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

This meeting may be filmed.*

please ask for Paula Everitt
direct line 0300 300 4196
date 10 March 2016

NOTICE OF MEETING

SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE

Date & Time
Monday, 21 March 2016 10.00 a.m.

Venue at
Council Chamber, Priory House, Monks Walk, Shefford

Richard Carr
Chief Executive

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

Cllrs P Hollick (Chairman), P Downing (Vice-Chairman), R D Berry, N B Costin, P A Duckett, C C Gomm, Mrs S A Goodchild, Mrs D B Gurney and G Perham

[Named Substitutes:

Mrs A Barker, K Ferguson, Ms A M W Graham, B Saunders and T Stock]

All other Members of the Council - on request

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

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AGENDA

1. **Minutes**

   To approve as a correct record the Minutes of the meeting of the Social Care Health and Housing Overview and Scrutiny Committee held on 26 January 2016 and to note actions taken since that meeting.

2. **Apologies for Absence**

   Apologies for absence and notification of substitute members

3. **Members' Interests**

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

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

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

5. **Petitions**

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

6. **Questions, Statements or Deputations**

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

7. **Call-In**

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

8. **Requested Items**

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

9. **Report by the Local Government Ombudsman**

   To scrutinise the findings of the Local Government Ombudsman on the complaint by Ms J. and the subsequent response and actions implemented by officers.

10. **Executive Members Update**

To receive a brief verbal update from the Executive Members for:-

Social Care and Housing and
Health

Part A: Health Scrutiny

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

Reports

Item	Subject		Page Nos.
11	**East of England Ambulance Trust Performance Report** To receive for information the East of England Ambulance Trust Performance Report and comment on the impact of the current service and performance on residents.	*	35 - 40
12	**BCCG Value Based Elective Commissioning** To scrutinise the Bedfordshire Clinical Commissioning Group's proposed value based elective commissioning service changes and provide feedback on the impact to Central Bedfordshire residents.	*	to follow
13	**BCCG Primary Care Strategy** To scrutinise the proposed Primary (Health) Care Strategy and the work underway to develop this from a Central Bedfordshire view and provide feed back on the strategic priorities and intentions of Bedfordshire Clinical Commissioning Group with regard to primary healthcare services, particularly general practice services. For the Committee to be assured as to how the views of local service users and residents have helped to shape the draft Primary Care Strategy.	*	41 - 50
14	**Excess Weight Services Strategy and Contract** That Members scrutinise the proposed Excess Weight Strategy, developed with partners, and provide feedback on future priorities.	*	51 - 78

Part B: Social Care and Housing

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

Reports

Item	Subject		Page Nos.
15	**Q3 Budget Monitoring Reports** To consider and comment on the Q3 Budget Monitoring reports for Social Care, Health and Housing and Public Health. The Executive Agenda dated 9 February 2016 contains full details of the Q3 capital and revenue budget and is available from this link: http://centralbeds.moderngov.co.uk/ieListDocuments.aspx?CId=577&MId=4922&Ver=4	*	79 - 88
16	**Work Programme 2015/16 and Executive Forward Plan** The report provides Members with details of the currently drafted Committee work programme and the latest Executive Forward Plan.	*	89 - 94

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CENTRAL BEDFORDSHIRE COUNCIL

At a meeting of the **SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE** held in Committee Room 1 - The Council Offices, High Street North, Dunstable, on Monday, 25 January 2016.

PRESENT

Cllr P Hollick (Chairman)
Cllr (Vice-Chairman)

Cllrs	R D Berry	Cllrs	C C Gomm
	N B Costin		Mrs S A Goodchild
	P A Duckett		Mrs D B Gurney

Apologies for Absence:	Cllrs	P Downing	
		G Perham	
Members in Attendance:	Cllrs	C Hegley	Executive Member for Social Care and Housing
		M R Jones	Deputy Leader and Executive Member for Health

Officers in Attendance:	Mrs P Everitt	–	Scrutiny Policy Adviser
	Mr D Galvin	–	Head of Financial Performance
	Mr T Hoyle	–	MANOP Head of Service
	Mr T Keaveney	–	Assistant Director Housing Services
	Mr S Mitchelmore	–	Assistant Director, Adult Social Care
	Mr N Murley	–	Assistant Director Resources
	Mr R Norris	–	Team Leader Housing Finance
	Mrs C Shohet	–	Assistant Director of Public Health
	Lorna Walker	–	Project Officer

Others in Attendance	Mrs M Bradley	Head of Mental Health and Wellbeing, Bedfordshire CCG
	Dr R Evans	Deputy Medical Director
	Mrs A Lathwell	Head of Strategy & Corporate Planning, Bedfordshire Clinical Commissioning Group
	Mr R Smith	Chairman Central Bedfordshire Healthwatch
	Mr J Wilkins	Managing Director ELFT & Deputy Chief Executive Beds and Luton Mental Health and Wellbeing Services

SCHH/15/62. **Minutes**

RESOLVED that the Minutes of the meeting of the Social Care Health and Housing Overview and Scrutiny Committee held on 14 December 2015 be confirmed and signed by the Chairman as a correct record.

SCHH/15/63. **Members' Interests**

None.

SCHH/15/64. **Chairman's Announcements and Communications**
The Chairman advised the Committee of his attendance at the opening of the Evergreen Step Up, Step Down facility in Ampthill that would serve residents in the north of the Central Bedfordshire. The Chairman also attended the Health and Wellbeing Board and encourage employers to respond to the campaign to look after the wellbeing of their workforces.

SCHH/15/65. **Petitions**
None

SCHH/15/66. **Questions, Statements or Deputations**
With the approval of the two members of the public that had registered to speak, it was agreed the Chairman would invite them to speak before the relevant item.

SCHH/15/67. **Call-In**
None.

SCHH/15/68. **Requested Items**
None.

SCHH/15/69. **Executive Member Update**
The Executive Member for Social Care and Housing advised the Committee of their attendance at the opening of the Evergreen Step Up, Step Down facility in Ampthill and funding for a neurological nurse that had been reinstated by the Bedfordshire Clinical Commissioning Group for suffers of motor neurone disease.

The Executive Member also raised her concerns regarding the budget settlement from the Government and resulting shortfall in funding. The 2% precept awarded for Social Care did not meet the shortfall in Grant Settlement.

The Deputy Leader and Executive Member for Health announced the appointment of the Accountable Officer at Bedfordshire Clinical Commissioning Group and the good settlement that had been received from the Government. The Executive Member advised of the opening of the Ivel Medical Centre in Biggleswade.

