most vulnerable groups. **Reducing the variation in the effective management of CVD by:** • Ensuring that good clinical outcomes for CVD are achieved consistently across General Practices, particularly for hypertension and diabetes. A summary of a number of actions to date is outlined in Appendix 2.

How will we know when we're successful?	
4.	The actions, milestones and KPIs are all set out for each element of the programme in the following pages. The overarching indictors are: • **Premature Deaths from CVD per 100,000 population** (target to be ranked as better than average compared to statistical Neighbours. The current CBC rate (2012-14) is 59.7 and is ranked as similar compared to statistical neighbours where the average rate is 61.9. • **Reduced Non Elective Admissions from heart failure and angina** - the baseline (2014-15) is 378 admissions for heart failure and 239 admissions for angina.

Preventing people from developing CVD



Identify people at high risk of developing CVD

Goals/ Objectives

Increasing the uptake of Healthchecks in the areas of higher deprivation and to the most vulnerable groups

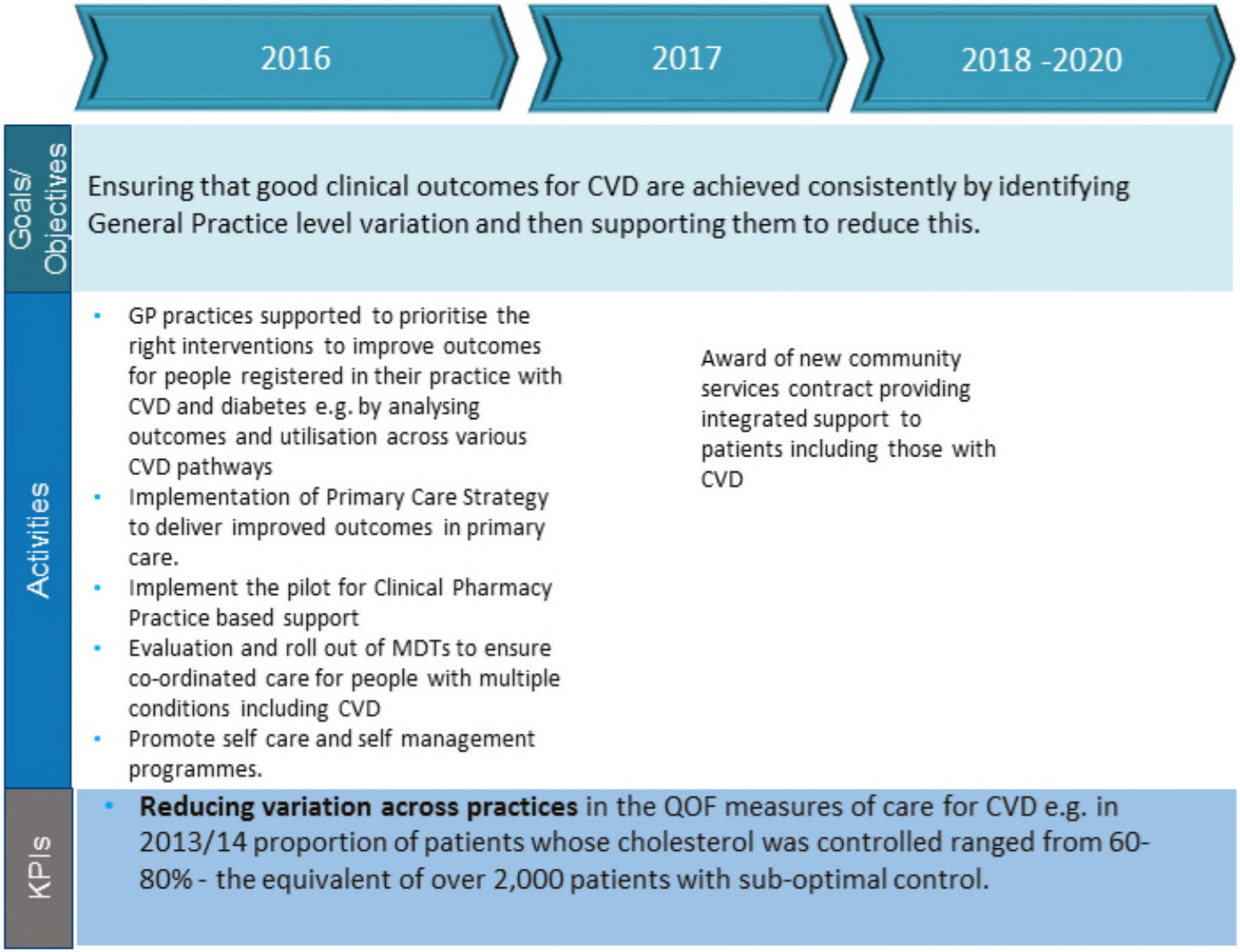
Activities

- Review the quality, outcomes and cost effectiveness of the Healthchecks programme.
- Explore alternative models of delivery to reduce variation and increase uptake of offer.
- Assess the impact that Healthchecks have had on referrals to services where reduce cardiovascular risk. Work with practices whose referral rates are low to undertsand why and how pathways could be more effective.
- Consideration of alternative programmes e.g. the national blood pressure programme
- Further targeting of the Healthchecks programme to the most vulnerable groups
- Implementation of a new model to identify people at high risk of CVD reflecting need and available resource.

KPIs

- Proportion of **Healthchecks delivered** (target 100%) 2014/15 outturn 77%
- Proportion of people **newly diagnosed as being at high risk of CVD** (no national target) April – September 2015 = 217 people
- Proportion of people **referred to services** to reduce their risk (increasing year on year) April – September 2015 no referred = 27

Reducing the variation in the effective management of CVD



What do we need organisations and individuals to do to deliver these outcomes?	
	Health and Wellbeing Board
5.	• Lead the integration of services with a focus on prevention, as well as delivering care to those who are at highest need of acute care and complex care packages. • Hold constituent members of the Board to account for delivery of the actions outlined in paragraphs 6-9.
	Central Bedfordshire Council
6.	• Ensure that the Making Every Contact Counts preventative approach is embedded within relevant provided and commissioned services e.g. care providers encourage and signpost clients to stop smoking services. • Use planning and development powers to deliver environments which encourage residents to be physically active. • Encourage front line staff to complete the on-line level 1 stop smoking advisor training e.g. housing support staff. • Deliver effective services to help residents modify their lifestyle. • Consider developing a greater understanding of how residents can be better supported to take action to change their lifestyle. • Review and revise the prevention strategy 'Never too early, Never too late'.
	Bedfordshire Clinical Commissioning Group
7.	• Ensure that prevention is mainstreamed into clinical pathways and services. • Ensure that the Primary Care Strategy and Co-commissioning arrangements mainstream healthy lifestyle, early identification and reduction in variation of care for patients known to have high blood pressure, diabetes and Stroke. • Promote self-care and self-management programs for all patients with CVD and Diabetes. • Include Public Health Plans into the quality schedules with providers, including the Luton & Dunstable Hospital.

	Primary Care (GPs and Community Pharmacists)
8.	• Deliver brief interventions and signpost for further support when patients would benefit from lifestyle modification. • Achieve the targets for the delivery of Healthchecks. • Refer patients in need of support to relevant services. • Review variation in outcomes and care for patients with CVD, specifically hypertension, cholesterol and other outcomes for diabetes.
	Provider Trusts
9.	• Implement the public health plans. • Take every opportunity to take preventative action e.g. when patients with a condition that would benefit from lifestyle modification, such as being more active or weight loss, that this is discussed as a core component of their care. • Encourage staff to complete the on-line level 1 stop smoking advisor training. • Promote self-care and self-management programs for all patients with CVD and Diabetes.
	Patients and Residents
10.	• Attend the Healthchecks appointment when invited. • Take medications as prescribed and attend any medical reviews. • Reduce and maintain alcohol intake to healthy limits. • Achieve and maintain a healthy weight. • Keep physically active. • Don’t smoke.

Issues	
Governance & Delivery	
11.	Progress will be reported to the Health and Wellbeing Board on a six-monthly basis but these are 'slow-burn, high impact' actions so short term changes may be difficult to see at a population outcome level.
Financial	
12.	These programmes will need to be delivered within the available resources and opportunities to improve outcomes and deliver efficiencies will be pursued. Elements of the programme are part of the Better Care Plan for Central Bedfordshire.
Public Sector Equality Duty (PSED)	
13.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
	Are there any risks issues relating Public Sector Equality Duty No

Source Documents	**Location (including url where possible)**
Joint Health and Wellbeing Strategy	http://www.centralbedfordshire.gov.uk/health-and-social-care/health/Health-and-Wellbeing-Board.aspx

Appendix 1: Outcomes for Staying Healthy for Longer indicators in Central Bedfordshire 2009 – 2015
Appendix 2: Update on new programmes which commenced in 2015
Presented by Muriel Scott

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Appendix 1: Outcomes for Staying Healthy for Longer indicators in Central Bedfordshire 2009 – 2015

Central Bedfordshire Council
Health Profiles
Produced by Public Health England
http://www.apho.org.uk/resource/view.aspx?RID=50215

Coloured indicator shows compaison with England for each year
Significantly better than England average
Not significantly different from the England average
Significantly worse than England average#

Indicator			Type	Time Period	2015					Trend 2009-2015 profiles	Trend line data (as per Health Profile)						Latest (Dec 2015)
					CB Number	CB Value	England Average	England Worst†	England Best†		2010	2011	2012	2013	2014	2015 (June)	
Children and young people's health	7	Smoking status at time of delivery	%	2014/15	336	11.1	11.4	27.5	1.9		17.4	15.4	12.6	14.1	13	12.6	11.1
	9	Obese children (Year 6)	%	2014/15	393	14.4	19.1	27.8	9.2		7.3	14.3	16.2	15.5	14.7	15.9	14.4
Adult's health and lifestyle	12	Smoking prevalence	%	2014	n/a	17.5	18.0	30	9		19.8	21.2	17.5	16.1	18.3	15	17.5
	13	Percentage of physically active adults	%	2014	n/a	60.9	57.0	43.5	66.7		12.1	11.3	10.9	55.8	55.8	53.8	60.9
	14	Obese adults	%	2012	n/a	23.7	23.0	35.2	11.2		24.8	24.2	24.2	24.2	23.7	23.7	23.7
	15	Excess weight in adults	%	2012-2014	n/a	69.1	64.6	75.9	45.9						69.1	69.1	69.1
Disease and poor health	18	Hospital stays for alcohol-related harm	DASR per 100,000	2013/14	1320	518	645	1231	366		1220	1374	1521	1521	518	518	518
	20	Recorded diabetes	%	2013/14	12062	5.9	6.2	9	3.4		3.63	5.08	5.3	5.5	5.7	5.9	5.9
Life expectancy and causes of death	25	Life expectancy - male	Years	2012-2014	n/a	81.5	79.6	74.3	83		79.1	79.2	79.5	80.1	80.5	81	81.5
	26	Life expectancy - female	Years	2012-2014	n/a	83.8	83.2	80	86.4		82.4	82.5	83	83.6	84	83.9	83.8
	28	Smoking related deaths	DASR per 100,000	2011-2013	333	255.6	289	472	167		183.6	202	192	182	261	255.6	255.6
	30	Under 75 mortality rate: cardiovascular	DASR per 100,000	2012-2014	409	61.9	75.7	137	37.1		63.5	59	56.6	51.9	64.8	62.6	61.9
	31	Under 75 mortality rate: cancer	DASR per 100,000	2012-2014	888	131.7	141.5	203	104		106.4	110.2	104	102.9	135	135	131.7

n/a in CB number = actual number not available † these values were published in the 2015 Health Profile and have not been updated here

Colour of indicator shows comparison with England in each year
NB definitions of some indicatiors has changed over time
Blue text shows a change in definition

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Appendix 2: Update on new programmes which commenced in 2015

Weight Management the newly commissioned weight management service for adults and children has a strengthened focus on prevention and early intervention services. The provider will deliver services for the prevention (Tier 1) and management (Tier 2) of excess weight providing a more integrated offer to local residents. This includes a number of new elements:

- A weight management programme for men - **Gutless**
- A maternal obesity pathway for the 600 obese pregnant women each year - **BZBumps**
- Slimming World and Weight Watchers commercial programmes
- Faith based weight management programme – community based- **Believe**
- 1-1 web chat support – **BZ Chat**
- Family weight management programmes for families with children aged 5 – 15 yrs old. **BeeZee Bodies**
- A Health, Exercise, Nutrition for the Really Young (**HENRY**) programme in Children's Centres 2 -4 yrs old.

They will also work with Health Visitors and the School Nursing teams to ensure a consistent approach to supporting healthy weight, nutrition and increased physical activity for children and families.

Multi-agency excess weight strategy and delivery – a partnership strategy to ensure that we are working effectively across Central Bedfordshire to prevent and reduce the proportion of people with excess weight. This is building on the existing offer from public health, leisure services, planning, natural environment and partners e.g. Sport England and the University of Bedfordshire to ensure opportunities are maximised and outcomes are improved. Whilst we have had good engagement at the workshops regarding the contribution that all partners can make, this is proving difficult to translate into tangible actions to deliver the strategy. The draft strategy is attached in Appendix 2 and the HWB is asked to consider what more they can bring to this strategy to tackle this important issue in Central Bedfordshire which will have a direct impact upon premature mortality.

Mobilisation of the new contract for alcohol treatment and prevention which will improve outcomes through early intervention, community based delivery, sustained recovery and place a greater emphasis on prevention. The new 5-year contract started on 1 September 2015 and whilst performance has dropped slightly (a drop in performance was expected; this is a national phenomenon when drug & alcohol providers change) the new provider has already put a number of measures in place. The new delivery model and staff structure will be in place by the end of January 2016. A communications plan to ensure that all stakeholders are aware of the new service is underway.

Re-shaped stop smoking offer providing more intensive and flexible support for more vulnerable groups including routine and manual workers, those with mental health issues and mothers smoking during pregnancy.

Review Health Checks Programme using the data from the new data management system, which supports the delivery and analysis of health checks performance and outcomes. An options appraisal of future options for delivery of health checks started in November 2015 using 2 quarters of validated data and the increasing body of evidence regarding the effectiveness of the checks.

A **Lifestyle Hub** is currently being piloted in the Chiltern Vale locality to support individuals to modify their lifestyle.

An interim evaluation has taken place using data from the first 5 months on the pilot. During that period, February to August 2015, 223 referrals of whom 80% of those referrals were due to excess weight. Clients were referred to :

Activity4Health – 67referrals
BeeZee Bodies - 2
Imperative Health - 20
Let's Get Moving/ Healthy eating goals - 43
Slimming World - 30
Weight Watchers - 9

Up to the end of August, data had been captured for 43 patients at follow up who had reduced their Body Mass Index (BMI) by an average 3.1%. Over half of respondents became more active as a result of the intervention.

As well as positive outcomes for weight loss and physical activity, CBC residents using the lifestyle hub have reported quitting smoking and reduction in their medication. The pilot is scheduled to run until 31 March 2016 and an options appraisal is being developed to inform future commissioning arrangements.

Community Physical Activity programme

The inactivity rate in Central Bedfordshire is 28% i.e. 1 in 4 adults are failing to do enough physical activity to benefit their heath (that's equivalent to 50,000 adults doing less than 30 minutes in a 7 day period). To bring physical activity into the everyday lives, in addition to the broad programme of community based physical activity, a number of new initiatives have been put in place:

- Ensuring physical activity pathways are available to patients accessing other public health prevention programmes such as weight management and alcohol treatment. The CBC leisure team are currently meeting with new commissioners for mental health and weight management programmes to offer a joined up approach for the customer with regards to physical activity pathways. In addition physical activity pathways are offered to drug and alcohol clients as part of their recovery programme. This started off as a pilot scheme in Dunstable with participants accessing the gym and 5 aside football at a reduced rate. The leisure team have since received some additional funding to offer programmes across Central Bedfordshire.
- The Our Parks pilot project offers free exercise classes in 5 areas in Central Bedfordshire based on 20%most deprived postcodes. 985 people have participated with good outcomes. The programme is being evaluated and future funding opportunities being considered.
- A new assessment tool (Boditrax) has been introduced to measure health improvement of people accessing community activities This has allowed participants to set realistic goals that are not just focusing on weight but the overall health of their body.

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Better Care Fund Plan – Update
Meeting Date:	20 January 2016
Responsible Officer(s)	Julie Ogley, Director of Social Care, Health & Housing Alison Lathwell, Interim, Director of Strategy and System Redesign Bedfordshire Clinical Commissioning Group
Presented by:	Julie Ogley, Director of Social Care, Health & Housing Alison Lathwell, Interim, Director of Strategy and System Redesign - Bedfordshire Clinical Commissioning Group

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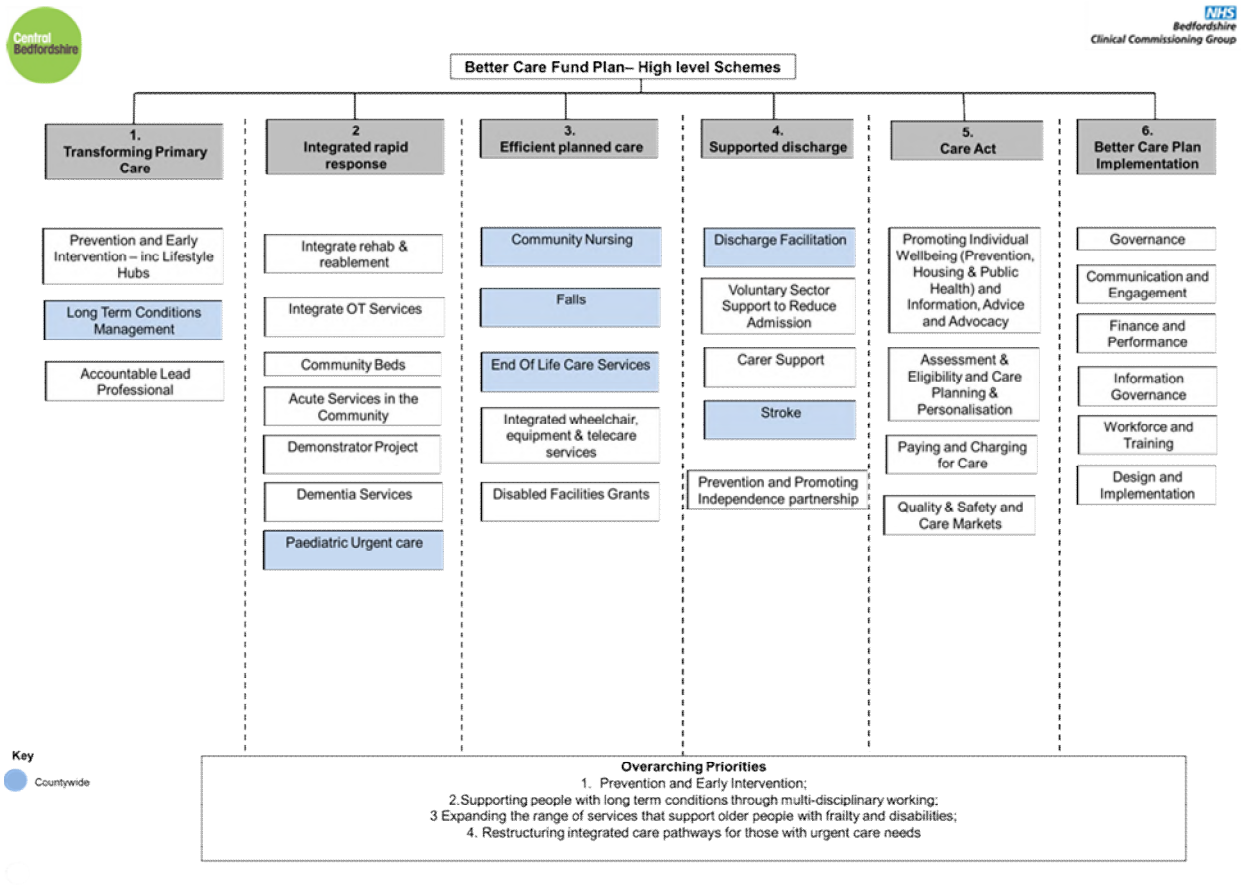
Recommendation(s) The Health and Wellbeing Board is asked to:

1. **review the progress on delivering the Better Care Fund Plan including the Quarter Two return to NHS England;**
2. **review current performance and the actions taken to support improvement; and**
3. **note the proposed process for producing the 2016/17 BCF Plan and to provide a steer on the key areas of focus.**

Purpose of Report	
1.	To update the Board on progress to date with the delivery of the Better Care Fund Plan and performance against key delivery targets.
2.	For the Board to note the submission of the BCF Quarter 2 performance return to NHS England and narrative on progress.
3.	For the Board to note the current financial position of the BCF Plan.
4.	To inform the Board on plans for the Better Care Fund Plan 2016/17.

Background	
5.	The Better Care Fund Plan is a catalyst for improving services through a shared vision for health and social care in Central Bedfordshire. The Plan aims to improve outcomes for local people by transforming services through joint working and integration.