The budget settlement for Public Health was expected in January 2016.

SCHH/15/70. **The Future of Greenacre Older Persons Home: Outcome of Consultation and Recommendations**
In accordance with the public participation procedure, two members of the public were invited to speak. The first speaker raised the following:

- Suggestions that any closure of the home be put on hold until the new provider had been registered with the Care Quality Commission.
- The importance of undertaking checks on the financial viability of a provider prior to the start of a consultation phase.
- Concerns that a provider could walk away from their contract should they fail to deliver.

- That the Committee ought to consider a recommendation to keep the Greenacre Care Home open.

The second speaker raised the following:-

- That consideration be given to the closure of the home, which is not fit for purpose for wheelchair users and the land be used by the Council to build and operate a new home.
- Support for Council owning and running care homes rather than the private sector.
- That when deciding on the new location of the step up, step down facility, the Council consider sites near public transport routes.

In response the Executive Member for Social Care & Housing advised that funding was not available for the Council to provide and run new care homes, however work with the private sector on recent developments had been successful. Comments from the speakers and responses to the consultation had been taken into account and learning would be taken into account in the future.

The Head of Managing the Needs of Older People (MANOP) delivered a presentation that outlined the need for change to meet the accommodation needs for older people. Greenacre did not meet the modern expectations and it would be expensive and impractical to update.

The Committee were also informed that other services located at Greenacre included a small day centre and a step up, step down short term residential reablement service. It would be necessary to move these two services to new sites should it be decided to close the home. Residents, their families and staff at Greenacre had been invited to 1:1 meetings held at the home to discuss the proposals. A full consultation had been published and the Director had asked for delegated authority to keep Greenacre open for as long it was necessary based on residents need.

A Member raised a concern regarding the registration of one of the care homes with CQC. In response the Head of MANOP advised the Council would need to reconsider its approach to the future of the home should Only Care Ltd not be successful in achieving registration.

Following the closure of Caddington Hall, a Member asked if lessons had been learnt and if learning would be used in preparation of the proposed closure of Greenacre? In response the Head of MANOP advised residents would receive an early assessment of their needs and abilities. Activities would be continued to maintain a positive atmosphere for those residents who remained at the home.

Members of the Committee were satisfied that the consultation process had been carried out in a comprehensive and diligent manner, however, but agreed with the view that with the idea that financial checks of a potential new care home provider could be carried out sooner.

Members were also satisfied that the needs of staff had been fully considered and help to support them during the process had been put in place.

RECOMMENDED

1. That the Committee recognised the need to offer improved accommodation for clients to meet modern physical and environmental standards and the increased expectation of our clients;
2. That the Committee is satisfied that the consultation process had been carried out in a comprehensive and diligent manner;
3. That in the future the investigation of the financial stability of a new provider is carried out and deemed satisfactory before consultation commences on the future of a home;
4. That the Committee noted the dependency of the proposals on the provider of Rosewood Court achieving CQC registration;
5. That the need to take account of the assessed eligible care and support needs of residents be emphasised;
6. That account be taken of the effect of the closure on staff;
7. That the Committee noted the need to explore further how the relocation of the day care centre was to take place;
8. That the Committee noted the need to explore further where the step up, step down facility may be sited.

SCHH/15/71. **Draft Budget & MTFP, Capital Programme and HRA 2016/17**

The Assistant Director Resources introduced the Draft Budget 2016/17 and Medium Term Financial Plan for Social Care, Housing and Public Health that had been presented to Executive in January 2016.

The Financial Settlement had been significantly worse than anticipated for the Council and exacerbated the substantial efficiencies contained in the draft budget and MTFP. The proposed 2% precept proposed by Government would not make up for the shortfall in funding.

A member raised his concern regarding the introduction of the living wage and the effect on care providers. In response the Assistant Director advised that an hourly rate template had been developed and used by providers to recognise the effect on all staff, and not just at the lower end of the pay scale. Officers continued to revisit and review care packages to find efficiencies and Members were aware of the continued community resilience support required within Social Care.

The Assistant Director Public Health advised that the Government had not divulged the grant settlement to be provided, but it was lower than in previous years. The settlement would, however, continue to be ring fenced.

The Assistant Director Housing advised of continued changes and reductions in Housing Revenue Account (HRA) that had caused a more cautious approach to the business plan, as a result of which the supported housing scheme was at risk Members of the Executive had lobbied their MP regarding this concern.

RECOMMENDED

1. That the pressures and efficiencies across Public Health and within the Social Care, Health & Housing directorate and the proposed delivery of the latter to meet budget constraints be noted.
2. That reserves be replenished from time to time to help meet deficits.
3. That the general approach concerning the General Fund Revenue budget, Medium Term Financial Plan and the Capital Programme be agreed.
4. That the Committee notes the inconsistencies in rents across the range of facilities, the challenges presented and that representations have been made to local Members of Parliament. In light of these concerns the Committee otherwise agreed to the proposals set out regarding Housing Revenue Account budgets.

SCHH/15/72. **Q2 2015/16 Performance Report**

The Committee received the Q2 performance for the month of July to September 2015. Members were advised there had been no movement in the historic red indicators, however, extra care flats had been completed and engagement with village care scheme was strong.

The Assistant Director Public Health advised of a below target in the number of Health Checks provided and officers would focus on those residents who declined a health check. Members were advised of a point of care blood testing service that would see the need for patients to attend hospital cease.

RECOMMENDED

1. That the Committee welcomed the generally good progress;
2. That the Committee Recognised ‘prevention rather than cure’ when offering health checks and the need to have a positive response from individuals.

SCHH/15/73. **Winter Resilience Exception Report**

The Acting Director of Strategy and System Redesign outlined the success in dealing with anticipated seasonal pressures in urgent care that had been experienced across Bedfordshire. The complex needs of some patients had caused workforce pressures in hospitals and social care, however in general the services had coped well.

A Member raised concerns that some residents required between 4 and 6 visits a day by domiciliary carers. The Assistant Director Adult Social Care advised that capacity to support patients for short time periods was not feasible, which was both a local and national challenge.

RECOMMENDED

1. That the Committee welcomed extensive and varied campaigns advising the public on how to survive the winter.
2. That the Committee recognised the tenner of the various campaigns, that success lies as much with individuals responding and taking care of their own health and taking up offers of vaccinations and health checks.
3. That the Committee receive a final Winter Resilience Report in June that looks solely at Central Bedfordshire Performance.

SCHH/15/74. **East London Foundation Trust - Mental Health Services Update**

The Managing Director and Deputy Medical Director of ELFT Bedfordshire introduced a report that outlined the progress made by the Trust, to provide high quality and integrated services through a single point of access for with patients with mental health illnesses. Partnership working had been established and the Trust's implementation of the one year plan was well advanced.

The need for patients to be cared for outside of area had been resolved and ELFT were confident that all patients on the inherited waiting list would have been seen. ELFT sought help and advice in their accommodation search that was required for therapists and working closely with officers to resolve this.

A Member raised a concern regarding Child and Adolescent Mental Health service and work with schools. The Managing Director advised ELFT had reduced the waiting list and was working with 12 schools in a specialist schools link project and that further details would be provided to the Children's Services Overview and Scrutiny Committee later that week.

The Assistant Director Public Health advised Members that new measures put in place by ELFT had ensured that patients in touch with the Drug and Alcohol Service had been seen quickly and effectively.

RECOMMENDED that the Committee welcomed a very positive and extensive report and the speed at which issues were being addressed. The Committee looked forward to further positive reports and further information relating to those schools that had taken part in the specialist schools link project.

SCHH/15/75. **Work Programme 2015/16 and Executive Forward Plan**

The Committee consider the current work programme and a Member request that a report be provided to a future meeting of the Committee on Homelessness.

RECOMMENDED that subject to the addition of those items noted in the Minutes the work programme be approved.

(Note: The meeting commenced at 10.00 a.m. and concluded at 1.17 p.m.)

Central Bedfordshire Council

SCHH Overview and Scrutiny Committee (21 March 2016)

Report by the Local Government Ombudsman

Advising Officers: Julie Ogley, Director of Social Care, Health and Housing Julie.ogley@centralbedfordshire.gov.uk and Iain Melville, Head of Business Systems iain.melville@centralbedfordshire.gov.uk

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Purpose of this report

1. To outline the findings and the Council's response and actions of the Local Government Ombudsman's Report in respect of Ms J. which was published on 15th January 2016.

RECOMMENDATIONS
The Committee is asked to:

1. To consider and comment on the content of the report.

Issues

Report by the Local Government Ombudsman

2. The Local Government Ombudsman independently and impartially investigates complaints made about Councils and then asks the particular Council to follow its recommendations.

3. This complaint relates to Ms J's direct payment that started with Bedfordshire County Council in October 2004. Since this time there have been numerous visits and discussion with Ms J about the use and running of her Direct Payment. This particular complaint originates in 2010 when Ms J had a new financial assessment which resulted in her having to contribute towards the cost of her care for the first time.

4. It was recognised at the beginning of Central Bedfordshire Council that Adult Social Care was performing inadequately at Bedfordshire County Council and so a Recovery and Improvement Board was established at Central Bedfordshire Council to improve the poor service that was being delivered.

5. The results of the Recovery and Improvement Board have helped to inform the Council's work in preparation for the Care Act. Consequently a lot of the areas for improvement highlighted by the Local Government

Ombudsman were already in progress. The report has helped to highlight the importance of this work.

6. A Review Meeting of this case, chaired by the Head of Safeguarding and Quality Improvement was held on 8th February 2016. The meeting considered the report, discussed the implications of the recommendations and the Council's approach to them.

Recommendations and Conclusions from the report

7. The Council has accepted the LGO's recommendations and these have now either been completed or are being worked through.

8. The LGO also stated five conclusions :

    a. Record-keeping
    b. Disability Related Expenditure (DRE) and charging
    c. Support Plan
    d. Monitoring of Direct Payments
    e. Complaint Handling

9. **Record keeping**

10. The LGO concluded that the Council had failed to keep adequate records and did not provide Ms J with clear information about its assessments and calculations.

11. Response and actions

12. The Council agrees that it is vital that it provides clear information about its assessments to the relevant client and/or their representatives. In order to support this, robust records must be kept and every interaction should be recorded. This allows all parts of the system to act on fact and to provide evidence based decision making.

13. Therefore in Ms J's case a meeting with her and her advocate (if she wishes to use one) is being arranged in March to clearly explain her Overview and Support Plans that have been independently carried out by Bedford Borough Council. This meeting will also set up a clear working agreement for future reviews and monitoring.

14. Clear management oversight is now in place to ensure that this is happening in all cases. This is achieved through regular case file audits being undertaken by managers, the Operational Reference Group also makes use of discussion papers to review and improve practice across the board and the importance good record keeping and providing clear information about assessments is regularly reinforced at team meetings.

15. Starting in February, this particular case is being presented as a case study that managers are discussing with their teams and the Council's key partners to ensure the lessons learnt are embedded into practice.

16. **Disability Related Expenditure and Charging**

17. The LGO concluded that the Council was not taking sufficient account of the impact of Ms J's disability on what she is able to do. This is in relation to costs associated with her inability to travel and the responsibilities of her Personal Assistants were not clear. The Council was also not clear in explaining why certain costs were not allowed for Disability related expenditure (DRE).

18. Explanation of DRE

19. DRE is a cost the client may incur because of their age, disability or medical condition. Examples could include extra laundry, incontinence aids, garden maintenance, transport, extra heating costs and specialist equipment.

20. The Council asks for receipts as proof of their spend because these costs (as well as 'protected income' – the basic amount of Pension Credit or Income Support plus 25% and 'property-related household expenses', such as rent, mortgage and council tax) are deducted from the client's total weekly income and a weekly 'tariff charge' of £1 for each £250 (or part of) on capital and savings between the lower (£14,250) and upper capital limit (£23,250). The final figure will be their 'disposable' income.

21. The disposable income is their assessed contribution towards the cost of their care. The amount the Council asks them to contribute will never be more than the full cost of their service. Further information and examples are provided in the Paying for Care leaflet.

22. Response and actions

23. In this case the financial assessment was completed following a visit from a Community Finance Adviser and the DRE was calculated on the receipts given at the time. In hindsight more information should have been given to Ms J and her advocate to very clearly explain what was covered by DRE and what was covered by the Direct Payment.

24. Therefore in Ms J's case the Council will be undertaking a brand new financial assessment in March and clearly explaining what can and cannot be taken into account for DRE and also what the Direct Payment can therefore be used for.