	This can help to mitigate the impact of increasing demand for services, complexity of need and financial challenges to ensure a sustainable local health and care system.
6.	Central Bedfordshire's Health and Wellbeing Strategy sets the overall vision for improving health, wellbeing and reducing health inequalities. The BCF Plan closely aligns with the Health and Wellbeing Strategy with the focus on improving outcomes for frail older people, and, sets out a cohesive approach to service delivery for older people, particularly in relation to urgent care treatment and the management of long term conditions.
7.	Implementation of Better Care Fund Plan commenced on the 1 April 2015 following the unconditional approval of the plan by NHS England in December 2014. The BCF for Central Bedfordshire is a pooled fund of £18.7millon which is to be delivered through 6 key schemes.
8.	A requirement by NHS England was for the Better Care Fund to be transferred into a pooled fund under a section 75 agreement between the Council and the Clinical Commissioning Group (CCG). The Health and Wellbeing Board approved the section 75 agreement in October 2015.
9.	The focus of BCF delivery is now on the operationalisation of the schemes (Figure 1) within the plan and successful delivery of the performance metrics, including the pay for performance element of the fund.

	Central Bedfordshire BCF Schemes
Figure 1	
	Update on Schemes
10.	A stocktake of current performance across BCF schemes has been carried out to provide a more detailed picture of the successes and challenges inherent in the current BCF plan. (Appendix 1). The progress made by each scheme has varied dramatically. However underlying all of this was that the number of unplanned admissions to hospital were increasing and not reducing. A workshop held in April 2015 identified a number of additional projects that needed to be developed to assist in delivering the Plan. This programme of work which is focused on four key areas: Care Homes; Falls; Long Term Conditions and End of Life Care for reducing non-elective admissions, has been mobilised and is being monitored by the BCF Commissioning Board. This approach was also set out in the HWB BCF update in July 2015. Appendix 2 provides further update on this programme of work. .

11.	There are a number of factors that have contributed to the slow pace of delivery of the BCF Schemes:
12.	• **The Community Health Services contract** re-procurement. The CCG and Council have been considering the procurement options for community health services and the initial extension of the contract was taken account of when planning the BCF Plan. Community health services provision is central the BCF Plan. The majority of the schemes set out in the BCF Plan require new ways of working and in particular integrated services to facilitate seamless and timely care pathways for frail older people. Uncertainties in the system have undermined the delivery of the BCF Plan.
13.	The ongoing review of community services now means that a number of BCF Plan projects are subsumed into the scope of the review and no longer described as individual projects. For example 'Integration of Rehabilitation and Reablement' and 'Acute Services in the Community'. The outcome of the review will influence how those services are delivered.
14.	• **The impact of the Clinical Commissioning Group's financial recovery and changes in** leadership has had an impact on the delivery of the BCF Plan and schemes.
	Performance Update
15.	Quarter two monitoring report was submitted to NHS England on 27 November 2015. The report was signed by both the Council and Bedfordshire Clinical Commissioning Group. A copy of the return is attached as Appendix 3. All but one of the National Conditions has been met as outlined in the attached report.
16.	Quarter 2 returns on overall progress for delivery of the Better Care Fund Plan noted that a number of projects had been mobilised to mitigate the challenge of reducing non elective admissions; successes of those projects were also described.(Appendix 2) Recent senior appointments at the CCG and changes within the Community Health Services leadership were noted as positive developments which would aid the successful delivery of the BCF Plan.
17.	Although compliant with the principle of 7 day working, further work is ongoing across the various general hospitals caring for Central Bedfordshire residents. Social workers at the Luton and Dunstable Hospital currently provide 7 day services. Discussion is ongoing with Care Providers to ensure 7 day services which will facilitate early discharge from hospital. Access to primary care services is also being considered as part of the ongoing work for transforming community health services.

	The ambition for integrated care hubs across four localities in Central Bedfordshire will also underpin this requirement through new ways of working and opportunities for timely access to care and support services.
	Overview of performance – Delivering the National Metrics
18..	Delivery against the BCF national metrics remains challenging. (Figure 2) The BCF performance framework which is monitored by the Commissioning Board is attached as Appendix 4.

Figure 2

Ref	Indicator	2015-16 Target	2015-16 (to date)	RAG rating and trend	Key issues for consideration	Mitigation Actions
BCF 1	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	6,380	6,868	R ⇧	Reduction remains challenging.	SRG work and response to winter pressures.
BCF 2	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	383.5	347.5	R ⇧	Not likely to meet full target.	Scrutiny of packages of care; crisis prevention through support for carers; discharge coordination.
BCF 3	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	93.8%	81.0%	R ⇧	On track but not likely to meet target. Community rehabilitation figures still missing.	Pursue completeness of data.
BCF 4	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	1008.3	897.7	G ⇧	Delayed transfers of care now green	Will continue to monitor performance
BCF 5	Customer/Patient Experience	65.8	63.1	A⇧	GP survey data only available twice yearly.	Other local measures more frequently available and are being considered. These include Adult Social Care Outcomes Survey and satisfaction with Disabled Facilities Grants.
BCF 6	Rate of emergency admissions for injuries due to falls in persons aged 65+ per 100,000 population	1,686.4	n/a	n/a	Rate of emergency admissions for injuries due to falls in people aged 65+ - no new data available	Although 2014/15 data awaited, there are ongoing initiatives to reduce falls. Falls prevention and awareness training is being rolled out. The Council's Urgent Homes and Falls Response Service is being extended into Care Homes.

BCF 1 Total non-elective admissions (General and Acute) per 100,00 population	
19.	This is a pay for performance element of the Better Care Fund and is focused on reducing non-elective admissions that could be avoided through management in primary or community care. This can be influenced by health and care systems working together and as such is measuring combined Health and Social Care performance on an annual basis. The Council is working with health colleagues through the Better Care Fund (BCF) around reduction in emergency admissions to acute settings for the Bedfordshire population. However, achieving the target remains challenging.

20.	A review of non elective admissions in Central Bedfordshire has been undertaken. Work has also begun in areas with higher rates of emergency admissions and includes a focus around proactively managing people with long term conditions. A risk stratification model is also been used to support the work of multidisciplinary teams as part of the Caring Together Project. In addition to this, the additional projects, (Appendix 2) with targets which have been mobilised should also deliver some reductions.
BCF2 – Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	
21.	Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency. Although on track for improved performance, the target for this measure is not likely to be met. Frailty and dementia remain the most common diagnosis for admissions. Since April 2015, there were 153 new placements into residential and nursing care against a target of 106. Packages of care are being scrutinised through a panel process to ensure that all alternatives have been explored and that the focus remains on helping people to remain in their own homes. Work is on going to improve hospital discharge coordination and reduce reliance on residential care. Crisis prevention plans with carers are also being put in place. The Council's development of more independent living (extra care) accommodation will help to mitigate admissions into residential care.
BCF3 – Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	
22.	The measure currently reports only on the Council's reablement service and does not include outcomes data in relation to rehabilitation/intermediate care provided through Community Health Services. Consequently, although this measure shows an improving trend, it is unlikely to meet the full target of the BCF Plan. Discussion is ongoing to enable access to community rehabilitation data in order to provide a complete picture of the effectiveness of intermediate and reablement services.
BCF4 – Delayed transfers of care (delayed days) from hospital per 100,000 population	
23.	This measure indicates the ability of the whole system to ensure appropriate transfer from hospital for all adults and is on target. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care. The main reasons for delay are attributed to patient and family choice and completion of assessment. A key issue is the number of hospitals which discharge patients into Central Bedfordshire and the need to support early discharge planning and coordination through joint working.

	Weekly monitoring is ongoing through the winter period to facilitate hospital discharge coordination as well ensuring clearer recording of reason for delay.
BCF5 – Patient/Service user experience	
24.	No single measure of integrated care is currently available for this metric on patient / service user experience. A new national measure is being developed, but will not be in place in time to measure improvements in 2015/16. In the meantime other metrics that can provide an indication of patient/service user experience are being used. • The GP Patient survey includes the question on whether patients have had enough support from local services or organisations to help manage long term health conditions. The proportion of people who reported being satisfied with the support they received for managing their Long-term Conditions fell slightly from 65% in October 2014 to 63% in April 2015. The proportion of people who said they have not needed support to manage their condition increased. More work will be needed to understand the influencing factors for more people not needing support. • Percentage of customers satisfied with Disabled Facilities Grant service. This measure scored 88% in quarter two and although marginally short of the target of 90%, this measure was green for the previous year outturn. • An annual Adult Social Care Survey also measures overall satisfaction of people who use services with their care and support. 63% of people reported overall satisfaction. This figure is comparable to the regional outturn of 63%. • Proportion of people who use services who find it easy to find information about services. Central Bedfordshire results of 74% for service users and 69% for carers are slightly higher than the Eastern region average of 73% and 65% respectively.
BCF6 – Rate of emergency admissions for injuries due to falls in persons aged 65+ per 100,000 population	
25.	Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, such as people needing to move from their own home to long-term nursing or residential care. The highest risk of falls is in those aged 65 and above and it is estimated that about 30% people aged 65 and above living at home and about 50% of people aged 80 and above living at home or in residential care will experience an episode of fall at least once a year. Falls that results in injury can be very serious and can result in a fracture or hospitalisation and can impact significantly on non-elective admissions and hospital bed days.

	This measure is reported annually and the 2014/15 data is outstanding. However, the outturn for 2014/15 showed improvements against the BCF baseline rate for 2012/13. There are ongoing initiatives to reduce falls and this is one of the key areas mobilised to reduce non-elective admissions.
	Implications of Performance for Delivery of BCF Plan
26.	It is clear that there are now real challenges within the health and social care system in Central Bedfordshire for delivering an ambitious BCF Plan, particularly in relation to reducing unplanned admissions to hospitals. Although there have been some successes, the review of schemes (Appendix 1), has shown that there are a number of key areas that would benefit from a greater focus and colleagues are working to scope these further to ensure a more focused and achievable plan for 2016/17. This will include the role and use of Care Homes, multidisciplinary team working, and, integrated therapy/intermediate care services. There is local recognition and agreement that a focus on these areas would deliver more significant benefits to the population. It is intended to report in more detail to a future meeting of the Health and Well Being Board.
	Financial Summary
27.	From the activity in all of the schemes set out in Appendix 1, the Pooled Fund of £18.707m shows a forecast underspend of £1.053m.
28.	As the non-elective admissions set out in the plan have not achieved the required 1.5% reduction, the Pooled Fund needs to make allowance of a Pay for Performance target payment of £0.527m.
29.	Deducting the Pay for Performance payments from the initial Pooled Fund under spend, this leaves an overall revenue surplus of £0.044m and capital surplus of £0.482m. Both elements will be rolled forward to support the BCF in 2016/17.
	Planning for BCF 2016/17
30.	The template for BCF 2016/17 is due to be issued in January. The process for development and assurance of local plans will be more streamlined and better integrated into the business as usual planning processes for Health and Wellbeing Board, CCGs and local authorities. A light touch monitoring is proposed by NHS England.

31.	The timescales for submitting Better Care Fund local plans will follow the deadlines set out in the NHS Planning Guidance: • First draft – 8 February 2016 • Refresh – mid-March 2016 • Final submission (signed off by Health and Wellbeing Boards) - mid-to-late April 2016
32.	In light of the tight timescales, the first draft submission of Better Care Fund local plans on 8 February will be high-level, focused around the finances and core principles, whilst providing sufficient detail to support Councils' budget setting processes. The detailed requirements for submissions and the exact timings for the March and April resubmissions will be confirmed in the guidance.
33.	Schemes and projects will need to be reviewed and consolidated to focus on immediate local priorities including, finances, and transformation of community services, 7 day working, information sharing and systems and delivery of future care models.
34.	Clearly the ongoing review of Community Health Services will influence how the next BCF Plan would need to be adapted to meet the current requirements of local health and care system. The BCF Plan would also need to set out plans for developing a system-wide plan for 2017.
	Conclusion
35.	Delivery of the BCF plan has been a challenge due to challenges and constraints within the local health and care system. Future care delivery requires a clear focus on what can be delivered within the current care economy and the levers to facilitate that which includes re-procurement of services will be required.
36.	Some progress has been made on a number of the projects within the six schemes. The pay for performance element of the Better Care Fund, which is focused on reducing non-elective admissions, remains a key priority; however achieving the required target reduction in non-elective admissions remains challenging. A reshaping of how care is delivered is required and importantly linked to the re-provision of community health services.
37.	Although transformation of Community Health Services is a key enabler for addressing some of the challenges described, there are other wider issues in the system such as, variations in care quality and experience and importantly workforce shortages in domiciliary care which has a real impact on the ability to keep people at home for longer.
38.	Central Bedfordshire Council, Bedford Borough and Bedfordshire Clinical Commissioning Group are working in partnership to agree a plan for the transformation of community services.

39.	The Chancellor for the Exchequer's announcement of the continuation of the Better Care Fund Plan for 2016/17, with available funding from 2017, to local government, worth £1.5 billion in 2019-20, to be included in the Better Care Fund, requires a robust Systems Plan. The intention is that by 2020 health and social care are integrated across the country, and a requirement for every part of the country to have a plan for this in 2017, implemented by 2020. Further information on the next iteration of the BCF Plan is expected in January.

Reasons for the Action Proposed	
40.	The Health and Wellbeing Board (HWB) has a statutory duty to promote integration and is seen as a valuable forum for stakeholders to come together to review performance of the BCF and consider opportunities for transforming health and social care. The expectation is that HWBs will continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners[1].
41.	NHS England guidance requires that local areas submit quarterly and annual reports. Health and Wellbeing Boards are required to sign off the performance report before it is submitted.
42.	There is a requirement to produce a BCF Plan for 2016/17 and a wider Systems Plan by 2017.
	Next steps
43.	• Continue to monitor the impact of key projects for reduction in non-elective admissions. • Produce draft BCF Plan for 2016/17 for submission in February 2016. • Implement a programme framework for delivery of BCF Schemes aligned to the wider integration agenda.

Issues	
Governance & Delivery	
43.	Progress on the Better Care Fund Plan will be reported to the Health and Wellbeing Board and delivery will be through agreed Joint Commissioning Board and governing boards for partners. The Health and Wellbeing board will provide overall assurance and sign off performance monitoring returns.

[1] Section 195 of the Health and Social Care Act 2012

Financial	
44.	The payment by result element of the BCF may pose a risk to both CBC and the CCG. Risks have been identified as well as mitigating actions which were recorded in the BCF Risk Plan. A risk sharing agreement has been produced and will form part of the Section 75 agreement. The section 75 agreement is a legal contract that outlines the responsibilities of both the CCG and CBC through the aligned and pooled budget arrangements.
Public Sector Equality Duty (PSED)	
45.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between and in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
46.	Are there any risks issues relating Public Sector Equality Duty Yes/**No**
47.	If yes – outline the risks and how these would be mitigated

Source Documents	**Location (including url where possible)**
BCF Plan	http://www.centralbedfordshire.gov.uk/Images/The-Central-Bedfordshire-Better-Care-Plan-final_tcm6-62825.pdf#False

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TBC - , Bedfordshire Clinical Commissioning Group

Appendices:.

Appendix 1 – High Level Scheme Analysis and Progress

Appendix 2 - Reducing Non- Elective Admission - Update January 2016

Appendix 3 – Quarter 2 Monitoring Report

Appendix 4 – Performance and Finance Report

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Appendix 1 – Better Care Fund - High Level Scheme Analysis and Progress

Scheme Area	Scheme Outline	Deliverables	Expected Outcomes	Current status
Scheme One Transforming Primary Care:	Transforming primary care is a key component of delivering person centred; locality based integrated health and social care with a focus on prevention and self-care. It is fundamental to responding to a rapidly growing and ageing population. This scheme has three elements. 1. Prevention and Early Intervention 2. Long-term conditions management in primary care 3. Accountable Lead Professional/GP Federations	• Establishment of integrated health and social care locality teams • Roll out and adoption of LTC SystmOne templates across all practices. • Determining the model for the lifestyle hub • Capacity within primary and community care services • Establishing robust KPIs for each scheme to effectively measure impact	Prevention and early identification of those at risk; single access point care-coordinator (named GP); Standardised high quality care consistent across all practices; Priority access rapid assessment and early diagnosis; Supported discharge self-management follow up and support and access to single patient record To ensure that care is co-ordinated, seamless and can effectively wrap around the patient, making their needs paramount	**Lifestyle Hubs:** The successful establishment of a lifestyle hub in Chiltern Vale which has been running since February 2015. Clients are pre-dominantly aged 46-55 and are referred for advice/support related to obesity. This has an approximately cost of £144 per patient. Although the benefit of this service is considered to be that it looks at the whole person. A full review of this pilot, which will include its cost effectiveness, is expected in Q4. **Accountable lead professional –** All patients over 75s have a named GP.. Provision of risk stratification tools (manual & electronic) to all General Practices **Long term conditions management in primary care:** A more standardised means of collecting data in the four disease areas- LTC Template production for SystmOne has been launched and is in use.
	Finance		The investment in Transforming Primary Care in the main comes from existing Primary Care and Public Health resources although £0.090m in 2015/16 was made available to support the creation of the Lifestyle Hubs. The forecast outturn is in line with this budget.	

Scheme Area	Scheme Outline	Deliverables	Expected Outcomes	Current status
Scheme Two Integrated Rapid Response:	**Integrated Rapid Response for people with long term conditions and the frail elderly.** This includes the following areas: • Caring Together (formerly Demonstrator project) • Community Beds • Acute services in the community – Hospital at Home, Specialist Nurses (neurology) • Paediatric Urgent care • Integration of OT Services • Integration of rehab and reablement The objectives of this scheme is to: • Use resources across the whole system more effectively and efficiently to maximise investment in prevention and early intervention • Provide targeted support and information at key life stages and events to prevent or delay the need for care and support or further deterioration • Work holistically to promote health and wellbeing.	To develop locality based models that provide an integrated rapid response to urgent health and/ or social needs as an integrated team, implementing an integrated/ co-ordinated care plan. Paediatric Urgent Care to reduce A&E attendances and admissions for children and young people with lower respiratory tract infection through a targeted approach to groups of the community Integrated Rehabilitation and Re-ablement in the 4 primary care localities in Central Bedfordshire a co-located health and social care team to facilitate an integrated rehabilitation & reablement service Integrated Occupational Therapy	To place the patient at the centre of their care Deliver safe care in the right setting, at the right time Support independence and self-care Reduce avoidable hospital admissions Reduce hospital and institutional length of stay Reduce the number of patients discharged into permanent institutional care settings Reduce the number of patients referred to institutional care following hospital discharge Decrease in the number of avoidable paediatric admissions.	**Slow progress on key elements of this workstream such as** • Integration of rehabilitation and Reablement – not achieved. • Integration of occupational therapy services – early discussions are now underway. • Acute services in the community – this will be taken forward as part of the review of community health services. • **Community beds:** Significant piece of work, reviewing the pathways has been completed. A key finding was that longer stay rehabilitation (slow stream) beds are an issue. However Ward 5 at the L&D, although high cost, delivers good length of stay figures **2.5 Demonstrator project (Caring Together): Initial plans for the demonstator project stalled. This has now been superseded with the Caring Together project. This has** Introduced a Multi-Disciplinary Team (MDT) working project to provide integrated response to those patients most at risk of admission and other people who would benefit from a more joined up response. A pilot across two GP Practices in two localities, Chiltern Vale and West Mid Beds is now underway. Lessons from

Scheme Area	Scheme Outline	Deliverables	Expected Outcomes	Current status
				the pilot will be used to inform the ongoing review of Community Health Services and the roll out of MDT working across Central Bedfordshire. **Dementia services:** Dementia Health Needs Assessment completed. Dementia Friendly Communities programmes initiated- Dementia project s now considered business as usual within commissioning. 280 CBC staff are dementia friends and nine care homes have gone through the CBC dementia quality mark process **Paediatric Urgent Care:** Project has been completed. It aimed to reduce urgent care admissions amongst children and young people, empower parents to recognise and manage minor ailments. It also increased staff training to manage certain conditions in the community.
	Finance		The investment in Integrated rapid Response is £7.144m in 2015/16. This includes activity through Reablement, Rapid Intervention, Community Capacity and Home from Hospital services. The projected forecast for the year is £7.220m, £0.076m above the budget. There is an over spend on Community Beds mainly offset by an under spend on the Demonstrator Project.	
Scheme Three Efficient Planned Care	To reshape the way in which planned care is provided and delivered through: • Implementation of the redeveloped community	Re-commissioned community services to work as part of a multi-disciplinary team, based on a Care Function Approach. A key design principle of this MDT will	The anticipated benefits from this scheme are a reduction of 225 non-elective admissions, a financial saving of £0.335m	**Community services** A programme of work for a complete transformation of adult and children's' community services has now commenced.