25. To support all our customers, a separate DRE leaflet is being produced to expand on the information contained in the Paying for Care Leaflet to give more detail on what DRE can be used for and therefore what receipts should be provided. The Direct Payments Practise Guidance is also being

strengthened to highlight these issues. This will enable social care professionals to provide better information to clients about the relevance of DRE and what is covered by it and also their Direct Payment.

26. **Support Plan**

27. The LGO concluded that the Council did not put the service user at the heart of the review and was not clear on the duties of her personal assistants or on other support to meet her needs.

28. Response and actions

29. It is vital that the support plan is about meeting the needs of the individual through a person centred approach and that the assessment clearly describes the person's needs. In Ms J's case the Council has asked Bedford Borough Council to undertake a brand new Overview Assessment and corresponding Support Plan. These have now been completed and Central Bedfordshire Council is now arranging to meet with Ms J in March to clearly explain these to her and therefore the options that she has.

30. The Care Act 2014 has supported the Council to develop its approach to assessment and support planning and being specific about eligibility. Work is also currently underway to review the Customer Pathway. This is to ensure that our engagement with customers is not about processes and systems but rather on the needs of the individual and how these can be best met. The review will also focus on the interactions between care management and the various teams that support customers to ensure timely and streamlined responses to support the assessment, care planning and review.

31. Once this work is complete later this year, we will be working closely with our software suppliers to ensure that the improvements to Swift will take this new approach into account.

32. Since 2014 the Council has developed a quality improvement programme of work to support implementing the Care Act and develop practice. This is includes governance arrangements for practice development, and a practitioner forum. Part of the role of the practitioner forum is to act as a reference group for policy and process development. New initiatives include a case file audit procedure, a process for learning from complaints and embedding regular quality assurance.

33. **Monitoring of Direct Payments**

34. The LGO concluded that the Council should have seen within a matter of weeks that Ms J was not paying her client contribution into her Direct Payment bank account. The Council's failure to deal with this straight away was fault. There was also poor exchange of information between the financial monitoring and review of care arrangements.

35. Response and actions

36. During the period in question, there was a large backlog in the monitoring of Direct Payments. It was also not possible to quickly establish that Ms J was not paying her contribution into her DP bank account because there were problems receiving bank statements and receipts from her despite various requests and visits.

37. In 2014 the Direct Payments Team was restructured and capacity was increased to four Direct Payment Officers. This has enabled more regular monitoring to take place and each new Direct Payment client is now offered a visit by a Direct Payment Officer to provide further advice and information, answer any further questions they might have about their Direct Payment and help them with the returns process.

38. The Direct Payments Policy has been updated to reflect the changes in the Care Act and this is now much clearer about the process for non returns. The responsibilities of the Direct Payment's customer are also explained more clearly in the Direct Payment Contract, by the social worker's and the Direct Payment Officer's visits.

39. Once the upgrades to Swift have been completed this year, a business case will be produced looking at moving Direct Payment customers away from bank accounts and onto pre-paid cards. Although there is a cost implication for this, there are many benefits for both the Direct Payment customer and the Council. In this case, the Council would have immediate access to the pre-paid card account and would have been able to instantly spot that no client contribution was being paid.

40. Communication between the Direct Payment Team and the Social Work Teams has improved greatly since this complaint originated. Any concerns with a Direct Payment account are discussed with the social worker and a weekly report is produced for Budget Managers highlighting any financial issues. Before any review Social Workers will discuss any issues about the Direct Payment with the Direct Payment Team.

41. As mentioned previously, one of the outcomes of the Customer Pathway Review is to reduce hand offs in the process and where this cannot be achieved ensuring everyone is clear on their particular roles and responsibilities. An emphasis on the assessment and support planning process as a means to take account of all aspects of a person's life will ensure better coordination between teams.

42. **Complaint handling**

43. The LGO concluded that the Council did not follow its complaints procedure when Ms J complained.

44. Response and actions

45. There were several complaints and communications from Ms J over an extended period of time and these complicated matters. However, Customer Relations have recognised the value of setting trigger points in cases with repeat communications and challenges.

46. A chronology is now put in place for cases with more than one challenge to a Local Resolution response. Cases are reviewed objectively and clear decisions made as to the best way forward, including ensuring the Assistant Director reviews the process and the option to refer matters to the Local Government Ombudsman is communicated appropriately to customers.

Council Priorities

47. One of the Council's priorities is to promote health and well being and protect the vulnerable. The Adult Social Car service welcomes complaints and is using the lessons from this complaint to improve the services that we provide to our clients.

Corporate Implications

Legal Implications

48. The Care Act 2014 came in to force on 1st April 2015 and this provides the legislative framework under which the Council operates when managing care and support needs. The Care Act 2014 and the companying statutory guidance specifically deal with direct payments. In particular, the statutory guidance sets out the detail of the circumstances in which direct payments can be provided and how they should be administered.

49. Many of the issues raised within the LGO report occurred prior to the Care Act 2014 being implemented. Moving forward, practice and procedure will reflect the Care Act 2014.

Financial Implications

50. Effective management of complaint issues focuses resources on resolution and reduces the risks of financial remedies being paid. This was not the case with this complaint but the learning from it is being used to inform service improvements.

Equalities Implications

51. Central Bedfordshire Council has a statutory duty to promote equality of opportunity, eliminate unlawful discrimination, harassment and victimisation and foster good relations in respect of nine protected characteristics; age, disability, gender reassignment, marriage and civil

partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

52. To support vulnerable people to feel safe it is important that they know how to complain about services they receive, feel heard when they raise complaints and that action is taken where appropriate. It is important that lessons are learnt from this case and acted upon to ensure that this happens to the level that it should.

53. This complaint has highlighted the need, when undertaking financial assessments and considering disability related expenses, to take sufficient account of the impact of an individual's disability on what they are able to do and to clearly explain why some expenditure is not classed as a disability related expense. The findings have also highlighted a need for greater awareness that an individual's disabilities can impact on their ability to participate in meetings and that alternative approaches, to facilitate engagement, need to be considered.

Conclusion and next Steps

54. The Committee is asked to scrutinise the findings of the Local Government Ombudsman complaint and consider the implications for the Council.

Appendices

55. Report by the Local Government Ombudsman 15 January 2016 (reference number 13 014 946)

Background Papers

56. The following background papers, not previously available to the public, were taken into account and are available on the Council's website:

None

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Local Government OMBUDSMAN

Report by the Local Government Ombudsman

Investigation into a complaint against

Central Bedfordshire Council

(reference number: 13 014 946)

15 January 2016

The Ombudsman's role

For 40 years the Ombudsman has independently and impartially investigated complaints. We effectively resolve disputes about councils and other bodies in our jurisdiction by recommending redress which is proportionate, appropriate and reasonable based on all the facts of the complaint. Our service is free of charge.

Each case which comes to the Ombudsman is different and we take the individual needs and circumstances of the person complaining to us into account when we make recommendations to remedy injustice caused by fault.

We have no legal power to force councils to follow our recommendations, but they almost always do. Some of the things we might ask a council to do are:

- apologise
- pay a financial remedy
- improve its procedures so similar problems don't happen again.

Investigation into complaint number 13 014 946 against Central Bedfordshire Council

Contents

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

Key to names used

Ms J - the complainant

Report summary

Adult care services – direct payments

Ms J complains about the way the Council has administered her direct payments and that it did not follow its complaints procedure when investigating her complaint. She says this has caused her significant avoidable distress, and meant she has not had as much care as she should have had.

Finding

Fault found causing injustice and recommendations made.

Recommendations

To put right the injustice arising from the fault we have identified, the Council should:

- apologise to Ms J
- confirm immediately that it will not seek to reclaim any unpaid contributions from Ms J, and write off any debts it is currently attempting to recover
- arrange for an independent social worker to carry out a new care needs assessment and prepare a new support plan, without delay
- set up a clear working agreement for future reviews and monitoring
- reconsider Ms J's disability related expenditure (DRE) and provide a clear explanation of why it does not consider some costs arise from her disability
- pay Ms J:
  - £5,000 to acknowledge the impact on her of being without adequate care and support for over two years
  - £2,000 to acknowledge the avoidable distress and frustration the Council's faults have caused her.

The Council has accepted our recommendations. It should confirm it has taken the action within three months of the date of this report.

Introduction

1. Ms J has limited mobility. She can stand and walk for short periods but cannot sit, so she has to spend most of her time lying on her back. She is in severe and constant pain, managed by medication which affects her concentration. She lives alone and is dependent on others for her personal care and all domestic tasks.

2. Ms J receives direct payments so she can arrange and purchase her own care. She complains that the Council:

   - has not been consistent about what items are covered by direct payments
   - has failed to adhere to government guidelines about what should be covered
   - increased her client contribution without carrying out a financial assessment
   - did not take account of all relevant information when it did carry out the financial assessment
   - did not follow its complaints procedure in investigating the complaint.

3. So she suffered:

   - reduced care, because it is not clear what her direct payment will cover and she has had to divert carer support to helping her pursue the complaint, and
   - significant avoidable stress.

Legal and administrative background

The role of the Ombudsman

4. The Ombudsman investigates complaints about 'maladministration' and 'service failure'. In this report, we have used the word fault to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. We refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1))***

5. The Ombudsman cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. We must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3))***

Relevant law and guidance about adult social care

Charging for care

6. Once an assessment has concluded a person is eligible for social care services, a care or support plan should follow without delay. The service user should receive a copy.

7. Most councils charge people for home care. To work out the person's contribution to the cost of care, they carry out a financial assessment. Guidance on charging for home care (*Fairer Charging*) tells councils they should carry out a prompt financial assessment and tell people about the charge when care starts.

8. *Fairer charging* gives detailed guidance about disregarding 'disability related expenditure' (DRE) when calculating a person's contribution. Any additional expenses claimed in relation to a person's disability should be considered. ***(para 53)***

Direct payments

9. Direct payments (DPs) are cash payments a council makes to a person with eligible care needs, instead of providing them with care services. They give people control and choice over their care arrangements, and let people have greater flexibility and independence by increasing the social, educational, employment and community involvement opportunities they can access.

10. The Council has procedures for assessing and monitoring direct payments. The first step is to assess the person's care needs. The Council then works with the person to produce a support plan setting out how those care needs will be met. The support plan should include:

- confirmation of which assessed needs will be covered by DPs, and how these needs will be met
- the indicative personal budget and how often it will be paid, and
- the initial review date.

11. Once it has completed the support plan the Council calculates an Actual Personal Budget (APB) to decide the final DPs amount. It sends a DPs agreement to the person. This sets out the person's contribution to the costs of care and the arrangements for paying contributions into the DPs bank account. All terms and conditions of the DPs agreement apply as soon as the DPs begin, even if the person has not signed the DPs agreement.

Monitoring direct payments

12. Councils should monitor and audit DPs. The frequency of monitoring will depend on how long the person has managed DPs (either alone or with help) and their particular circumstances. The timing of the first review should be set at the beginning and should cover how the person is managing the DPs. If financial monitoring and review of the care arrangements are not done by the same officer, councils should ensure they exchange information.

13. The Council monitors DPs to check:

- the purchased care and support meet the person's needs
- the person's ability to manage the DPs bank account and employer responsibilities (if employing a personal assistant), and
- the person is paying the correct contributions to the DPs bank account.

14. People send spending receipts and bank statements to the Council monthly, or annually if the Council decides this is sufficient. Triggers for the Council to intervene include:

- more than 12 weeks of DPs in the bank account, above any sum set aside for planned expenditure such as respite
- less than two weeks of DPs in the bank account, or
- the person reporting problems or concerns about money management and record-keeping.

15. DPs must be used to meet the person's eligible care needs. Examples include:

- employing a personal assistant/carer of the person's choice, instead of an agreed home support package
- transport at actual cost
- a respite (short) break
- equipment to support independent living
- support to help people stay independent in the home and reduce risks
- support to reduce social isolation
- support to access or maintain employment
- support to participate in physical activities, and
- support to access cultural or religious activities, social event or outings.

16. There are restrictions on using DPs. They cannot be used for the costs of day to day living, or any service or activity that cannot be shown to improve or maintain support for the person's quality of life.

Adult social care complaints procedure

17. The Council's procedure for considering complaints about adult social care says it will take all reasonable steps to resolve the complaint by local resolution. The Council aims to resolve complaints within 20 working days or, where this is not possible, as soon as reasonably practicable. The Council then writes to the complainant to say if it upholds the complaint and give the reasons why.

18. After this, a complainant can ask for an independent investigation. A person from a different service area in the Council investigates the complaint. The Council sends an investigation report to the complainant within 65 days and may then offer an adjudication meeting. But if there are difficulties in setting up such a meeting the Council sends the complainant a written response on the complaint. The Council will send its final response within six months of receiving the complaint.