Scheme Area	Scheme Outline	Deliverables	Expected Outcomes	Current status
	nursing specification • End of Life (EoL) services • Integrated falls, osteoporosis, and fracture prevention services • Integrated wheelchair, equipment and telecare services • Disabled Facilities Grant 1. Improved care co-ordination should: 2. 3. Reduction in 'unplanned' admissions into hospital or institutional care for patients 75+ initially 4. Early intervention in care, improving patient outcomes 5. Enhance patient experience and improve independence 6. Decrease in hospital length of stay 7. Increase training and education, especially for carers 8. Provide better care without unnecessary delays	be that care will be delivered holistically wherever possible, by any member of any team that has the capacity and capability. The Care Function Approach includes seven Care Functions: 1. Access and Coordination 2. Rapid Response 3. Facilitated and Supported Discharge 4. Maximising Independence 5. Complex Case Management 6. Scheduled and On-going Care 7. Specialist Input **End of Life (EoL) services** - to systematically review all the services that support End Of Life Care pathway. **Integrated falls, osteoporosis, and fracture prevention services-** With four sub-projects: 1. A Fracture Liaison Service 2. Community Falls Prevention Coordinators 3. Community Strength and Balance Exercise Classes 4. A Central Bedfordshire Physiotherapy Falls Service **Integrated wheelchair, equipment and telecare services** Streamlining and integrating these services into a co-	in 2015/16. In addition savings of £0.164m are proposed from the Telecare, Equipment and Wheelchair services as we combine service delivery. Contractual savings of £0.100m will be sought from End of Life Services.	**Falls** The full programme of work outlined in the plan has not been delivered however, work has now commenced and is linked to facilitating a reduction in non-elective admissions. Fall prevention training is being delivered to Care Homes and Domiciliary Care providers. The Council's Urgent Homes and Falls Response Service is piloting support into Care Homes. Each Care Home is to identify a Falls Champion. **End of life services** Five Step EOL training to Care Home staff, designed to not only improve EOL care but assist with best interest decision making on preferred place of death. Training provided to Ambulance staff to support non-conveyance has by month 8 resulted in 201 non-conveyances. **3.4 Integrate wheelchair, equipment and telecare services** Project on hold. **3.5 Disability facility grants** Rolling programme with quarterly monitoring – existing. To date (8th Dec), the Council have spent £1.4M on major adaptations but have £2.9M of work in progress. The

Scheme Area	Scheme Outline	Deliverables	Expected Outcomes	Current status
		commissioned arrangement.		Council has £708k of BCF funding but also obtains contributions from customers and housing associations on occasion. The impact of DFG's is difficult to quantify accurately. Adaptations will improve the safety, independence and accessibility for people in their of homes, preventing falls and accidents, (particularly on stairs and in bathrooms), and assisting carers by reducing need for lifting minimising the risk of moving and handling of disabled people. Recent research by the charity Foundations concludes that DFG adaptations reduce admissions by around 4 years on average. Adaptations are undertaken within the 12 week target, however waiting times for OT assessment can impact on the DFG service. The OT service will screen each individual referral and respond promptly with appropriate recommendations where high risk is identified, facilitating and supporting DFGs with housing colleagues. Currently the average length of time from Occupational Therapy referral to DFG approval is better than 2014/15, currently at 8 weeks compared to a 2013/14 average of 10.9 weeks.
	Finance		The investment in Efficient Planned Care is £7.755m in 2015/16. This includes activity through Community Nursing & Matrons, Equipment,	

Scheme Area	Scheme Outline	Deliverables	Expected Outcomes	Current status
			Telecare, Wheelchair, End of Life and additional Falls services. The projected forecast for the year is £7.373m, £0.382m under budget. The main reason for this is an under spend against the new anticipated Falls activity.	
Scheme Four Supported discharge	Co-ordinated and supported discharge from hospital with ongoing community care: • To deliver fully integrated, IT generated communication links for all patient discharges from acute hospitals, initially starting with the Luton and Dunstable Hospital. • To enable both GPs and community teams to continue the care of the patient as soon as possible following discharge, with the key aim of preventing re-admission • To enable patients to return back to their usual place of residence once confirmed medically fit	To develop a daily IT driven data flow between acute hospitals initially providing discharge information. Care Home staff to carry out an assessment on the patient within L&D Hospital, prior to arranging for the patient to be discharged. To engage a dedicated Locality Discharge Coordinator role specifically focused on providing co-ordinated discharges from acute providers for patients over the age of 18 years, for both elective and non-elective admissions. Improve support to Carers	Integrated patient care at the right time by the appropriate service. Defined and streamlined communication links Enhanced and streamlined way of working between provider services. Enabling patients to return back to their usual place of residence as soon as possible once confirmed Medically Fit. Decrease Length of stay (LOS) by 1 day for patients awaiting assessment for Restart by Care Homes. Reduction in LOS / reduction in excess bed days for patients receiving Social Care input. Reduction in LOS for any Delayed Transfer of Care (DTOC). People are supported to	**Discharge facilitation pilot in West Mid Beds –** pilot completed. Decision taken not to recommission as resulting efficiencies did not cover the cost of the service. Learning from the pilot will be used to work closely with current providers of discharge coordination to improve existing patient pathways and outcomes. **Voluntary sector support to reduce re-admission** Ongoing work to explore how the voluntary sector can help to reduce hospital admissions and to facilitate discharge from hospital to reduce delayed transfers of care. **Carer support** Care Act-Workstream established which includes response to meet carer needs. A carers' lounge has been opened at the L&D to mirror that at Bedford Hospital **Prevention and promoting independence partnership:** A multi-agency partnership established. Physical activity and

Scheme Area	Scheme Outline	Deliverables	Expected Outcomes	Current status
			settle back into their own home effectively, after a hospital stay People are supported to settle back into their own home effectively, after a hospital stay Supporting the carer to enable the cared for to live at home as independently as possible.	exercise trainer programmes for frail older people is being commissioned. Time bank coordination in place. Promoting Independence Fund Scheme to be launched.
	Finance		The investment in Supported Discharge is £2.682m in 2015/16. This includes activity through providing care home placements together with discharge facilitation through hospital social work teams and discharge coordinators. The projected forecast for the year is £2.455m, £0.253m under budget. The main reason for this is an under spend against new Discharge Facilitation activity.	
Scheme Five Care Act	Councils now have a duty to consider the physical, mental and emotional wellbeing of the individual needing care and a new duty to provide preventative services to maintain people's health. This scheme incorporates four key workstreams: 1. Promoting Individual Wellbeing (Prevention, Housing & Public Health) and Information, Advice and Advocacy 2. Assessment & Eligibility and Care Planning &	**Implementation of the Care Act** Phase One.	Reducing emergency admission and delayed transfer of Care Supports for Carers - to enable them continue their caring role, remaining healthy and promoting their independence. This relates to all carers across the social care client groups: Older people; with learning disability; mental health, parent carers and young carers.	Duties set out in Phase One of the Act are now being embedded in local practice. Phase two implementation has been deferred.

Scheme Area	Scheme Outline	Deliverables	Expected Outcomes	Current status
	Personalisation 3. Paying and Charging for Care 4. Quality & Safety and Care Markets		Person centred and flexible support based on assessment of carer needs Timely access to Information and advice Support to stay in employment	
	Finance		The Better Care Fund allowed for an allocation of £0.554m in 2015/16 to support the implementation of the Act. The forecast spend position is as per the budget.	
Scheme Six Better Care Fund Implementation	This scheme established a robust framework for the enablers to ensure that the other schemes can be successfully delivered including: • Robust Governance framework • Communications & engagement • Finance and performance • Information governance • Workforce and training Design and implementation	The key success factors will be: • A strong Programme Management approach • Capacity and capability of staff to deliver requirements • Strong partnership working across organisations • Strong financial management and oversight of pooled budget • Clear communication and engagement with all stakeholders • Shared Patient Record with real-time information across multiple agencies to support integrated joined up care	Senior executives from all participating organisations will be engaged at the appropriate level Communication and engagement plan developed is delivered appropriately to all audiences. Creation and monitoring of the pooled budget, Performance against the requirements is monitored and interacts with relevant projects to ensure action is taken to bring performance in line To identify, evaluate and	**6.1 Governance** Commissioning Board established. Operational delivery group in place. Provider Alliance launched Links with CCG Locality Boards established. **Communication and engagement** Stakeholder analysis- commenced & ongoing **Finance and performance** Pooled budget established and S75 agreement signed. Performance and finance monitoring framework agreed and reviewed monthly. Quarterly reporting to NHS England. **Information governance** NHS number is now used

Scheme Area	Scheme Outline	Deliverables	Expected Outcomes	Current status
			agree how patient information will be shared. Thinking from patients, health and social care colleagues in order to design aspects of what the integrated care model should look like and how it should operate Ensure standardised approaches across the area and that key learnings are shared. Increase in skill, knowledge and confidence throughout workforce Improved co-ordination and efficiency between health and social care Streamlined communication	predominantly as primary identifier across all agencies and systems. Key issues remain in relation to IT solutions and data sharing to facilitate joint care planning and assessments. **Workforce and development** Staff engagement and new ways of working being explored. **Design and implementation** Creation of BCF design principle – existing. This is now being used as part of the Transforming Community Services programme.
	Finance		The allocation of £0.482m under this scheme was of a capital nature. No capital expenditure as such has been incurred during the year and therefore this allocation of £0.482m will roll forward into 2016/17.	

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Appendix 2

Reducing Non- Elective Admission - Update January 2016

Long Term Conditions

People with long term conditions continue to see variation in care and services. The current system fragments care for individual patients and the lack of continuity often leads to poorer outcomes and hospital admissions. There is limited proactive care and the standard of care is inconsistent across practices, there are multiple access points for patients, a level of inappropriate admissions and delayed transfers of care in a system where it is difficult to navigate between health and social care. Care is often only provided in response to a crisis or cry for help and there is poor access to information and data. The aim of this work is to:

- increase prevention and early identification of those at risk of developing a Long Term Condition
- standardise high quality care, reduce variation and ensure consistency across LTC management in all practices
- develop and implement SystmOne templates to support practices to manage patients with Long Term Conditions and improve quality and consistency of care

A number of templates have been finalised and were launched at a Long Term Conditions Conference in October.

End of Life Care (EoL)

The objective of the initiative is to avoid hospital admissions. This is done by East of England Ambulance Service Trust (EEAST) not conveying EoL patients to hospital (where appropriate) and instead working with the Partnership in Excellence for Palliative Care (PEPS), which is a single point of access for patients, carers and professions to co-ordinate care for the patient in their own home. The benefits of this initiative will be to patients who wish to remain in their own homes for EoL care. Through the PEPS service, patients receive a coordinated timely response that is appropriate to their needs. 42% of EEAST frontline staff have been trained on the End of Life Pathway/PEPS service and this initiative is showing reduction in non-conveyance. Actual numbers of non-conveyance has increased from 15 in April to 34 in August 2015.

Falls

The project aims to reduce the number of emergency admissions for falls by ensuring the opportunities for avoiding hospital admissions are maximised in the current pathway and by ensuring that Falls Prevention training is provided to high risk populations to both prevent falls and reduce the harm caused due to falls. It will identify populations at high risk of falls with proactive response through training to Care Homes and Domiciliary Care Providers and the extension of the Council's Urgent Home and Falls Response Service into Care Homes. A Falls prevention and awareness training programme is being offered to all Care Homes in Bedfordshire. The launch event for Care Home

training took place in September and representatives from 25 care homes attended, 34 people including EEAST, Complex Care Team and SEPT representatives. Further training is planned. Each Care Home will be asked to identify a falls Champion and a falls support/service director will be developed for Care Homes.

Care Homes

To ensure improved and consistent quality of care to care home residents with timely input to prevent/reduce inappropriate hospital admissions. Following a review of ambulance data, the Council and CCG are undertaking joint visits to care/nursing homes with high numbers of ambulance conveyancing to ensure they are getting appropriate support and accessing all services available to reduce the number of people transferred to hospital. PEPs is also being extended to provide information and advice to all Care Homes, so that patients and family members can be supported with enquires and decisions on preferred place of death for patients, avoiding unnecessary conveyance to hospital. PEPs are also delivering 5 Step EOL training to Care Home staff, designed to not only improve EOL care but assist with best interest decision making on preferred place of death.

This initiative will also identify any gaps in providing good physical healthcare, as well as promoting access to falls service, diagnosis for dementia and the End of Life pathway. An extension of the Council Urgent Falls and Homes Response Service into Care Homes is also being piloted.

In addition to these projects work is also under way, in view of **Winter Pressures**, to review bids for winter schemes to facilitate discharge. Systems Resilience Group is reviewing the proposals to meet winter challenges. £1.3m of funding has been allocated for winter pressures schemes across the Bedfordshire health system. It will support the following:

- Hospital at Home
- Clinical Navigation
- Ambulatory emergency care
- Discharge assessor

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 27th November 2015.

The BCF Q2 Data Collection

This Excel data collection template for Q2 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on BCF metrics. It also presents an opportunity for Health and Wellbeing Boards to feedback on their preperations for the BCF in 16/17 and register an interest in planning support.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an explanation of any material variances against planned performance trajectories as part of a wider overview of progress with the delivery of plans for better care.

Collecting Data for New Integration Metrics

In addition, as part of this data collection we are also asking for information to support the development of new metrics for integration. These relate to Jeremy Hunt's announcement at the Local Government Association Conference in July that a new set of metrics is needed to measure the degree to which a health and social care economy is making progress towards delivering integrated, coordinated and person-centred care. This set of metrics is currently in the development stages, and we are taking the opportunity through the Q2 reporting process to trial a small number of new measurements.

We welcome your feedback on the new collections included in the Q2 reporting template, as well as the integration metrics project as a whole: your input will be vital in designing a set of measures that can help to monitor and accelerate the move towards a more coordinated, person-centred health and care system.

Cell Colour Key

Data needs inputting in the cell
Pre populated cells
Question not relevant to you

Content

The data collection template consists of 9 sheets:

Validations - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements- this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Non-Elective and Payment for Performance - this tracks performance against NEL ambitions and associated P4P payments.
5) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
6) Metrics - this tracks performance against the two national metrics, locally set metric and locally defined patient experience metric in BCF plans.
7) Preparations for the BCF 16-17 - this assesses your current level of planning for next year
8) New Integration metrics - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care
9) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Validations

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 8 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the Q1 2015-16 submission and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously the 2 further questions are not applicable and are not required to be answered.
If your previous submission stated that the funds had not been pooled via a Section 75 agreement, can you now confirm that they have?

If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track to be met through the delivery of your plan (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please provide a target date when you expect the condition to be met. Please detail in the comments box what the issues are and the actions that are being taken to meet the condition.

'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.

Full details of the conditions are detailed at the bottom of the page.

4) Non-Elective and Payment for Performance

This section tracks performance against NEL ambitions and associated P4P payments. The latest figures for planned activity and costs are provided along with a calculation of the payment for performance payment that should have been made for Q1. Two figures are required and one question needs to be answered:

Input actual Q2 2015-16 Non-Elective performance (i.e. number of NELs for that period) - Cell M12
Input actual value of P4P payment agreed locally - Cell E23
If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box
Please confirm the Q4 15/16 plan figure that should be used either by re-entering the figure given or providing a revised one - Cell E46

5) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Forecasted income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1 and Q2
Forecasted expenditure from the pooled fund for each quarter of the 2015-16 financial year

Confirmation of actual expenditure into the pooled fund in Q1 and Q2

Figures should reflect the position by the end of each quarter. It is expected that planned income and planned expenditure figures for Q4 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan.

6) Metrics

This tab tracks performance against the two national, the locally set metric and locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:

An update on indicative progress against the four metrics for Q2 2015-16
Commentary on progress against the metric

Should a local and/or a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

7) Preparations for BCF 16-17

Following the announcement that the BCF will continue in 2016-17 this section assesses where you are at in terms of the level of preparation so far. There is also an opportunity to advise if you would like any support with preparation of your BCF plan and in what format you would like this to take.

8) New Integration Metrics

This tab requests information as part of the development of a new set of metrics to measure the degree to which a health and social care economy is making progress towards delivering integrated, coordinated and person-centred care.

This set of metrics is currently in the development stages, and we are taking the opportunity through the Q2 reporting process to trial a small number of new measurements. There are three metrics for which we are collecting data. The detail of each is set out below.

The data collected on these subjects will be used as part of a wider suite of metrics that will be published in beta form in the new year, with a view to launching an official set of integration metrics in the first quarter of the next financial year. This set of metrics will be used in a similar fashion to the current BCF reporting process, allowing best practice to be collected and shared, and support to be targeted towards those areas that would most benefit from it.

1. The development and use of integrated care records.
There is widespread consensus that having digital care records that are available across health and care settings will facilitate the delivery of more coordinated, person-centred care. However, it is equally clear that this is a long-term ambition that will take several years to realise. In the first instance, therefore, we will be seeking to measure early progress towards this goal by asking you slightly modified versions of the pre-existing reporting questions on use of the NHS number and open APIs.

Proposed metric: Integrated Digital Records. To be assessed via the following questions:
• In which of the following settings is the NHS number being used as the primary identifier? (To select all of the following categories which apply (Y/N) – GP / Hospital / Social Care / Community / Mental health / Specialised palliative)
• In which of the following settings is an open API (i.e. systems that speak to each other) in place? (To select all of the following categories which apply (Y/N) – GP / Hospital / Social Care / Community / Mental health / Specialised palliative)
• Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2? (Y/N)

2. Risk stratification
The second new measurement concerns the use of risk stratification tools to inform both strategic commissioning across health and social care, and case finding of those individuals who would most benefit from preventative care. Again, while this practice is recognised as an effective way to deliver more appropriate, targeted and responsive services, it is also in the relatively early stages of development. In the short term we are looking to understand how many CCGs are using risk stratification tools, and how they are being used to inform strategic commissioning decisions on the one hand and the use of care plans on the other.

Proposed metric: Use of Risk Stratification. To be assessed via the following questions:
• Is the local CCG(s) using an NHS England approved risk stratification tool to analyse local population needs? (Y/N)
• If yes: Please provide details of how risk stratification modelling is being used to allocate resources
• Based on your latest risk stratification exercise what proportion of your local residents have been identified as in need of preventative care? (%)
• What proportion of local residents identified as in need of preventative care have been offered a care plan? (%)

3. Personal Health Budgets
Finally, personal budgets in both health and social care are likely to play an important role in the evolution of the health and social care system towards a greater degree of personalisation. In the long-term we expect individuals who hold personal budgets in both health and social care to benefit from combining these into an integrated personal budget. However, at this stage we are interested to learn what progress areas are making in expanding the use of personal health budgets beyond people in receipt of continuing health care.

Proposed metric: Personal Health Budgets. To be assessed via the following questions:

- Have you undertaken a scoping exercise in partnership with local stakeholders to understand where personal health budgets would be most beneficial for your local population? (To select from drop down: No / In the planning stages / In progress / Completed)
- How many local residents have been identified as eligible for PHBs, per 100,000 population?
- How many local residents have been offered a PHB, per 100,000 population?
- How many local residents are currently using a PHB, per 100,000 population?
- What proportion of local residents currently using PHBs are in receipt of NHS Continuing Healthcare?

9) Narrative

In this section HWBs are asked to provide a brief narrative on overall progress in delivering their Better Care Fund plans at the current point in time with reference to the information provided within this return.

Better Care Fund Template Q1 2015/16

Data collection Question Completion Validations

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

S.75 pooled budget in the Q4 data collection? and all dates needed
Yes

3. National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" estimated date if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

4. Non-Elective and P4P

Actual Q1 15/16	Actual payment locally agreed	Any unreleased funds were used for: Q2 15/16	Q4 2015-16 confirmed NEA plan figures
Yes	Yes	Yes	Yes

5. I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the annual totals and the pooled fund
Income to	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes			
	Actual					
Expenditure From	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes			
	Commentary	Yes				

6. Metrics

	Please provide an update on indicative progress against the metric?	Commentary on progress
Admissions to residential Care	Yes	Yes

	Please provide an update on indicative progress against the metric?	Commentary on progress
Reablement	Yes	Yes

If no metric, please specify	Please provide an update on indicative progress against the metric?	Commentary on progress
Local performance metric	Yes	Yes	Yes

If no metric, please specify	Please provide an update on indicative progress against the metric?	Commentary on progress
Patient experience metric	Yes	Yes	Yes

7. Preparations for BCF 16-17

Have you begun planning for 2016/17?	Yes
Confidence in developing BCF plan?	Yes
Pool more, less, or the same amount of funding?	Yes
Support in developing plan?	Yes

If yes, support area?	Interested in support?	Preferred support medium	If preferred support medium is 'other', please elaborate
Developing / reviewing your strategic vision	Yes	Yes	Yes
Building partnership working	Yes	Yes	Yes
Governance development	Yes	Yes	Yes
Data interpretation and analytics	Yes	Yes	Yes
Evidence based planning	Yes	Yes	Yes
Financial planning	Yes	Yes	Yes
Benefits management	Yes	Yes	Yes
Other	Yes	Yes	Yes

8. New Integration Metrics

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS number being used as the primary identifier?	Yes	Yes	Yes	Yes	Yes	Yes
Open API in place?	Yes	Yes	Yes	Yes	Yes	Yes

Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?
Yes

Is the local CCG(s) using an NHS England approved risk stratification tool to analyse local population needs?	
	Yes
If 'Yes', please provide details of how risk stratification modelling is being used to allocate resources	
	Yes
How many local residents have been identified as in need of preventative care during the quarter?	
	Yes
What proportion of local residents identified as in need of preventative care have been offered a care plan during the quarter?	
	Yes

Have you undertaken a scoping exercise in partnership with local stakeholders to understand where personal health budgets would be most beneficial for your local population?	Yes
How many local residents have been identified as eligible for PHBs during the quarter?	Yes
How many local residents have been offered a PHB during the quarter?	Yes
How many local residents are currently using a PHB during the quarter?	Yes
What proportion of local residents currently using PHBs are in receipt of NHS Continuing Healthcare during the quarter?	Yes

9. Narrative

Brief Narrative
Yes

Cover and Basic Details
Q2 2015/16

Health and Well Being Board	Central Bedfordshire

completed by:	Patricia Coker
E-Mail:	patricia.coker@centralbedfordshire.gov.uk
Contact Number:	0300 300 5521
Who has signed off the report on behalf of the Health and Well Being Board:	Julie Ogley, Director of Social Care, Health and Housing

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. Non-Elective and P4P	4
5. I&E	15
6. Metrics	10
7. Preparations for BCF 16-17	28
8. New Integration Metrics	25
9. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:

Central Bedfordshire

Data Submission Period:

Q2 2015/16

Budget arrangements

Have the funds been pooled via a s.75 pooled budget?	No
If it has not been previously stated that the funds had been pooled can you now confirm that they have?	Yes
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q1 data collection previously filled in by the HWB.