How we considered this complaint

19. This report has been produced following the examination of relevant documents and an interview with the complainant.

20. The complainant and the Council were given a confidential draft of this report and invited to comment. The comments received were taken into account before the report was finalised.

Investigation

Events leading to the complaint

21. Until late 2010, the Council paid Ms J DPs which met the cost of her support in full. In October 2010 the Council carried out a new financial assessment. As a result of this, the Council asked Ms J to contribute £57 a week towards the cost of her care. Ms J complained and provided more information about her DRE. The Council reduced Ms J's contribution to £24 a week.

22. Ms J says when she told her social worker that she could not afford this, the social worker told her to reduce the number of hours her carers worked, and this would cancel out her contribution. The Council has no record of this conversation. But this is what Ms J did.

23. In November 2011 the Council carried out an annual review of Ms J's support plan and direct payments. Ms J continued to receive the same DPs and continued not to pay her contribution.

24. In 2012 there were problems between Ms J and her care provider. Ms J complained about the standard of care she received. This complaint was not resolved and in August Ms J cancelled her contract with the agency. The Council knew about this and decided it needed to reassess Ms J's care needs.

25. Officers tried to arrange an appointment with Ms J to do this. When Ms J did not respond the Council sent a letter to her, saying if she did not arrange an appointment her DPs might be suspended. Ms J complained.

26. Officers met Ms J at her home at the end of November 2012 to discuss this complaint. The Council then reviewed Ms J's care needs by speaking to her care provider.

27. Ms J regularly sent the Council receipts for items she paid for from her DPs. In December 2012 officers raised concerns internally that some of Ms J's receipts were for items which were not to meet her care needs. In particular, officers were concerned that physiotherapy sessions were to meet a health need so the costs should not come from DPs, which were intended to meet care needs. Ms J had been submitting receipts for physiotherapy since 2006.

28. The Council was also at this time catching up on monitoring DPs accounts. On 18 February 2013 the Council wrote to Ms J to say:

- she could not claim for some items from her DPs (physiotherapy, vet bills)
- she needed to pay her client contribution of £24 a week into the DPs account, and
- the current balance on the account was nearly £14,000, so Ms J needed to repay the Council £10,500.

29. Ms J queried the content of the letter and the Council agreed to allow physiotherapy and vet bills up to March 2013. It said these items would not be allowed in future. The Council offered Ms J a meeting to discuss her DPs account. Officers visited on 10 April 2013. The Council has no record of this meeting.

30. On 30 April 2013 officers found an Actual Personal Budget (APB) for Ms J dated November 2011. This reduced the number of hours of support Ms J received, and therefore the payments she would receive, by about half. The Council did not immediately apply the reduction.

31. In June the Council carried out a financial reassessment of Ms J. This calculated her contribution as £48 a week. The Council told Ms J this in August. Ms J complained to the Council's chief executive.

32. In August 2013 the Council applied the reduction to Ms J's DPs from the November 2011 APB. Ms J noticed the payment had significantly reduced and made a further complaint.

33. Officers discussed the situation internally by email. They established that the APB from November 2011 had not been actioned until August 2013. It had created an overpayment of some £13,000 which the Council could recover from Ms J. But it was not clear whether anybody had told Ms J about the outcome of the November 2011 assessment. It was also not clear whether the November 2011 APB was correct – her social worker's recollection was that this assessment had not resulted in any change to Ms J's budget.

34. The Council decided to visit Ms J to discuss this, and also the high balance on her account, her failure to provide receipts for six months, and her failure to make a payment to HMRC in 2012. An officer contacted Ms J to arrange a meeting. Ms J said she was still waiting for a response to her complaint to the chief executive. The Council sent a response on 24 September. Ms J told the Council she was not satisfied with this response.

35. The Council arranged to meet Ms J on 4 November. Ms J was unhappy about her contribution to her budget, the reduction in her DPs, the response to her complaints, and the planned reassessment of the activities her DPs could fund. Officers established what support Ms J's carers provided.

36. The Council completed a review of Ms J's support plan, which restored her APB to the higher level. It carried out a financial reassessment and decided Ms J's contribution should be £36 a week, with effect from 5 August 2013. The Council wrote to Ms J (and to her MP, whom Ms J had now involved) explaining this. The Council also said Ms J needed to pay all the client contributions she had missed since January 2011. The Council offered to visit Ms J again to discuss this.

37. Ms J said she did not want another visit so the Council finalised her support plan and sent it to her on 26 November 2013. The support plan listed items which Ms J could and could not pay for using her direct payments.

38. Ms J could not understand the Council's calculations and asked the Council to explain them. She also complained to the Ombudsman. We referred her complaint back to the Council because she had not yet exhausted the Council's full complaint procedure. The Council held a meeting of officers to decide how to respond to the complaint and asked Ms J to confirm she wanted to pursue the complaint. The Council said it would soon be sending Ms J a letter explaining its calculations and Ms J might want to read this before deciding.

39. At Ms J's request, the Council delayed sending this letter until early January 2014. In February the Council asked Ms J if she still wanted to pursue her complaint. Ms J said she was still waiting for a response to the complaint she had made to the chief executive in August 2013. The Council offered Ms J a meeting to discuss her complaint. It repeated its offer four weeks later, at the end of March. By this time the Council had also written to Ms J saying her financial returns were overdue – Ms J disputed this, saying she had posted them on time.

40. The Council met Ms J to discuss her complaint on 15 April. The Council has no notes of this meeting. Ms J sent clarification of her complaint following this meeting and Council officers met to discuss the complaint on 29 April. The Council sent its written response to Ms J's complaint on 16 May 2014.

41. In early June 2014 Ms J's new social worker tried to set up a meeting with Ms J to discuss her direct payments and review her support plan. Ms J responded on 2 July. She did not feel able to meet with a new professional to discuss a situation which was causing her significant distress.

Ms J's support plan

42. Ms J's support plan sets out the tasks with which she needs help. It says this will be delivered by a daily morning and evening call from a carer, which totals 7 hours a week, and by a personal assistant providing 15 hours of support a week. It is not clear how this number of hours of personal assistant support has been calculated. The total weekly budget for this (at November 2013) is £253.10 a week.

43. The support plan does not outline any other form of support to be met from Ms J's personal budget.

Calculation of Ms J's contribution to her budget (November 2013)

44. First the Council considered Ms J's income. It deducted some of her disability benefits and her savings (which are too low to be significant). This gave a figure of £234.15 for her total income.

45. Then the Council considered items which Ms J has to pay for because of her disability (that is, DRE), and items which she has to pay for as a householder. The Council added these expenses to the part of Ms J's income which is 'protected' so she has enough to live on. This gave a figure of total allowances of £197.37.

46. The Council deducted the total allowances from the total income. This gave a figure of £36.78 for Ms J's contribution to her budget.

47. The dispute here arises from the calculation of Ms J's DRE. The Council has included:

- £5 a week for laundry, and
- £5 a week for garden maintenance.

And these figures are clearly marked as such.

48. It has also included a list of figures marked 'Any other'. These figures include disposable gloves and nappy sacks (£1.69 a week) and a list of equipment which averages £10.46 a week.

49. It is not clear if the Council has included:

- transport costs – an ambulance is not always available to take Ms J to appointments and activities
- assistance dog costs
- visiting costs – that is, the extra charge professionals make to visit Ms J, because she cannot easily travel to their premises
- the cost of complementary therapies which ease Ms J's condition
- domestic costs such as window-cleaning, which Ms J cannot do herself and which is not one of the tasks listed for her personal assistant or carers, and
- delivery costs for items which Ms J cannot easily leave the house to buy.

50. Ms J had provided the Council with information about these costs. The Council said they could not be met from her DPs, which were intended only to meet the costs of her care. It is not clear whether the Council considered including them as DRE.

Conclusions

Record-keeping

51. The Council has failed to keep adequate records. It cannot provide:

- Ms J's care needs assessment
- records of meetings, or
- confirmation of whether the APB of November 2011 was correct or not.

52. The Council has not provided Ms J with clear information about its assessments and calculations. Some of its attempts to do this simply fail to make sense.

53. These failings are fault.

DRE and charging

54. It is not our role to arbitrate on what amounts to DRE. But the Council has not properly considered Ms J's DRE in accordance with *Fairer Charging*. This calls into question its financial assessment of Ms J.

55. The Council does not have a list of what it will and will not class as DRE. This is not fault, because *Fairer Charging* is clear that the Council needs to be flexible on this, and it cannot be flexible if it works to a list.

56. But *Fairer Charging* is also clear that any additional expenses claimed in relation to a person's disability should be considered. The Council is not taking sufficient account of the impact of Ms J's disability on what she is able to do.

- Ms J physically cannot travel to a location and then wait for a professional to see her, because she cannot easily travel by car, and is not able to wait for an appointment standing or sitting. So she incurs costs associated with the professional visiting her at home which arise from her disability.
- The responsibilities of Ms J's personal assistants are not clear. If their duties include tasks which Ms J cannot do, such as cleaning windows or visiting shops, this should be clear in the support plan, and part of the calculation of hours of support Ms J needs. If their duties do not include these tasks, then the costs of hiring other help or having purchases delivered arise from Mrs J's disability.

57. So these costs are not a 'lifestyle choice'. They arise directly from Ms J's disability and should be considered as DRE. The Council's failure to accept such costs as DRE is fault.

Ms J's support plan

58. In 2012, the Council reviewed Ms J's care needs by speaking to her care provider. It was not fault to consult the care provider. But it was fault not to put the service-user at the heart of the review.

59. As we have said, Ms J's support plan is not clear on the duties of her personal assistants. It is also not clear on other support to meet her needs.

- The plan does not include complementary therapies, which provide Ms J with some respite from the pain associated with her condition. They are therefore activities which improve her quality of life and can legitimately form part of her support plan.
- The plan does not identify the purpose of vocal coaching and swimming lessons. If these are activities to improve her mental and physical health, and reduce her isolation, these are grounds to include the whole cost of the activity, not just the transport cost.
- Ms J says she has trained her dog as an assistance dog, in which case it should be identified in her support plan and the associated costs included in her personal budget. If the Council does not accept the dog is an assistance dog, it should record the reasons why. It could still take the view that the dog has a role in promoting Ms J's

mental health (by providing company) and physical well-being (as she can sometimes mobilise to exercise it herself).

60. A support plan is not just about calculating the number of hours of support with personal care a service user needs. It is about meeting the needs of the individual. The Council's failure to take a person-centred approach in preparing Ms J's support plan is fault.

Monitoring of DPs

61. There is no documentary evidence that a social worker told Ms J to avoid the charge for her care by reducing the hours of care she purchased. However the fact that Ms J reduced the hours of care she purchased does suggest that she was told this. And irrespective of this, the Council should have seen within a matter of weeks that Ms J was not paying her contribution into the DPs bank account. The Council's failure to deal with this straight away was fault.

62. The guidance is clear that if financial monitoring and review of the care arrangements are not done by the same officer, councils should ensure they exchange information. So the delay from November 2011 to April 2013 in updating its own records about Ms J's personal budget was also fault.

63. The failure to inform Ms J of the change to her assessed charge in November 2011 was further fault. This was compounded by the Council backdating the charge when it did finally update its records some 18 months later. The Council has not sought to recover unpaid charges from Ms J but its administrative faults here have caused her significant stress.

Complaint handling

64. The Council did not follow its complaints procedure when Ms J complained.

- it did not provide a local resolution or written response within 20 working days
- when Ms J said she was not happy with the Council's response to her complaint, it did not begin an independent investigation, and
- the Council did not reach a final view of the complaint and signpost Ms J to the Ombudsman within six months.

65. Instead, the Council attempted to resolve the complaint by arranging meetings with Ms J. This failed to take account of the impact of Ms J's disabilities on her ability to participate in such meetings.

66. These failings are fault.

Injustice

67. Because of the Council's faults, Ms J:

- does not have a support plan which adequately reflects her needs
- has not had an accurate financial assessment since 2010, and is likely to have been wrongly charged

- has had less care and support than she should have had, from 2011, both because she could not afford the support she needed, and because she has had to use her personal assistants to help her pursue her complaint
- has lost trust in the Council, and
- has suffered significant avoidable distress and frustration, which has affected her mental health.

Ms J is an extremely vulnerable service-user. Her disability leaves her isolated and entirely dependent on others, and she does not have an informal network of support she can turn to in times of extra need. She has also been affected over a number of years by the Council's fault. Our *Guidance on Remedies* is clear that such circumstances justify a greater remedy than would usually be the case.