National Conditions

Selected Health and Well Being Board:

Central Bedfordshire

Data Submission Period:

Q2 2015/16

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a date **and** a comment in the box to the right

Condition	Q4 Submission Response	Q1 Submission Response	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Commentary on progress
1) Are the plans still jointly agreed?	Yes	Yes	Yes		
2) Are Social Care Services (not spending) being protected?	Yes	Yes	Yes		
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes	Yes	Yes		
4) In respect of data sharing - confirm that:					
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	Yes	Yes		
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	Yes	Yes		
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes	Yes	Yes		
6) Is an agreement on the consequential impact of changes in the acute sector in place?	No - In Progress	No	No	01/04/17	The LA and CCG are working together to complete a full transformation of adult and childrens' community services.

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)

Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number

The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector

Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Footnotes:

Source: For each of the condition questions which are pre-populated, the data is from the Q1 data collection previously filled in by the HWB.

Better Care Fund Revised Non-Elective and Payment for Performance Calculations

Selected Health and Well Being Board: Central Bedfordshire

	Baseline				Plan				Actual				% change (negative values indicate the plan is larger than the baseline)	Absolute reduction in non elective performance	Total Performance Fund Available	Planned Absolute Reduction (cumulative) (negative values indicate the plan is larger than the baseline)				Maximum Quarterly Payment				Performance against baseline				Suggested Quarterly Payment				Total Performance fund	Total Performance and ringfenced funds	Q4 Payment locally agreed	Q1 Payment locally agreed
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16				Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16				
D. REVALIDATED: HWB version of plans to be used for future monitoring	5,434	5,708	5,815	6,232	5,434	5,600	5,835	5,988	6,041	6,241	6,239		1.5%	354	£527,460	0	108	88	354	£0	£160,920	-£29,800	£396,340	-609	-533	-624		£0	£0	£0		£527,460	£4,033,000	£0	£0

Which data source are you using in section D? (MAR, SUS, Other)	MAR
Cost per non-elective activity	£1,490

If other please specify

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggested quarterly payment (taken from above*)	£0	£0	£0	
Actual payment locally agreed	£0	£0	£263,730	

If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box (max 750 characters)	Agreed adjustment of cash flow from the CCG to the Council, who is hosting the pool, as the failure to reduce the non elective admissions target to the end of Q2.

	Total Unreleased Funds			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggested amount of unreleased funds**	£0	£160,920	-£29,800	
Actual amount of locally agreed unreleased funds	£0	£160,920	-£293,530	

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Confirmation of what if any unreleased funds were used for (please use drop down to select)	acute care	acute care	acute care	

Confirming Q4 2015-16 Non-Elective Admissions figures

During the exercise to allow HWBs to revise their baseline and plan figures for Non-Elective admissions we only requested the confirmation of figures for the Payment for Performance period (Q4 2014/15 to Q3 2015/16). In order to ensure we have a consistent and accurate set of numbers for the financial year 2015-16 we are now asking HWBs to reconfirm their **plan** figure for Q4 2015-16. The below table has been pre-populated with the original figures for Q4 2015-16 which you submitted as part of your approved BCF plan. Please confirm the plan figure that should be used either by re-entering the figure given or providing a revised one.

	Q4 15/16 figures previously provided	Q4 15/16 confirmed figure
Plan (taken from original HWB BCF plans)	5,033	6,041
Baseline (Q4 14/15 actual - as confirmed by HWBs in July 2015)	6,041	

Footnotes:

Source: For the Baselines, Plans, data sources, locally agreed payment and cost per non-elective activity which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs as at 10am on 19th August 2015. (Except cell C46 taken from original BCF plan database as at February 2015)

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Central Bedfordshire

Income

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£0	£0	£0	£0	£0	£18,707,000
	Forecast	£0	£0	£0	£0	£0	
	Actual*	£0					

Q2 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£0	£0	£0	£0	£0	£18,707,000
	Forecast	£4,676,750	£4,676,750	£4,676,750	£4,676,750	£18,707,000	
	Actual*	£4,676,750	£4,676,750				

Please comment if there is a difference between either annual total and the pooled fund	No difference

Expenditure

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£0	£0	£0	£0	£0	£18,707,000
	Forecast	£0	£0	£0	£0	£0	
	Actual*	£0					

Q2 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£0	£0	£0	£0	£0	£18,707,000
	Forecast	£4,665,865	£4,665,865	£4,665,865	£4,665,865	£18,663,460	
	Actual*	£4,534,000	£4,797,730				

Please comment if there is a difference between either annual total and the pooled fund	There will be a difference in the end of the year betwen the pooled amount and the annual total as the new investment of £571,000 created as the pool was formed will not be spent by the end of the year. However this will be used to offet the pay for performance target relating to the reduction in non-elective admissions (£527,460) leaving a notional balance of £43,540.

Commentary on progress against financial plan:	On track

Footnote:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a Q1 collection previously filled in by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Central Bedfordshire

Admissions to residential Care	% Change in rate of permanent admissions to residential care per 100,000
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	The focus of the Better Care Plan Schemes is to reduce admissions into Residential and Nursing homes through integrated working with health. Packages of care continue to be scrutinised through the panel process, to ensure that all alternative have been explored and that the focus remains helping people to remain in their own homes.

Reablement	Change in annual percentage of people still at home after 91 days following discharge, baseline to 2015/16
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Further work is necessary to aquire complete information on the performance of this measure. Currently this measure counts only Council reablement services this is ASCOF 2b part 2. More information on Community rehabilitation services and their effectivneess is needed.

Local performance metric as described in your approved BCF plan / Q1 return	Rate of emergency admissions for injuries due to falls in persons aged 65+ per 100,000 population
If no local performance metric has been specified, please give details of the local performance metric now being used.	
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Although 2014/15 data awaited, there are ongoing initiatives to reduce falls. Falls prevention and awareness training is being rolled out. The Council's Urgent Homes and Falls Response Service is being extended into Care Homes.

Local defined patient experience metric as described in your approved BCF plan / Q1 return	GP Patient Survey - In last 6 months, had enough support from local services or organisations to help manage long-term health condition(s)
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	Data not available to assess progress
Commentary on progress:	Awaiting more up to date data. Locally patient experience is being measured as part of the 'Caring Together' project. Work is also commencing on triangulating with other patient/customer outcomes data such as the Adult Social Care Survey.

Footnotes:

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Preparations for the BCF 16-17

Selected Health and Well Being Board: Central Bedfordshire

Following the announcement that the BCF will continue in 2016-17 have you begun planning for next year?	Yes
How confident do you feel about developing your BCF plan for 2016-17?	High Confidence
At this stage do you expect to pool more, less, or the same amount of funding compared to that pooled in 15/16, if the mandatory requirements do not change?	The same amount of funding

Would you welcome support in developing your BCF plan for 2016-17?	Yes

If yes, which area(s) of planning would you like support with, and in what format?	Interested in support?	Preferred support medium	If preferred support medium is 'other', please elaborate
Developing / reviewing your strategic vision	Yes	Hands on technical or delivery support	
Building partnership working	Yes	Hands on technical or delivery support	
Governance development	Yes	Hands on technical or delivery support	
Data interpretation and analytics	Yes	Hands on technical or delivery support	
Evidence based planning (to be able to conduct full options appraisal and evidence-based assessments of schemes / approaches)	No		
Financial planning (to be able to develop sufficiently robust financial plans that correctly describe the impact of activity changes, and the investments required)	Yes	Hands on technical or delivery support	

New Integration Metrics

Selected Health and Well Being Board: Central Bedfordshire

1. Proposed Metric: Integrated Digital Records

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
In which of the following settings is the NHS number being used as the primary identifier? (Select all of the categories that apply)	Yes	Yes	Yes	Yes	Yes	Yes
Please indicate which care settings can 'speak to each other', i.e. share information through the use of open APIs? (Select all of the categories that apply)	No	No	No	No	No	No

Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes
Comments:	NA

2. Proposed Metric: Use of Risk Stratification

Is the local CCG(s) using an NHS England approved risk stratification tool to analyse local population needs?	No
If 'Yes', please provide details of how risk stratification modelling is being used to allocate resources	[redacted]
Based on your latest risk stratification exercise what proportion of your local residents have been identified as in need of preventative care? (%)	2.00%
What proportion of local residents currently identified as in need of preventative care have been offered a care plan? (%)	0.0%
Comments:	The CCG does not hold information on the number of care plans as part of the GP DES for 2015/16

3. Proposed Metric: Personal Health Budgets

Have you undertaken a scoping exercise in partnership with local stakeholders to understand where personal health budgets would be most beneficial for your local population?	In the planning stages
How many local residents have been identified as eligible for PHBs during the quarter?	0
Rate per 100,000 population	0
How many local residents have been offered a PHB during the quarter?	1
Rate per 100,000 population	0
How many local residents are currently using a PHB during the quarter?	6
Rate per 100,000 population	2
What proportion of local residents currently using PHBs are in receipt of NHS Continuing Healthcare during the quarter? (%)	100.0%
Comments:	NA
Population (Mid 2015)	269,600

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014).
http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html

Narrative

Selected Health and Well Being Board:

Central Bedfordshire

Data Submission Period:

Q2 2015/16

Narrative	Remaining Characters	31,076

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time, please also make reference to performance on any metrics not directly reported on within this template (i.e. DTOCs).

Reduction of non-elective admissions remains challenging. A number of projects have been mobilised to mitigate this. This includes the introduction of templates for the management of some long term conditions; proactive response to falls through training to Care Homes and Domiciliary Care Providers and the extension of the Council's Urgent Home and Falls Response Service into Care Homes. Following a review of ambulance data, the LA and CCG are undertaking joint visits to care/nursing homes with high numbers of ambulance conveyancing to ensure they are getting appropriate support and accessing all services available to reduce the number of people transferred to hospital. This initiative will also identify any gaps in providing good physical healthcare, as well as promoting access to falls service, diagnosis for dementia and the End of Life pathway. Currently, 42% of EEAST frontline staff have been trained on the End of Life Pathway/PEPS service.
Carers Lounge opened at Luton and Dunstable Hospital; Lifestyle Hub pilot on going and review of outcomes planned in Q4.

The Operational Resilience and Urgent Care Plan is currently being reviewed for 2015/16 and sets out a broad approach to delivering sustainable capacity and operational resilience across the Bedfordshire health economy.

The LA and CCG are working together to complete a full transformation of adult and childrens' community services. Data sharing, systems alignment and interoperability remains a challenge.

Recent appointments in the CCG and changes within the Community Health Services leadership team engenders more confidence about the future and successful delivery of the BCF Plan.

NHS Bedfordshire Clinical Commissioning Group

Central Bedfordshire

Central Bedfordshire Better Care Fund

Performance and Finance Report

September 2015 Data

Produced November 2015

Contents

Performance Summary

Ref	Indicator	2015-16 Target	2015-16 (to date)	RAG rating and trend
BCF 1	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	6,380	6,868	**R** ⇧
BCF 2	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	383.5	347.5	**R** ⇧
BCF 3	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	93.8%	81.0%	**R** ⇧
BCF 4	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	1008.3	897.7	**G** ⇧
BCF 5	Customer/Patient Experience	65.8	63.1	A⇧
BCF 6	Rate of emergency admissions for injuries due to falls in persons aged 65+ per 100,000 population	1,686.4	n/a	n/a

Key:

Rating	Thresholds	Trend	Meaning
G	Improvement on baseline and target met	⇧	Performance from the last two data points indicates a positive direction of travel
A	Improvement on baseline yet below Target	⇔	Performance from the last two data points indicates no change
R	Deterioration on baseline	⇩	Performance from the last two data points indicates a negative direction of travel

Finance Summary

	Variance to date	Forecast variance	RAG rating and trend
Expenditure v budget			
Savings v forecast			
Units of Planning			

Key:

Rating	Thresholds	Trend	Meaning
G	In line with plan. Costs are at or below budget or savings are at or above forecast.	⇧	Performance from the last two months indicates a positive direction of travel
R	Below plan. Costs are above budget or savings are below forecast.	⇔	Performance from the last two months indicates no change
		⇩	Performance from the last two months indicates a negative direction of travel

Key Messages

REF	Key issues for consideration	Risk	Mitigation Actions
Performance			
BCF 1	Reduction remains challenging.		SRG work and response to winter pressures.
BCF 2	Not likely to meet full target.		Scrutiny of packages of care; crisis prevention through support for carers; discharge coordination.
BCF 3	On track but not likely to meet target. Community rehabilitation figures still missing.		Pursue completeness of data.
BCF 4	Delayed transfers of care now green		Will continue to monitor performance
BCF 5	Patient/customer experience: GP survey data only available twice yearly.		Consideration of other metrics that are more frequently available to commence.
BCF 6	Rate of emergency admissions for injuries due to falls in people aged 65+ -no new data available		Although 2014/15 data awaited, there are ongoing initiatives to reduce falls. Falls prevention and awareness training is being rolled out. The Council's Urgent Homes and Falls Response Service is being extended into Care Homes.
Expenditure			
	Section 75 agreement has been signed		

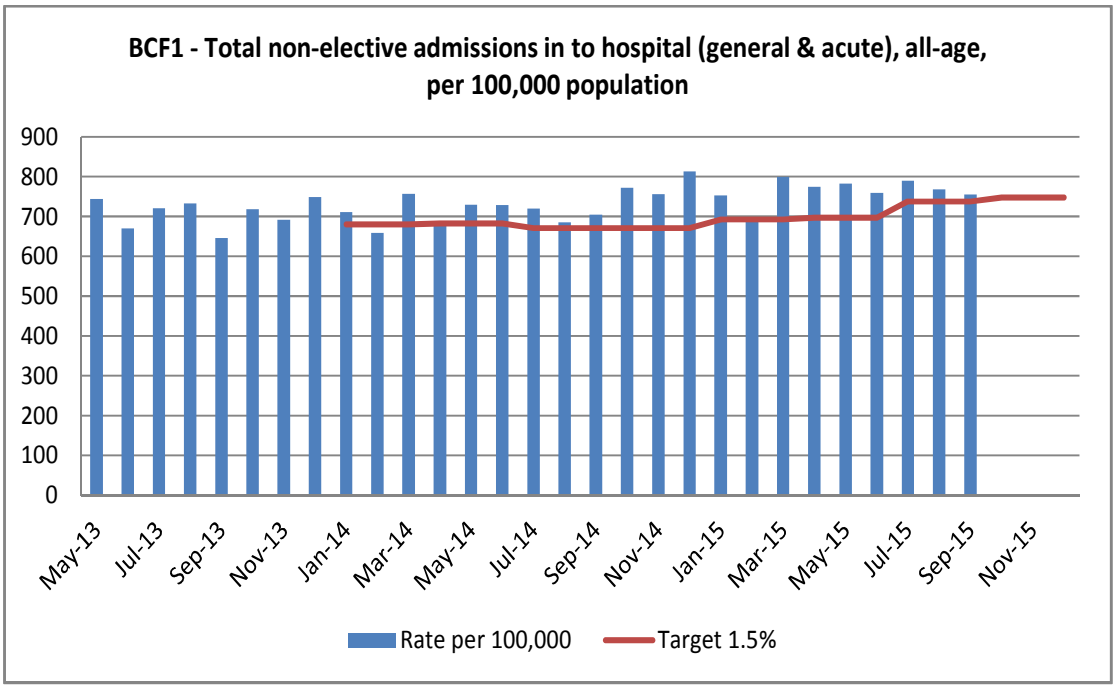
Key

Rating	Thresholds
G	No or Low Risk
A	Medium Risk
R	High Risk

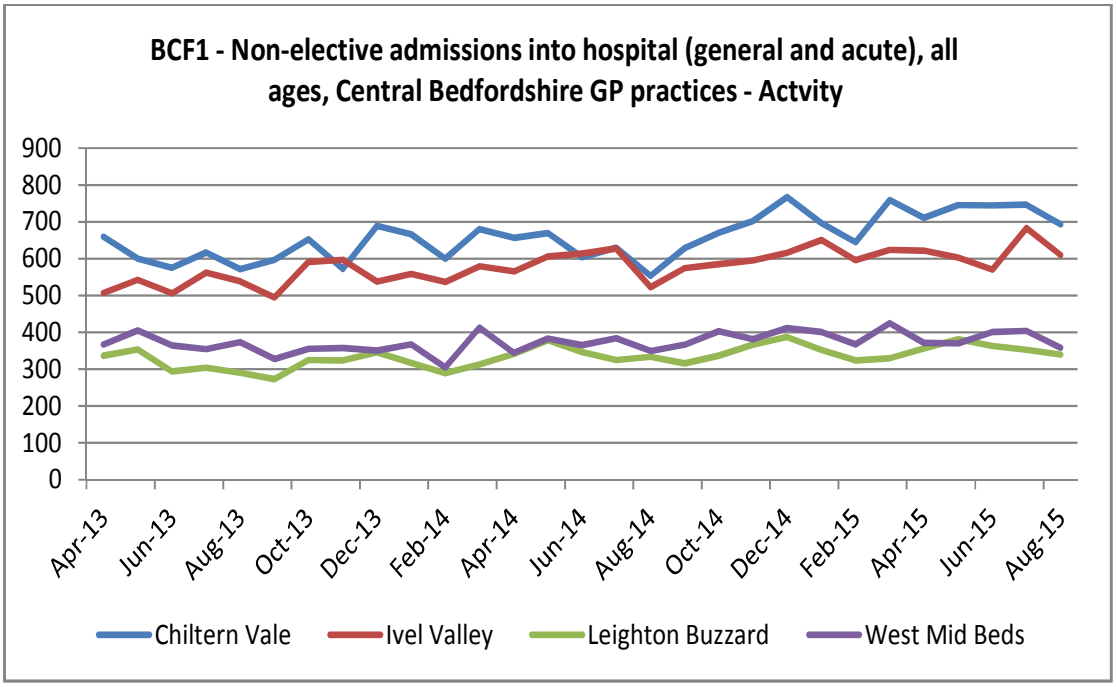
BCF1 – Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population

BCF metric is all non-elective admissions in to hospital (all ages) for the Central Bedfordshire resident population.
BCF Aim – to reduce the number of non-elective admissions to hospital
Data is reported monthly, two months in arrears (targets quarterly)
High values are **poor**
Data Source – Hospital Activity Data – NHS England

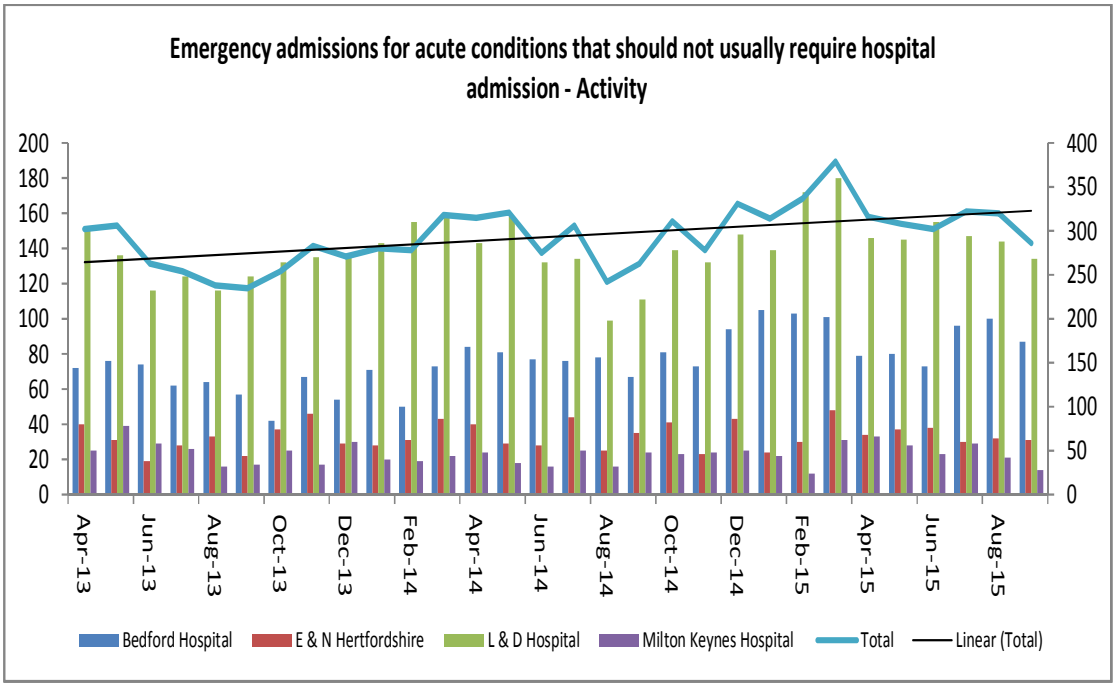
(Note – Rounding up/down occurs)			**Current Performance** June 2015	Current RAG rating and trend	R ⇧
Baseline rate (Jan – Dec 14 planned)	Jan – Mar 14	2,040	2,125		
	Apr – Jun 14	2,048	2,143		
	Jul – Sep 14	2,012	2,108		
	Oct – Dec 14	2,011	2,340		
Pay for Performance Target (Jan – Dec 15)	Jan – Mar 15	2,077	2,240		
	Apr – Jun 15	2,090	2,315		
	Jul – Sep 15	2,213	2,312		
	Oct – Dec 15	2,241			
Comments	Reduction of non-elective admissions remains challenging.				
Key Issues					
Mitigation Actions	The Operational Resilience and Urgent Care Plan is currently being reviewed for 2015/16 and sets out a broad approach to delivering sustainable capacity and operational resilience across the Bedfordshire health economy. In addition, new guidance issued from NHS England in April 2015 highlights the requirement for Operational Resilience Plans to incorporate eight high impact interventions.				



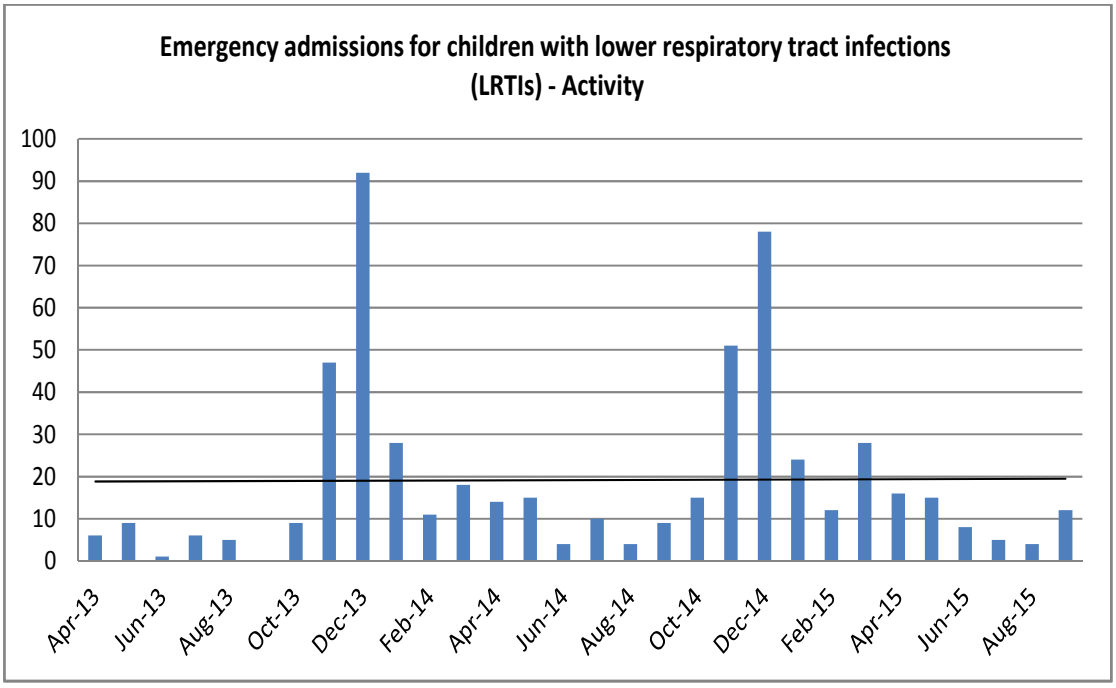
Source: Hospital Activity Data – NHS England



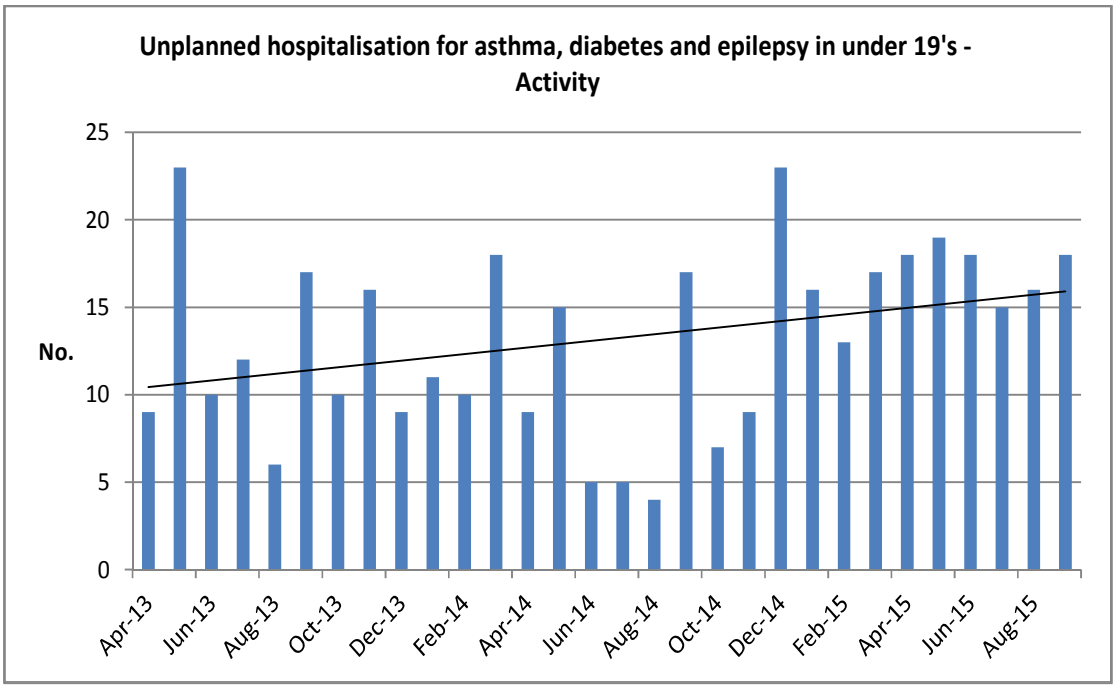
Source: Bedfordshire CCG



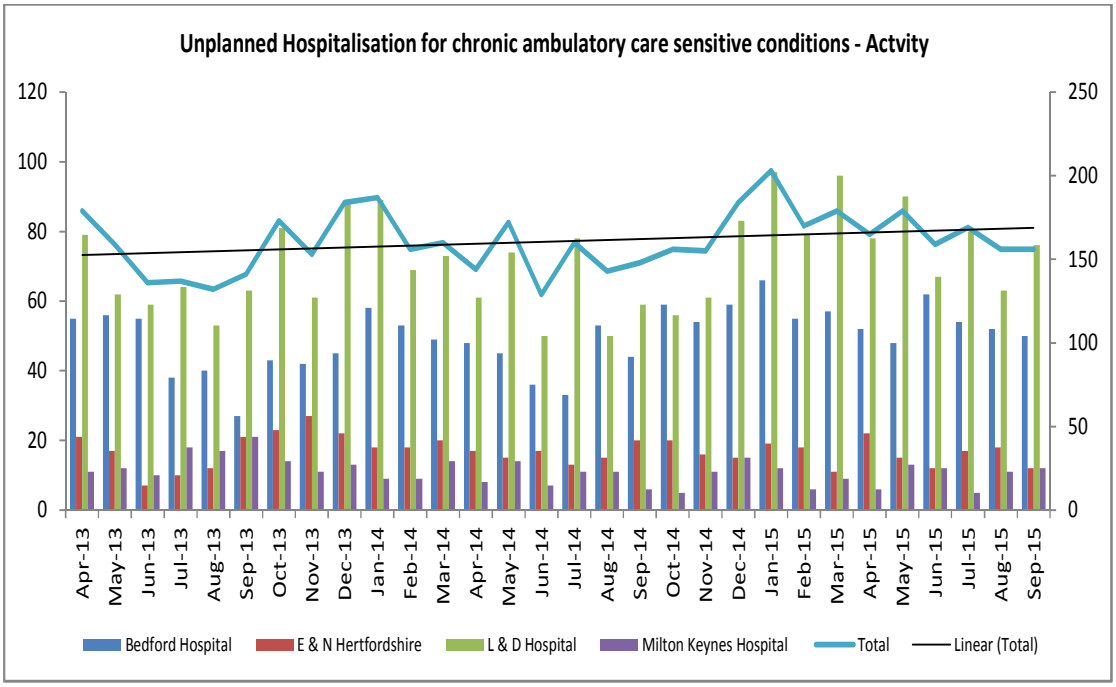
Source: Bedfordshire CCG



Source: Bedfordshire CCG



Source: Bedfordshire CCG

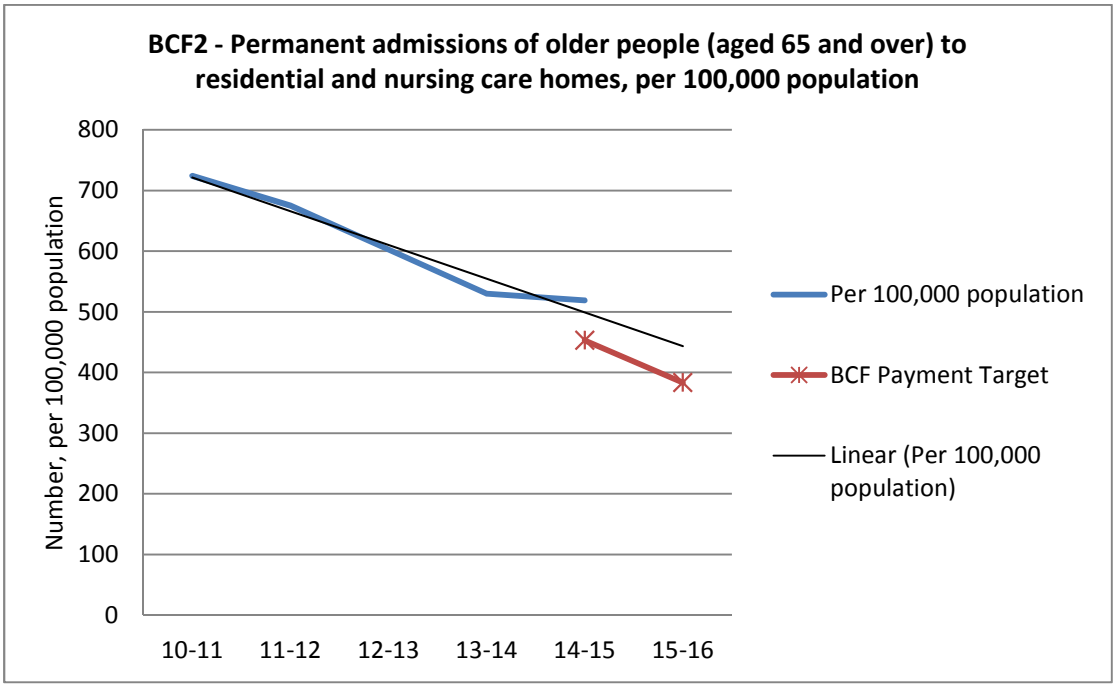


Source: Bedfordshire CCG

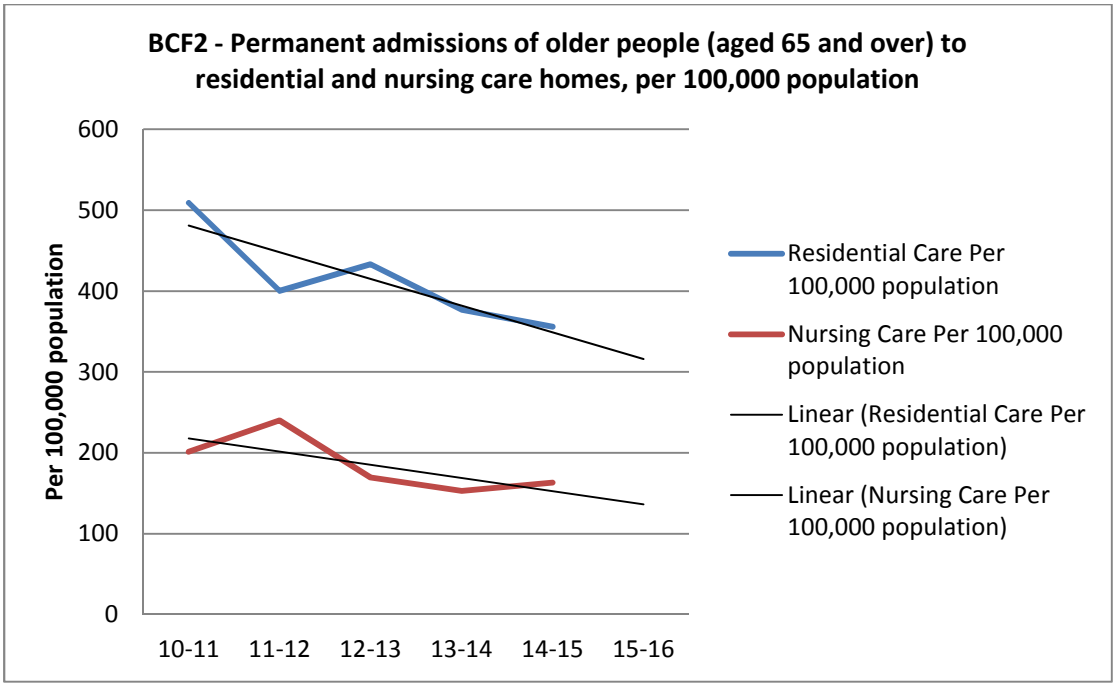
BCF2 - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

Annual rate of council-supported permanent admissions of older people to residential and nursing care. An admission is a new admission, so does not include people transferring from one home to another or from residential to nursing. It does include people moving from temporary to permanent care.
BCF Aim – To reduce the number of admissions into residential and nursing care homes
Data is reported monthly, one month in arrears
Cumulative measure
High values are **poor**
Data Source – Adult Social Care

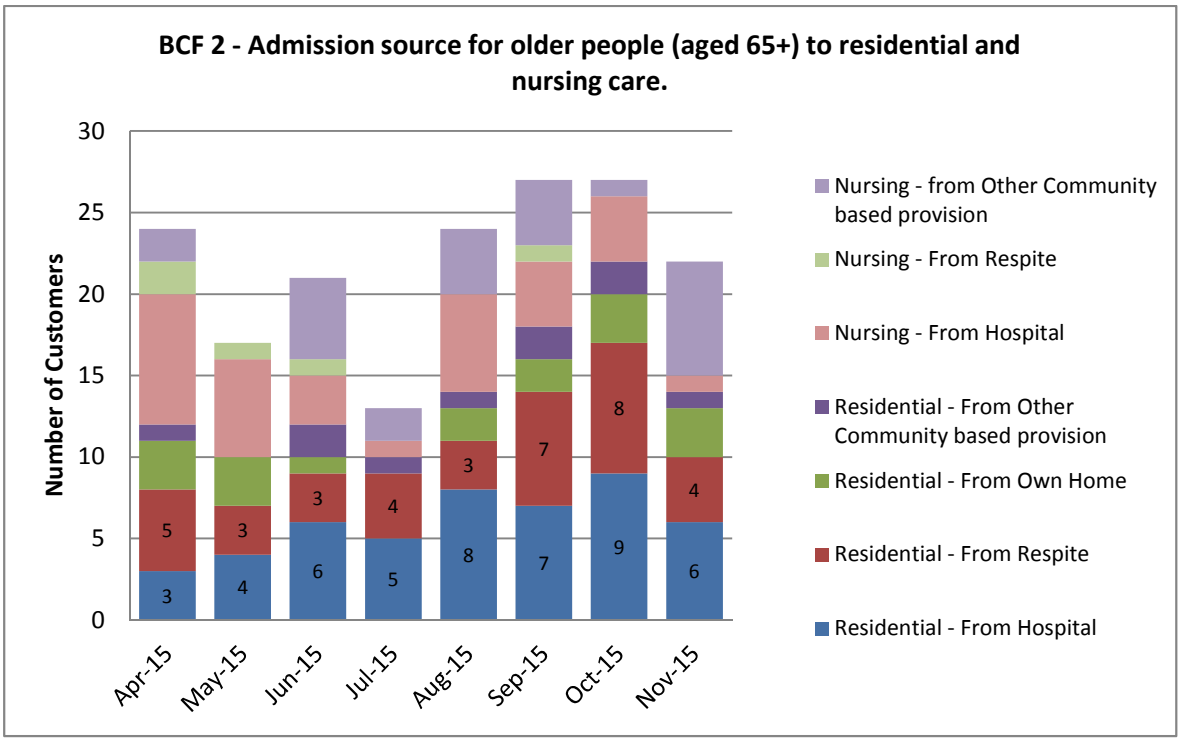
Baseline Rate (Apr 13 – Mar 14)	529.9	**Current RAG rating and trend**	**R ⇧**
2014-15 target	453.0		
2015-16 target	383.5		
Current performance October 2015	324.2		
Comments	Since April 2015 there have been 153 new placements into Residential and nursing care compared with the target of 106.		
Key Issues	Hospital discharge coordination and crisis prevention plans to support carers.		
Mitigating Actions	Packages of care continue to be scrutinised through the panel process, to ensure that all alternative have been explored and that the focus remains helping people to remain in their own homes. The development of more independent living (extra care) accommodation will help to mitigate admissions into residential care.		



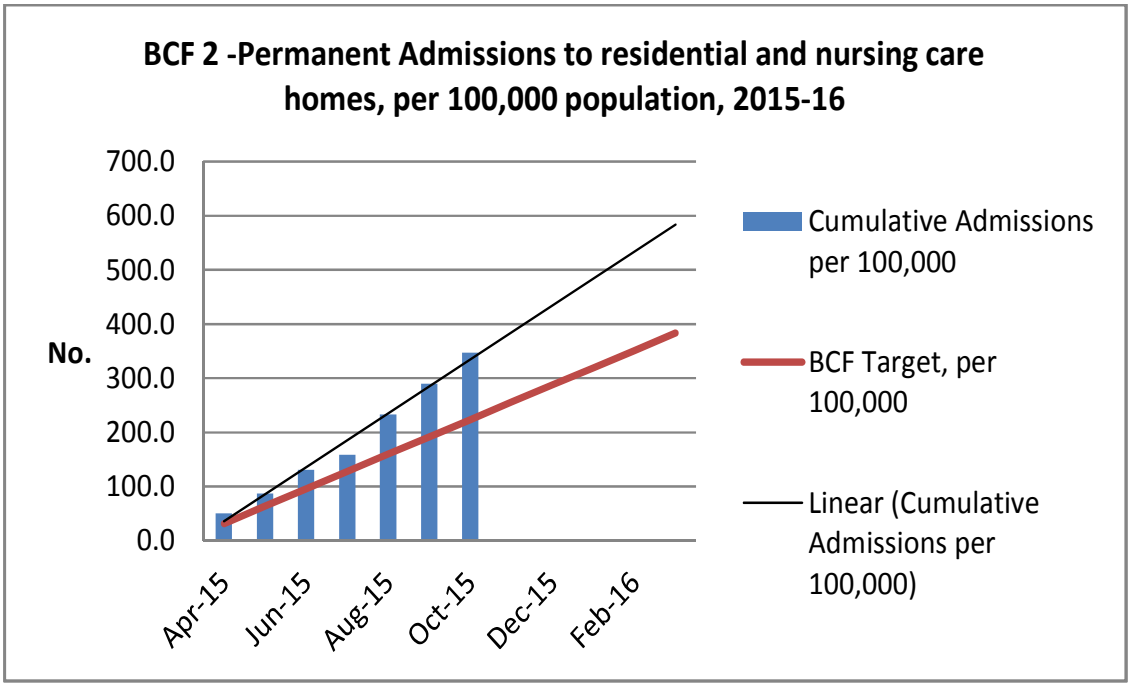
Source: Adult Social Care



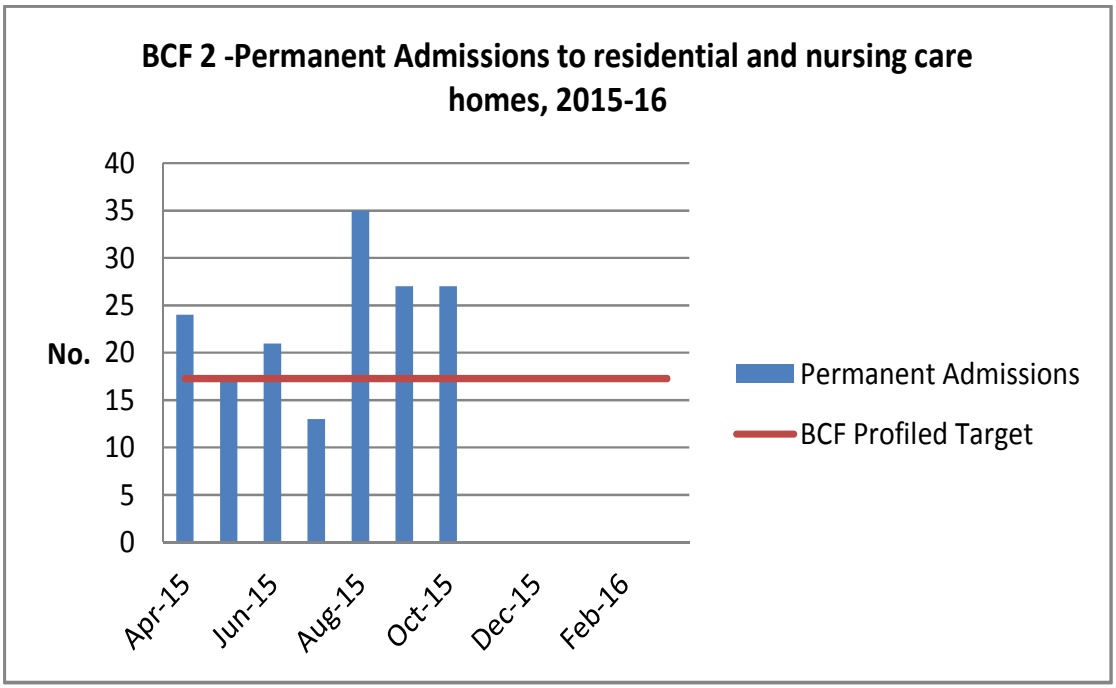
Source: Adult Social Care



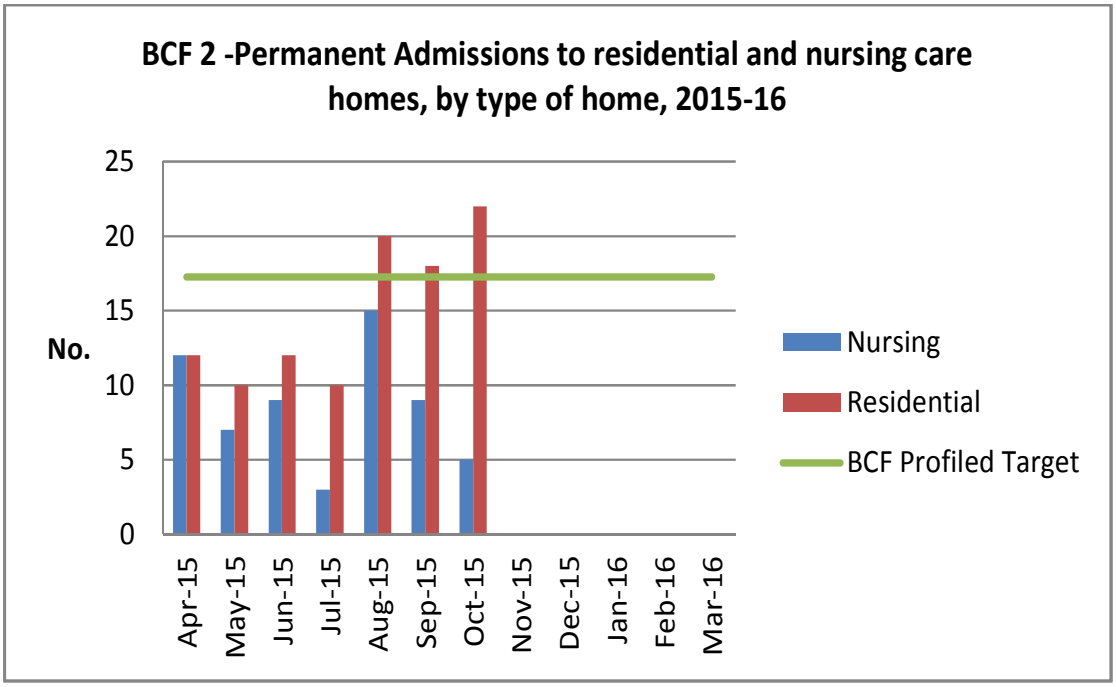
Source: Adult Social Care



Source: Adult Social Care



Source: Adult Social Care

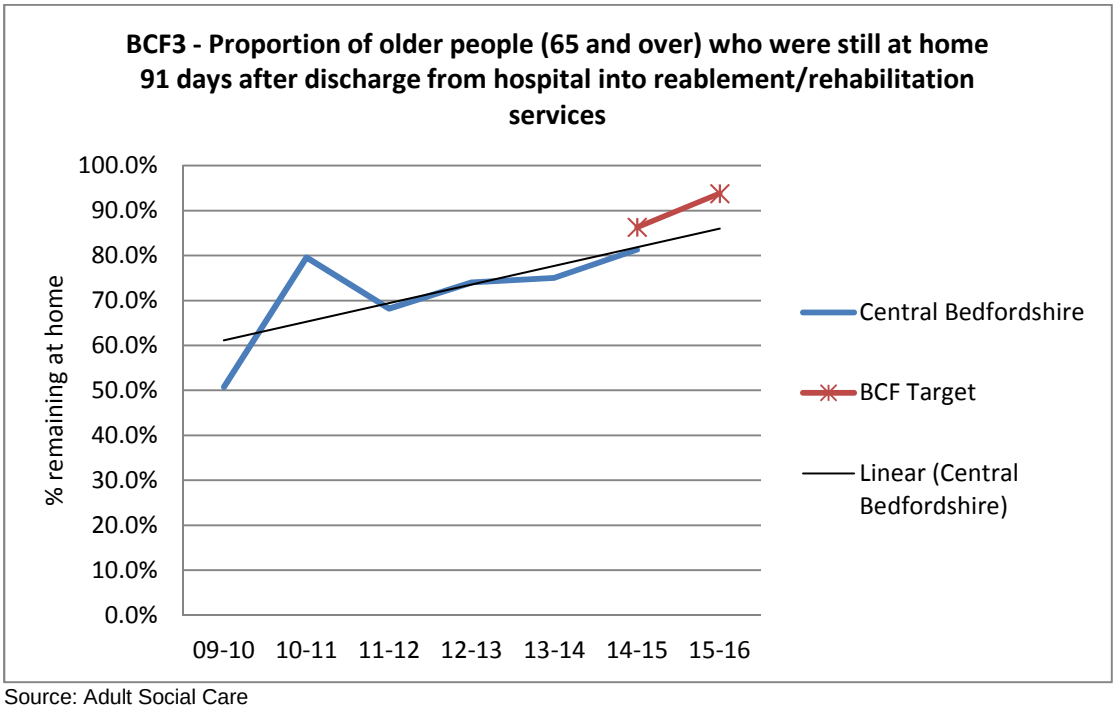


Source: Adult Social Care

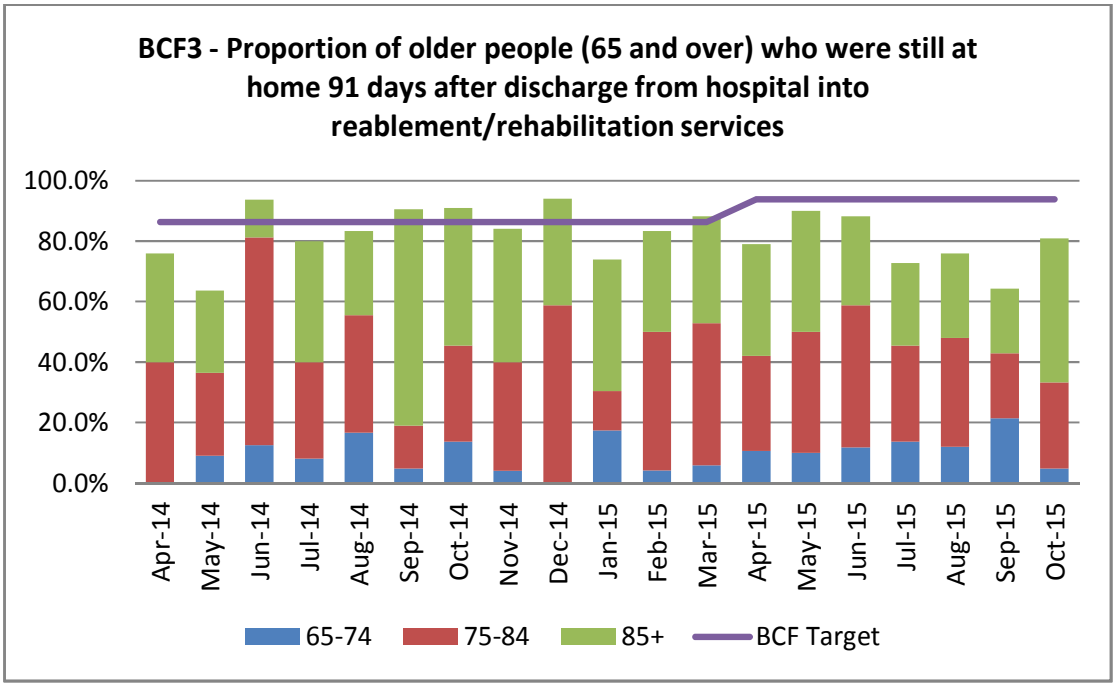
BCF3 - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

Numerator
Those who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. People who are in hospital or in a registered care home at the three month date and those who have died within the three months are not included in the numerator.
Denominator
Older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation with a clear intention that they will move on/back to their own home.
Rehabilitation includes START reablement and intermediate care in both community and residential settings.
BCF Aim – To increase the proportion of people discharged from hospital remaining at home
Reported monthly
High values are **good**
Data Source – Adult Social Care

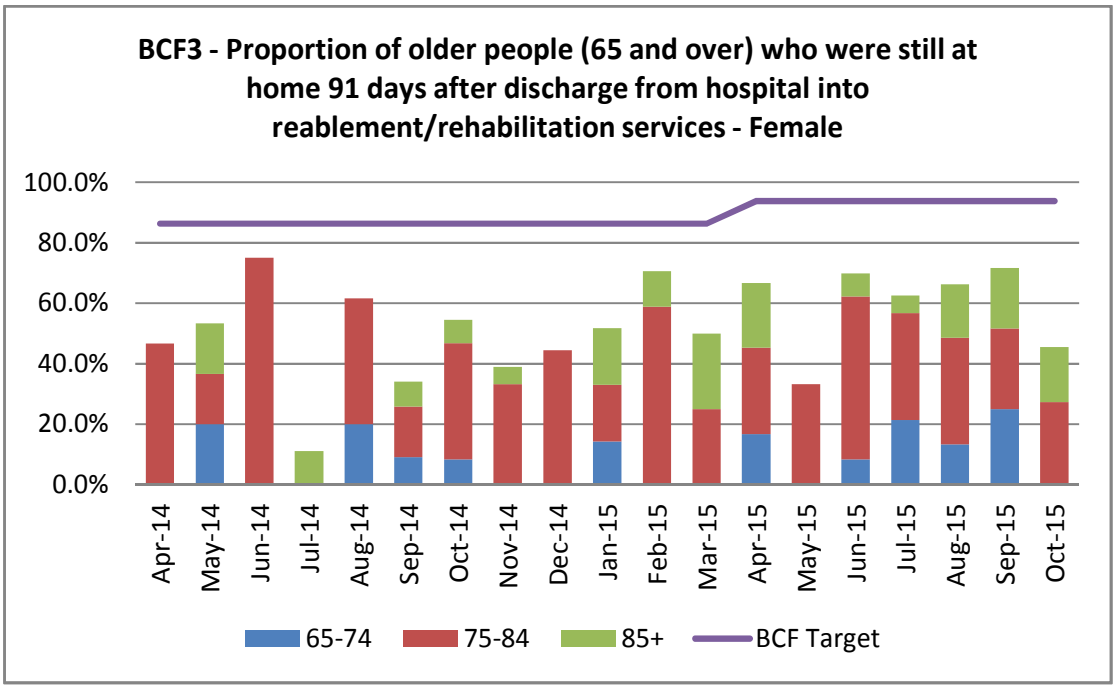
Baseline Rate (Apr 13 – Mar 14)	75.0	**Current RAG rating and trend**	**R ⇧**
2014-15 target	86.3		
2015-16 target	93.8		
Current performance October 2015	81.0		
Comments	On track but not likely to meet full target		
Key Issues	Incompleteness of data		
Mitigating Actions	Access to community rehabilitation outcomes		



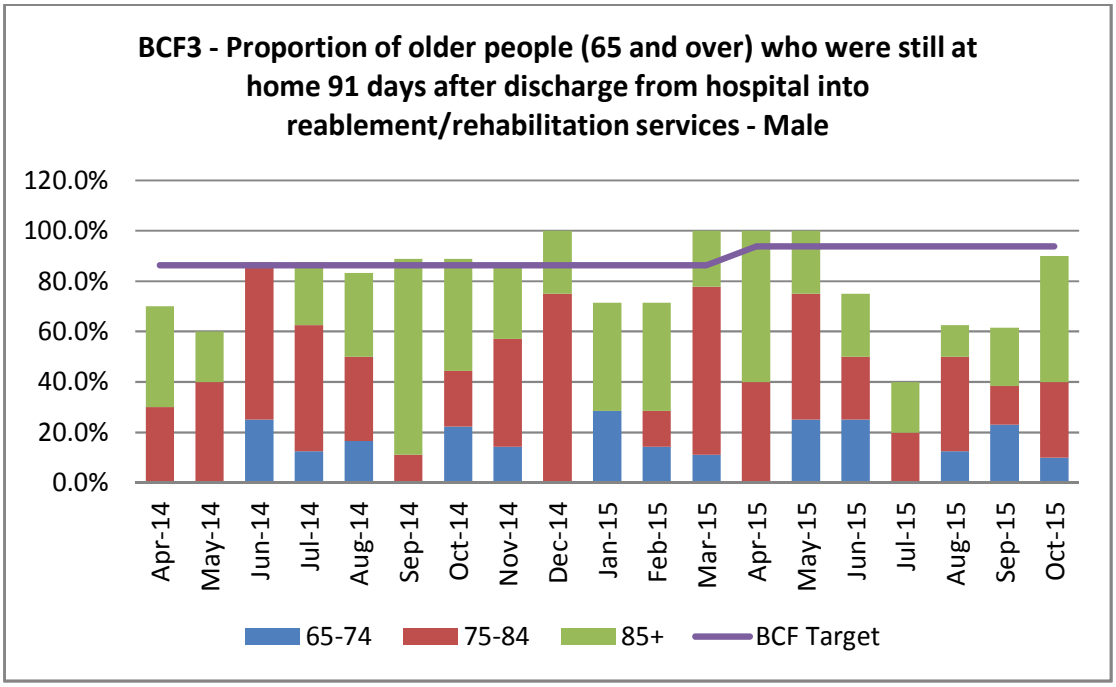
Source: Adult Social Care



Source: Adult Social Care



Source: Adult Social Care

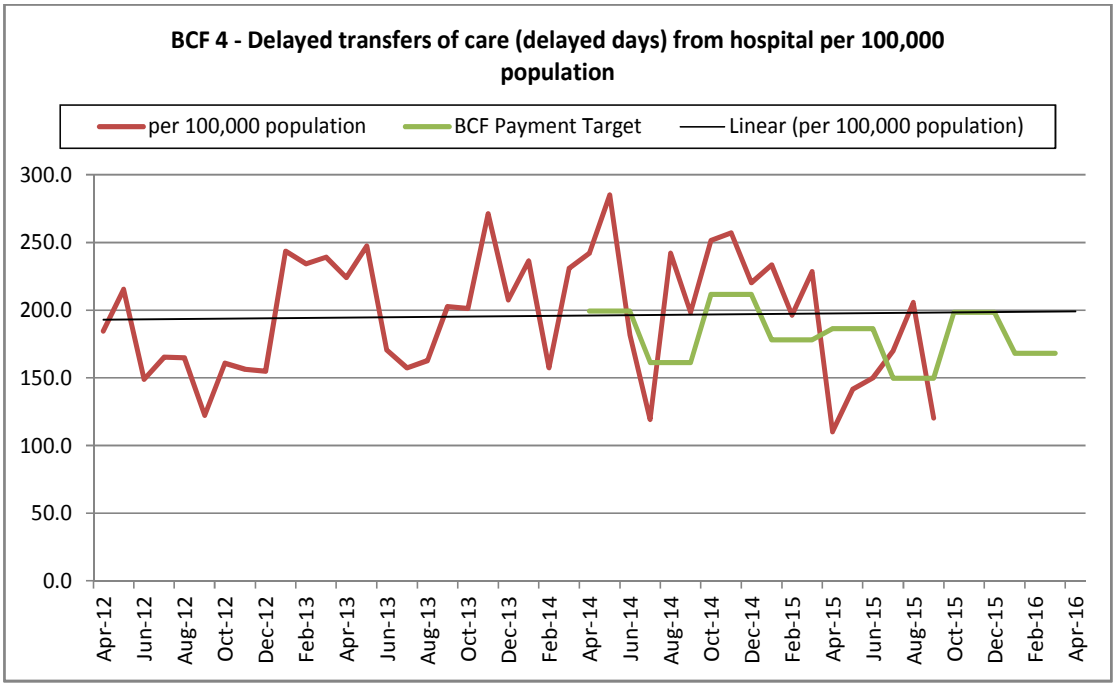


Source: Adult Social Care

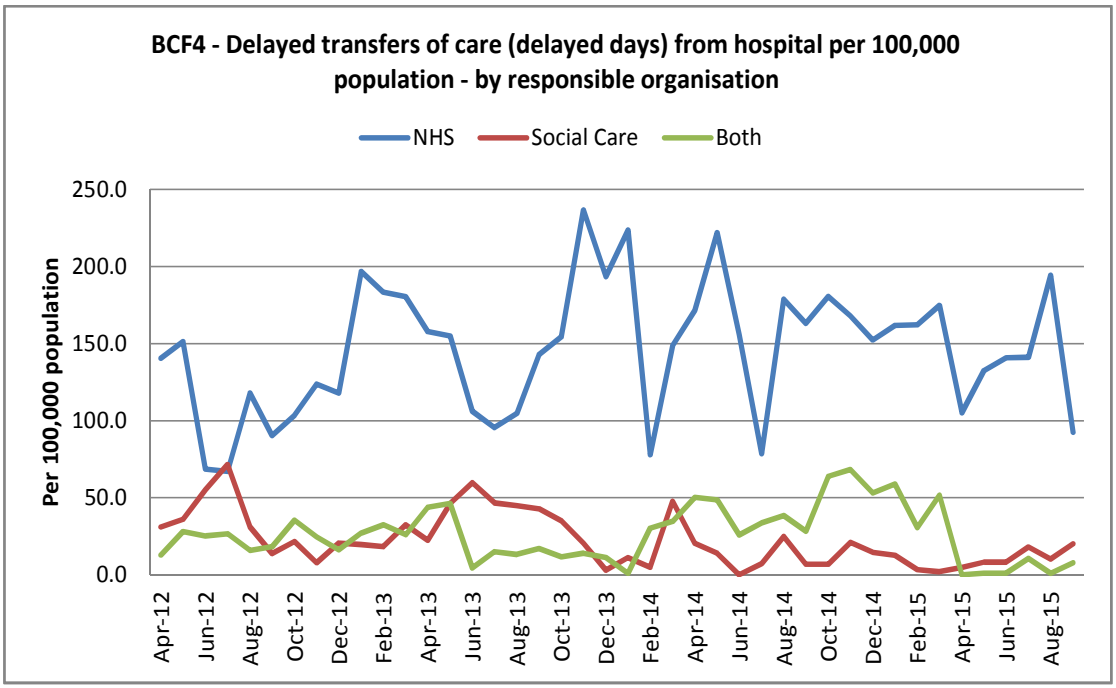
BCF4 - Delayed transfers of care (delayed days) from hospital per 100,000 population

Average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month. A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:
(a) a clinical decision has been made that the patient is ready for transfer AND
(b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer.
BCF Aim – to reduce the number of delayed transfer of care (days) from hospital
Data is reported monthly, one month in arrears
Cumulative measure
High values are **poor**
Data Source – Delayed Transfers of Care – NHS England

		Target	Current Performance		
Baseline rate (2013-14)	Apr – Jun 13	642.0			
	Jul – Sep 13	522.7			
	Oct – Dec 13	680.0			
	Jan – Mar 14	571.7			
2014-15 target	Apr – Jun 14	598.0	242.1		
			285.0		
			181.7		
	Jul – Sep 14	483.7	119.3		
			242.1		
			198.3		
	Oct – Dec 14	635.0	251.3		
			257.2		
			220.2		
	Jan – Mar 15	534.2	233.3	**Current RAG rating and trend**	**G ⇧**
			196.3		
			228.5		
2015-16 target	Apr – Jun 15	559.4	110.1		
			141.7		
			150.0		
	Jul – Sep 15	448.9	170.0		
			205.6		
			120.3		
	Oct – Dec 15	595.4			
	Jan – Mar 16	504.6			
Comments	On target				
Key Issues					
Mitigation Actions	Will continue to monitor performance				



Source: Delayed Transfers of Care – NHS England



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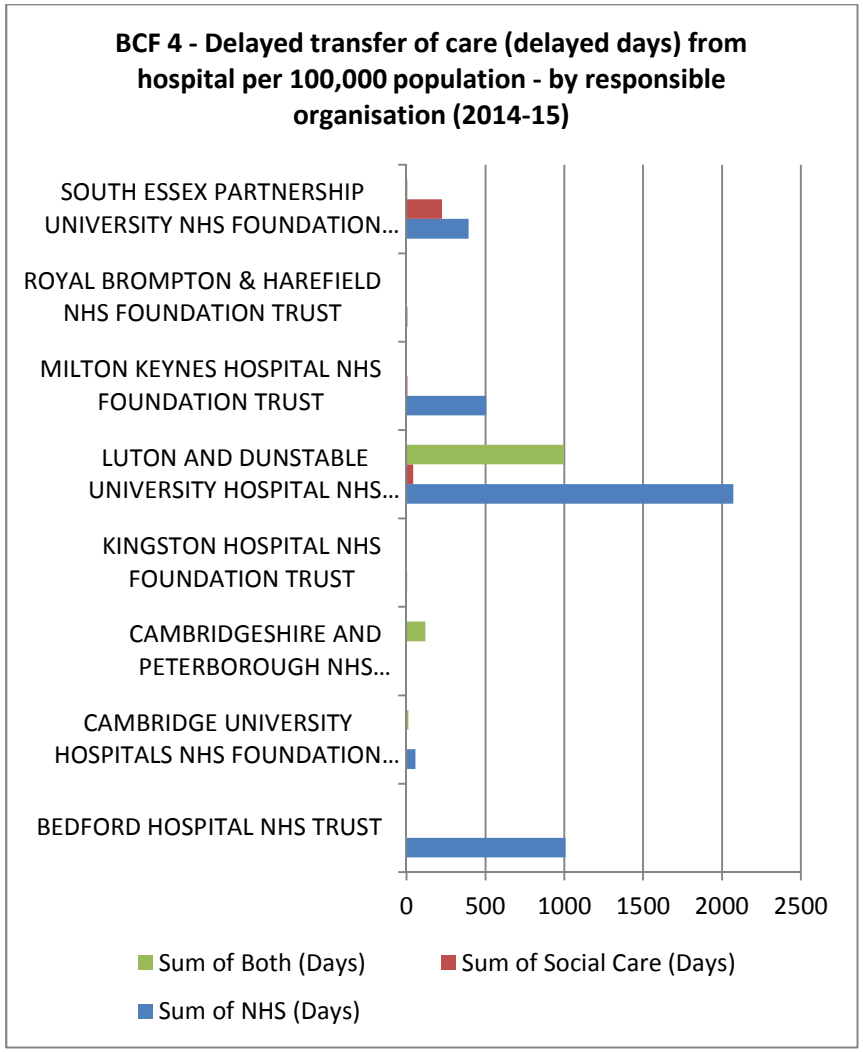
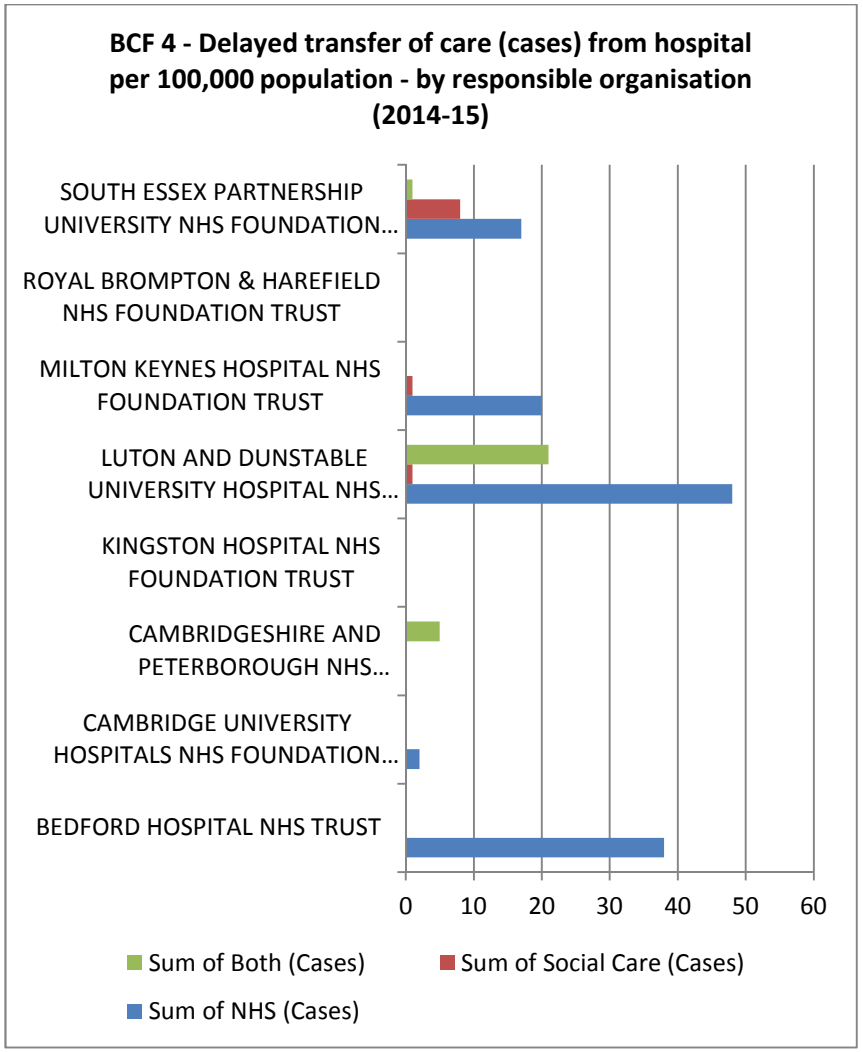
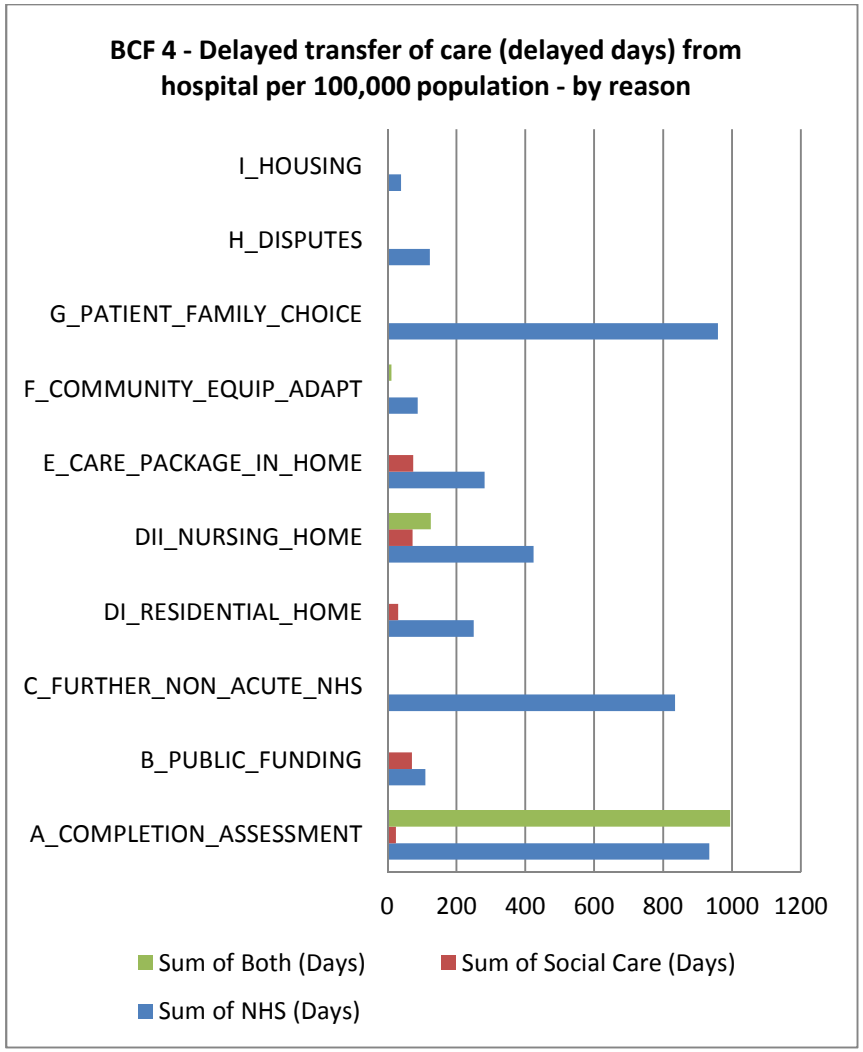


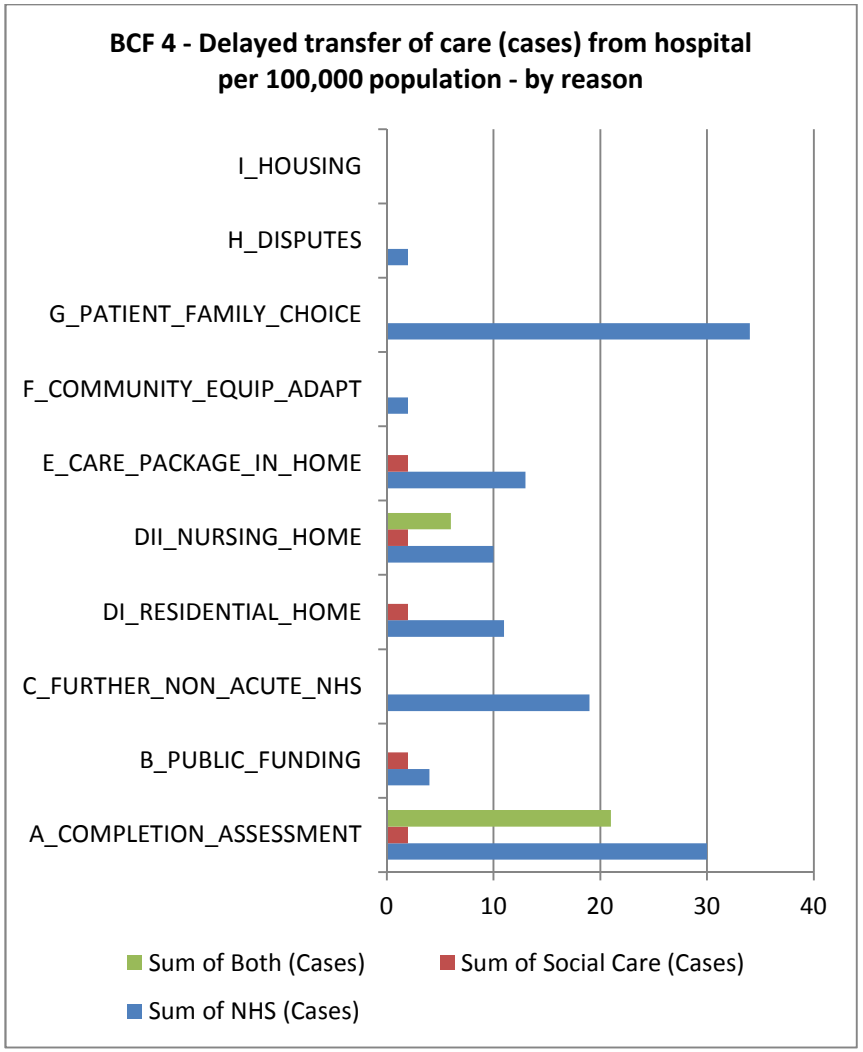
Source: Delayed Transfers of Care – NHS England



Source: Delayed Transfers of Care – NHS England



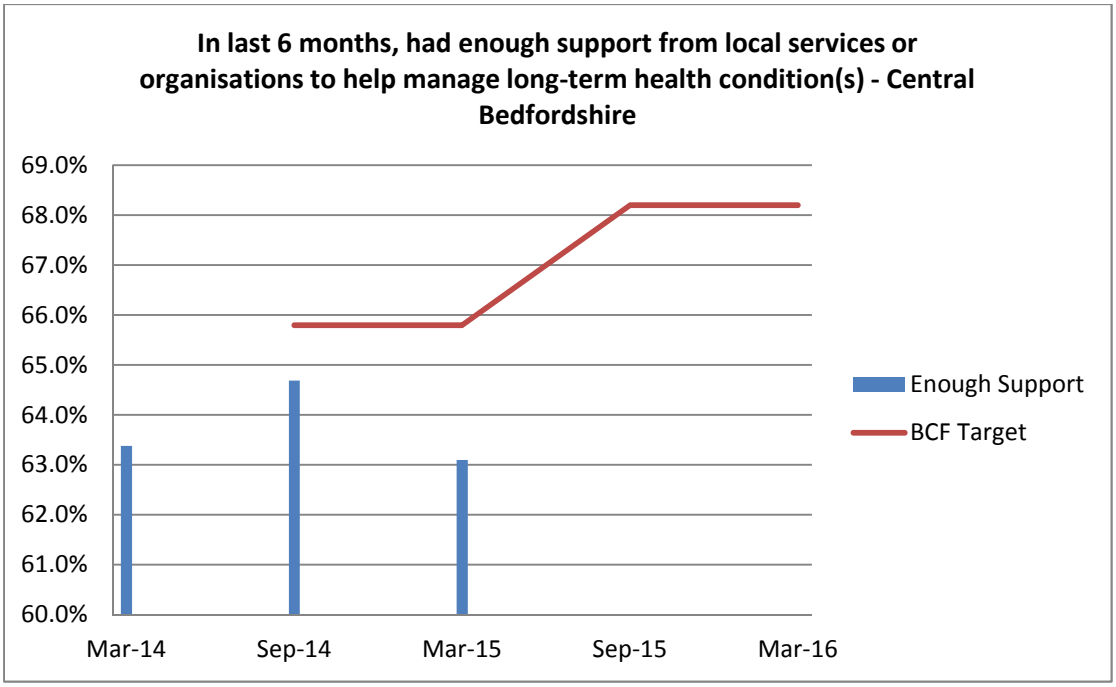
Source: Delayed Transfers of Care – NHS England



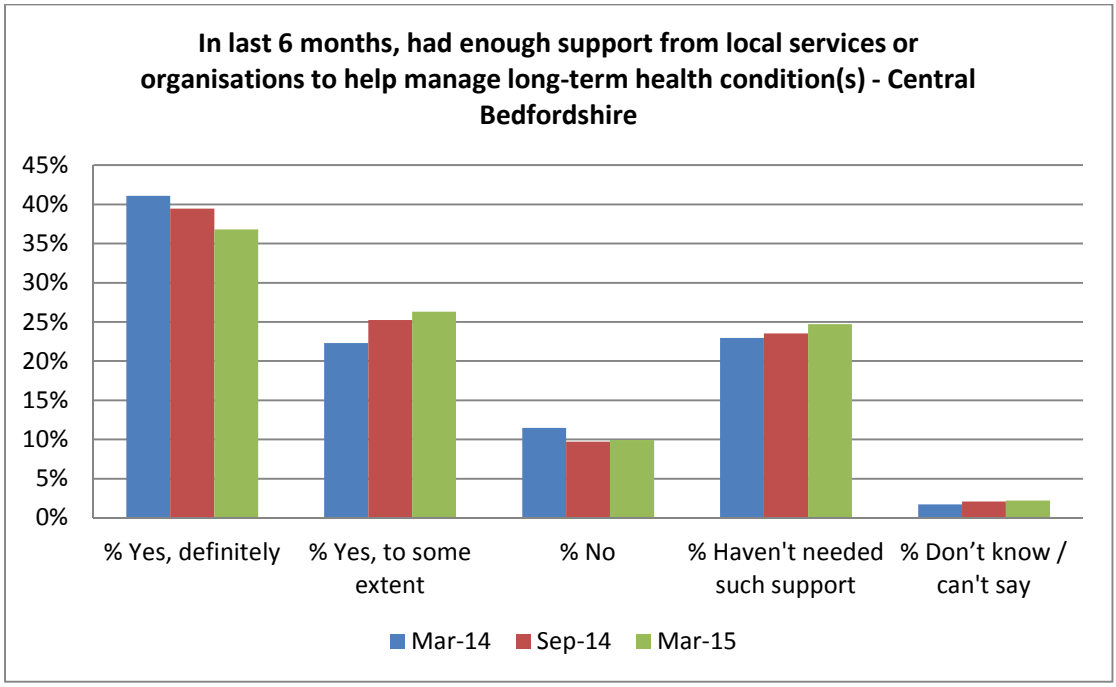
Source: Delayed Transfers of Care – NHS England

BCF5 - Patient / service user experience

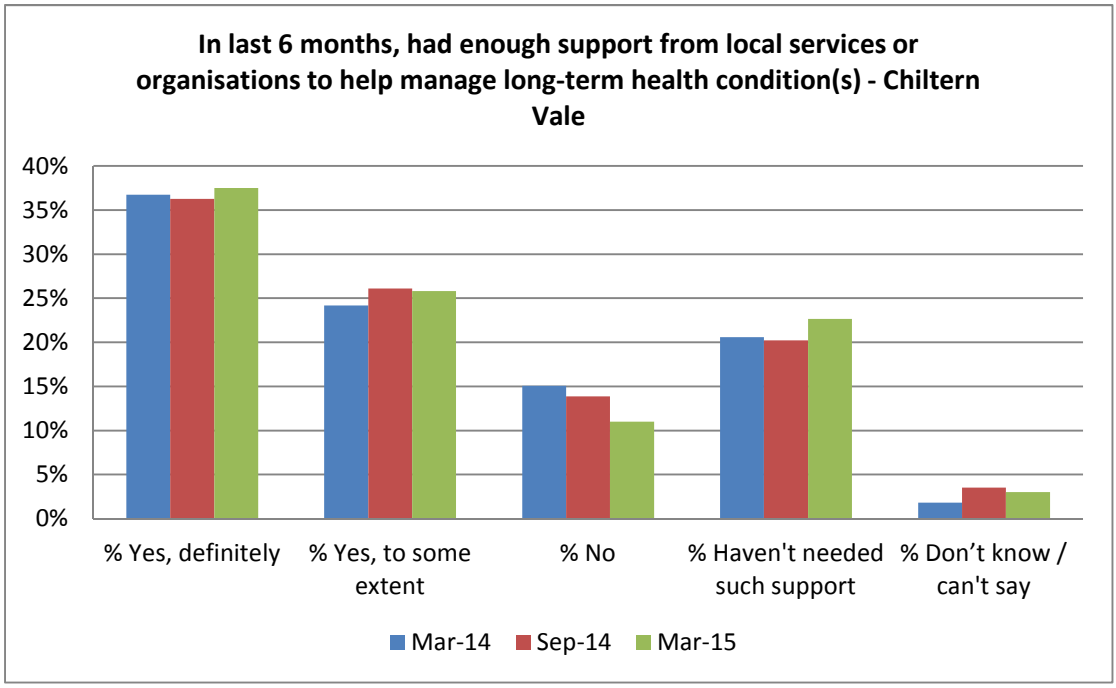
In the last six months, have you had enough support from local services or organisations to help manage long-term health condition(s) BCF Aim – to increase patient/customer satisfaction with services Data is reported six monthly High values are **good** Data source – GP Patient Survey			
Baseline Rate (Apr 13 – Mar 14)	63.4%	**Current RAG rating and trend**	**A ⇧**
2014-15 target	65.8%		
Current performance March 2015	63.1%		
2015-16 target	68.2%		
Comments	Awaiting more up to date data. Performance has previously been falling slightly (this is a national trend); will continue to monitor performance as soon as data is available.		
Key Issues			
Mitigating Actions	NHS England review the GP survey results and practices who are outliers on six or more points are reviewed. The results of the GP survey are one source of data the the CCG locality teams use to inform their practice visits. Consideration of other metrics that are more frequently available to commence.		



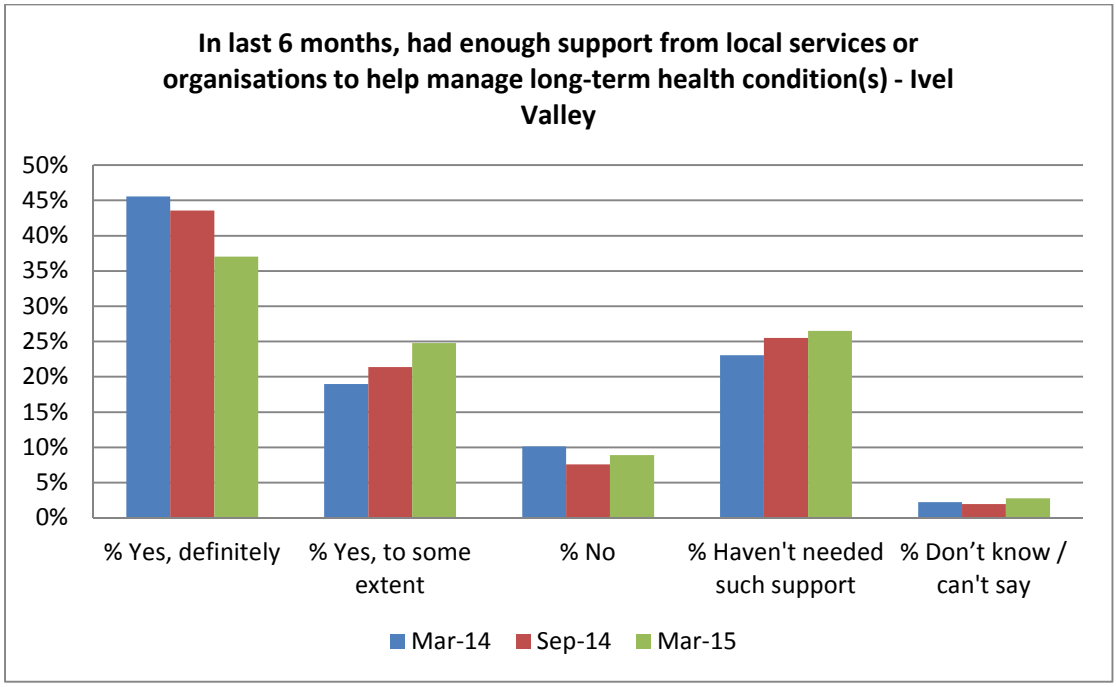
Source: GP Patient Survey



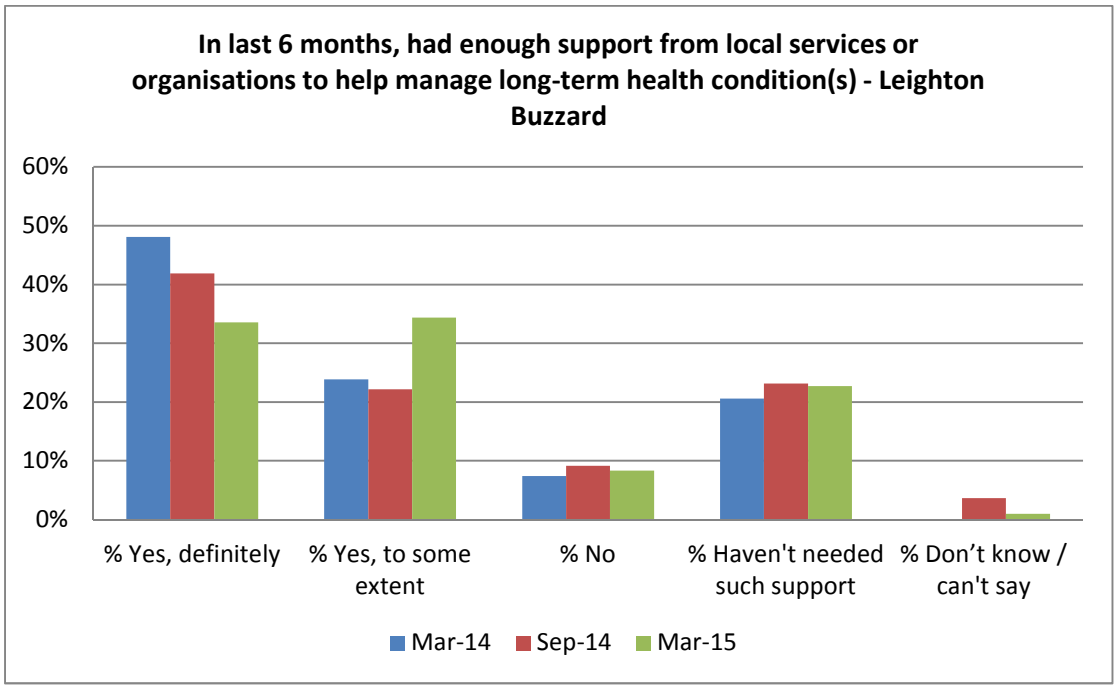
Source: GP Patient Survey



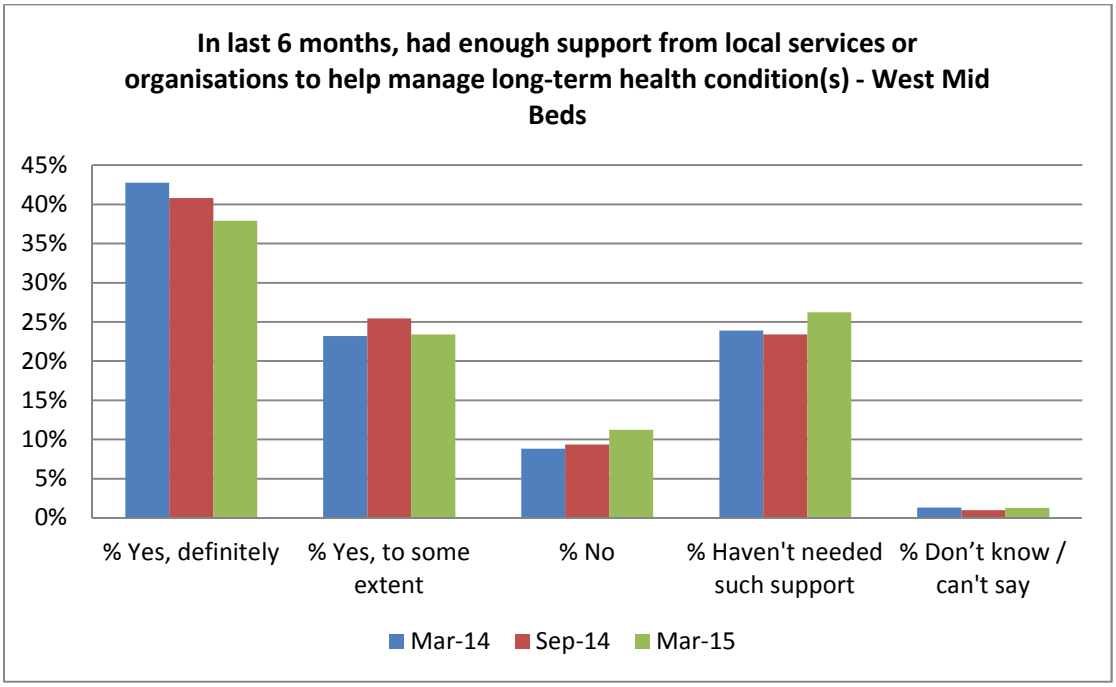
Source: GP Patient Survey



Source: GP Patient Survey



Source: GP Patient Survey



Source: GP Patient Survey

Supporting Patient and Customer Satisfaction metrics

Disabled Facilities Grant (DFG)

The DFG is provided for adaptations that meet the needs of the disabled person. The Occupational Therapist recommendation to Housing includes the justification on why the adaptation recommended will meet the specific customer's needs. This is a requirement of DFG legislation.

Percentage of customers satisfied with the DFG service provided Data is reported quarterly High values are **good`** Data source – DFG Financial assistance satisfaction form			
Baseline Rate (Apr 13 – Mar 14)	93%	**Current RAG rating and trend**	**A ⇧**
2014-15 target	90%		
2015-16 target	90%		
Current performance			
April - June	88%		
July – September	88%		
October – December			
January - March			
Comments	Performance is marginally short of the target. Although the outturn for the previous year was green. The reason for dissatisfaction provided by the customers stating that they are dissatisfied is generally the length of time that disabled customers have had to wait for works to be completed. The whole process includes three key parts; 1. The length of time waiting for an Occupational Therapy assessment (and sometimes the agreement of the recommended adaptation), 2. The length of time to prepare & approve the DFG.		

	3. The subsequent time it takes for a contractor to undertake the agreed works. Currently the average length of time from OT referral to DFG approval is better than 2014/15, currently at 8 weeks (compared to 2014/15 average of 10.9 weeks). On average DFG's are being approved quicker. The dissatisfaction is likely to come from those customers who have had to wait far longer than 8 weeks for their grant to be approved.
Key Issues	Requirement for drawings and relevant permisisons can delay DFG approval. Customers are not always aware of this oingoing work.
Mitigating Actions	Operational managers will review case loads and individual cases with officers at 1-1 meetings, particularly for more complex cases where drawings and relevant permissions are required.

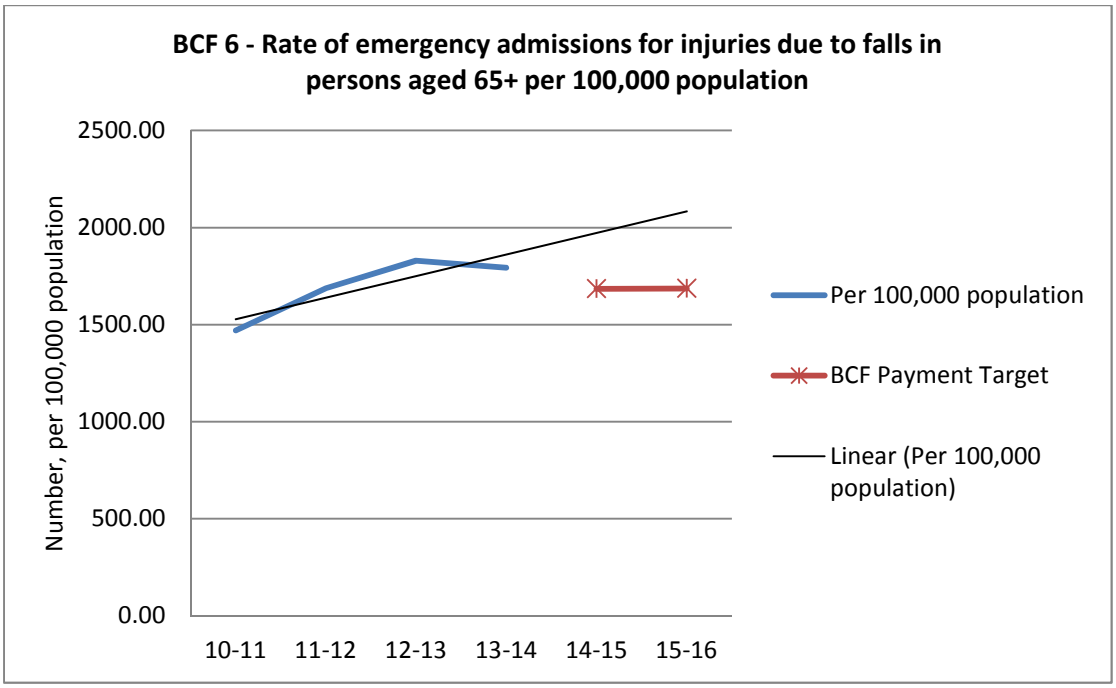
Social Care

ASCOF 3a Overall satisfaction of people who use services with their care and support Data is reported annually High values are **good** Data source – Adult Social Care Survey			
Baseline Rate (Apr 13 – Mar 14)	63.6%	**Current RAG rating and trend**	
2014-15 target	65.6%		
Current Performance			
2014-15	63.0%		
2015-16 target	67.7%		
Comments	This measure is part of the adult social care survey. Performance in 2014/15 is consistent with the regional average.		

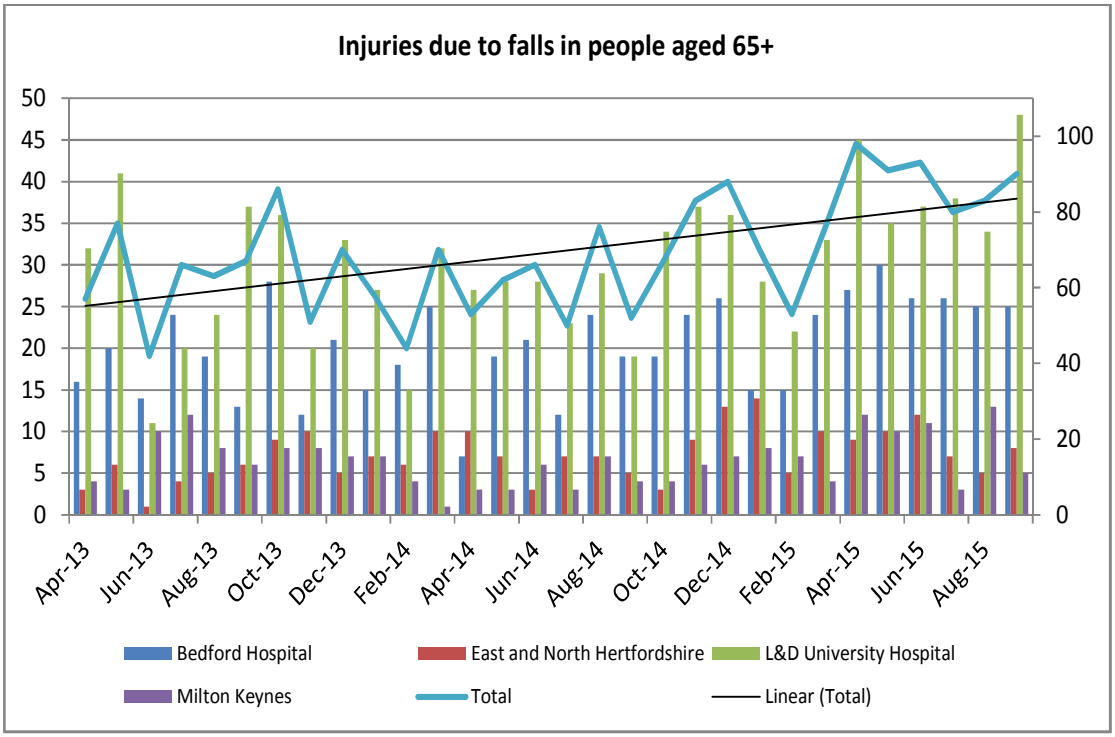
ASCOF 3d Proportion of people who use services who find it easy to find information about services Data is reported annually High values are **good** Data source – Adult Social Care Survey				
Baseline Rate (Apr 13 – Mar 14)	73.0%		**Current RAG rating and trend**	
2014-15 target	75.3%			
Current Performance				
2014-15	74.3%	Service Users		
	69%	Carers		
2015-16 target	77.4%			
Comments	This measure is part of the annual adult social care survey and measures ease of access to information for both service users and carers. Central Bedfordshire results is slightly higher than the Eastern Region average of 73% for service users and 65% for Carers.			

BCF6 - Rate of emergency admissions for injuries due to falls in persons aged 65+ per 100,000 population

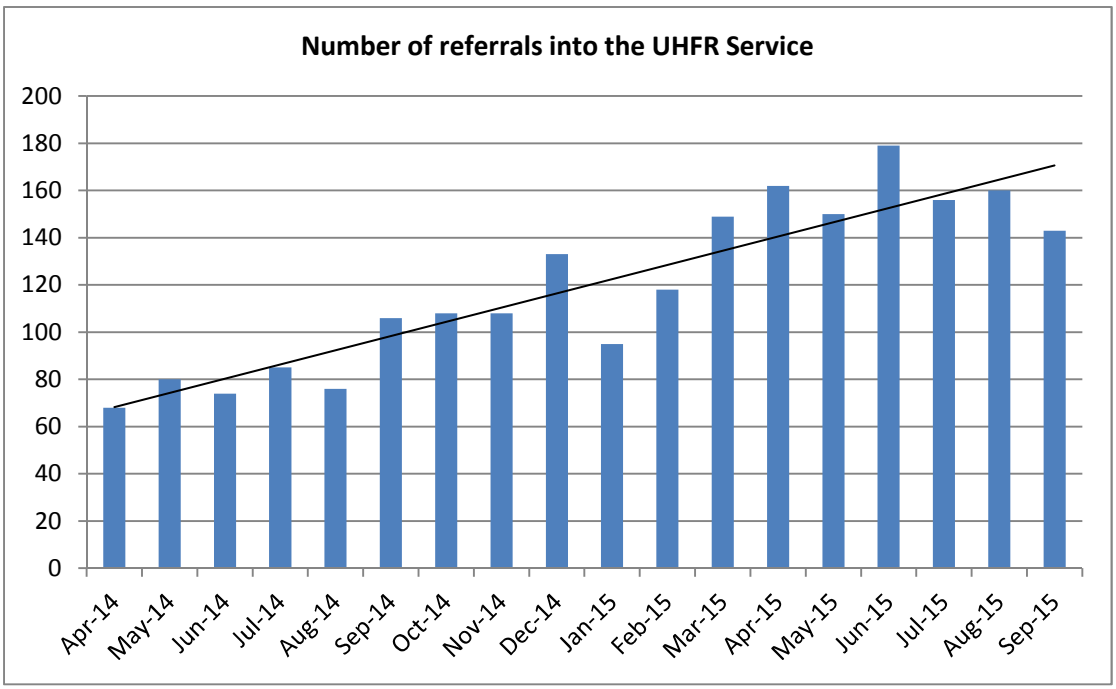
Emergency admissions to hospital for falls injuries. BCF Aim – to reduce the number of emergency admissions in older people due to falls Data is reported annually High values are **poor** Data source – Public Health Observatory				
Baseline Rate (Apr 12 – Mar 13)	1829.7		**Current RAG rating and trend**	
2014-15 target	1685.0			
2015-16 target	1686.4			
Comments	No data as yet.			
Key Issues				
Mitigating Actions	Although 2014/15 data awaited, there are ongoing initiatives to reduce falls. Falls prevention and awareness training is being rolled out. The Council's Urgent Homes and Falls Response Service is being extended into Care Homes.			



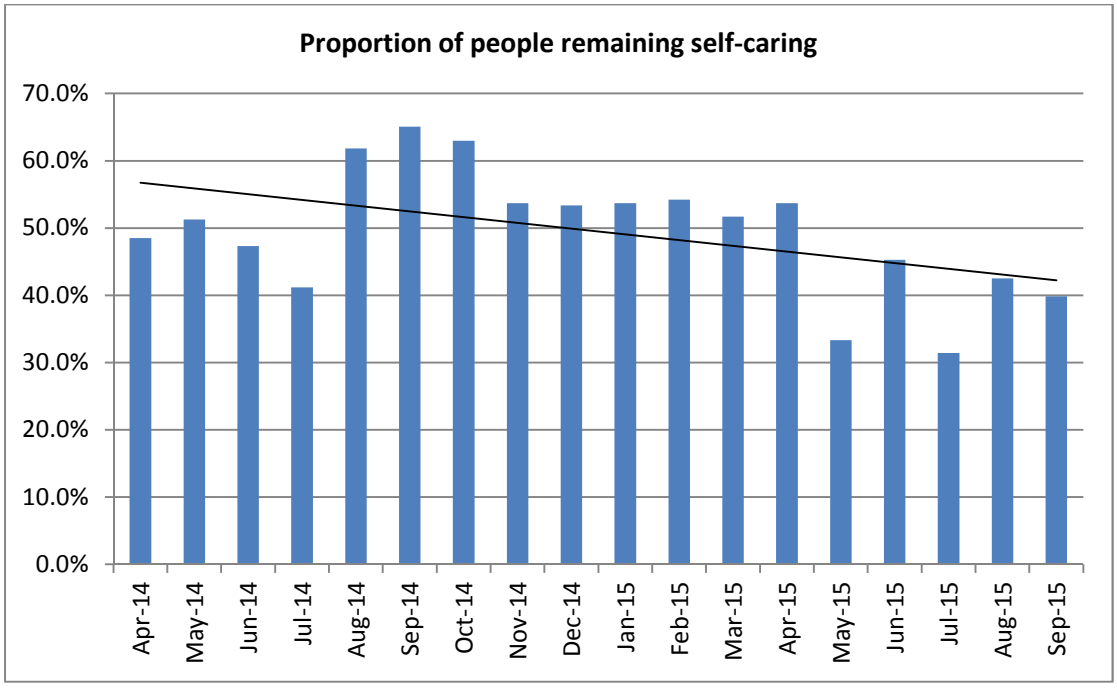
Source: Public Health Observatory



Source: Bedfordshire CCG



Source: UHFRS, Central Bedfordshire Council



Source: UHFRS, Central Bedfordshire