Decision

68. We have completed our investigation into this complaint. There was fault by the Council which caused injustice to Ms J. The Council should take the action identified in paragraph 70 to remedy that injustice

Recommendations

69. To put right the injustice arising from the fault we have identified, the Council should:

- apologise to Ms J
- confirm immediately that it will not seek to reclaim any unpaid contributions from Ms J, and write off any debts it is currently attempting to recover
- arrange for an independent social worker to carry out a new care needs assessment and prepare a new support plan, without delay
- set up a clear working agreement for future reviews and monitoring
- reconsider Ms J's DRE and provide a clear explanation of why it does not consider some costs arise from her disability
- pay Ms J:
  - £5,000 to acknowledge the impact on her of being without adequate care and support for over two years
  - £2,000 to acknowledge the avoidable distress and frustration the Council's faults have caused her.

70. The Council has accepted our recommendations to remedy the complaint. It should confirm it has taken the action within three months of the date of this report.

Central Bedfordshire Council

SOCIAL CARE HEALTH AND HOUSING OVERVIEW AND SCRUTINY COMMITTEE

21 March 2016

East of England Ambulance Service Trust Progress Report

Advising Officers: Chris Hartley, Director of Communications
East of England Ambulance Service Trust
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Clive Goodson, Senior Locality Manager
East of England Ambulance Service Trust
Clive.goodson@estamb.nhs.uk

The purpose of the attached report is to provide Members with details of the East of England Ambulance Services Trust's (EEAST) progress to improve the service and to consider the performance data for 2015/16.

RECOMMENDATIONS

The Committee is asked to scrutinise the report and provide comments on the provision and performance of the Service.

Council Priorities

This report supports the following council priority

- Protecting the vulnerable, promoting well being

Corporate Implications

East of England Ambulance Service Trust Progress report has been produced by the EEAST and any corporate implications to the Council are detailed in the report.

Conclusion and next Steps

Members are requested to consider and comment on the information provided by the East of England Ambulance Service Trust.

Appendices

Appendix A – East of England Ambulance Service Trust Progress Report.

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Appendix A

East of England Ambulance Service NHS Trust

Over the last year the Trust has made significant progress in developing the organisation including:

1. Recruiting a permanent executive team to provide stable leadership
2. Launch of a cultural review, developing a people and culture strategy and improved NHS staff survey results
3. Continued frontline recruitment to increase staffing levels
4. Focus on staff, volunteer and stakeholder engagement
5. Implementation of new computer aided dispatch system in Trust's control rooms
6. Collaboration with blue light partners

Within North Bedfordshire (covering Bedford, Ampthill, Shefford and Biggleswade area), the Trust has recruited 17 new frontline staff and upskilled five emergency care assistants (ECA) to emergency medical technicians (EMT). This means that all those ECAs in the local area who have wanted to complete the upskill training opportunity have done so.

EEAST has also set up a scheme with Bedford Hospital whereby paramedics take pre-hospital blood samples. EEAST has also worked with the hospital to set up our Hospital Ambulance Liaison Officer scheme, with three staff seconded into this role and will remain in place until at least April 16. HALO's help manage the relationship between EEAST and the hospital and reduce the pressure of hospital handover delays.

Additionally EEAST has been involved in a new scheme with police and fire colleagues aiming to improve inter agency group working at incidents.

EEAST works with the Bedfordshire Partnership for Excellence in Palliative Support (PEPS) to co-ordinate care for palliative patients who are in the last year of their lives. EEAST has worked with St Johns Hospice, and the majority of ambulance staff have attended a bespoke end of life course which has resulted in better services for the end of life care for patients. It has been well received by staff, patients and relatives and has saved many unnecessary transfers to A&E

Challenges
The Trust is facing a number of challenges including increasing 999 calls, higher acuity of patients, hospital handover delays and abstraction for student ambulance paramedics to complete their education and training.

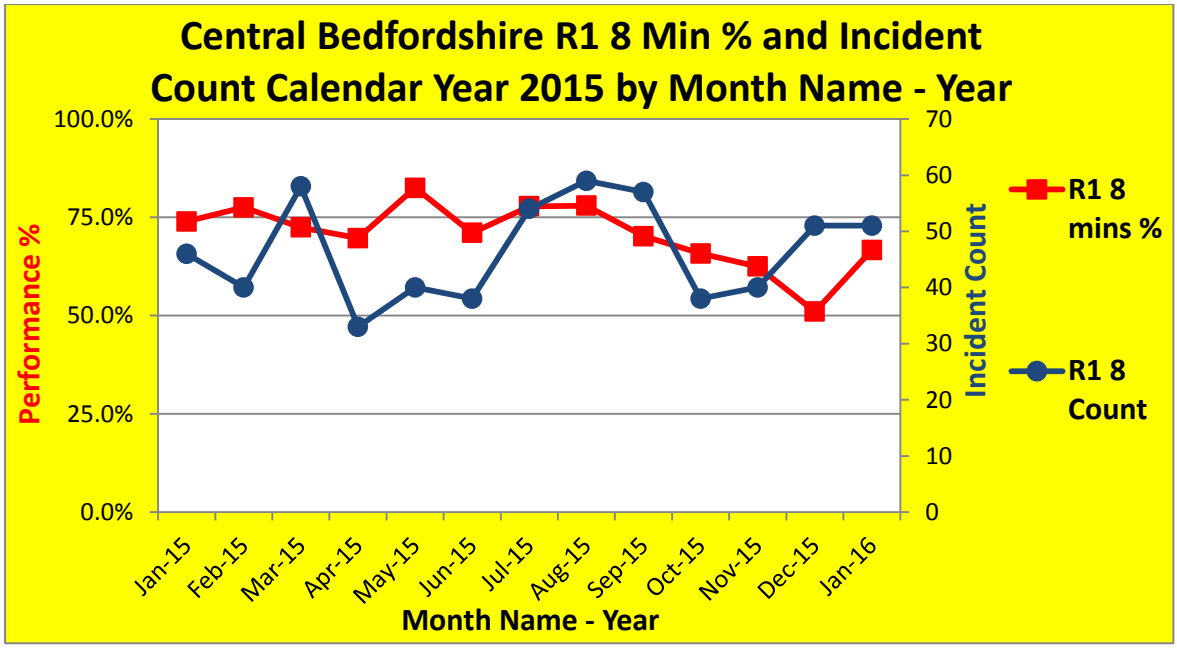
EEAST is addressing these challenges through developing a new strategy and operating model, working with partners to tackle some of the system pressures, continued frontline staffing recruitment and putting in place a number of actions to maximise frontline capacity in the short term.

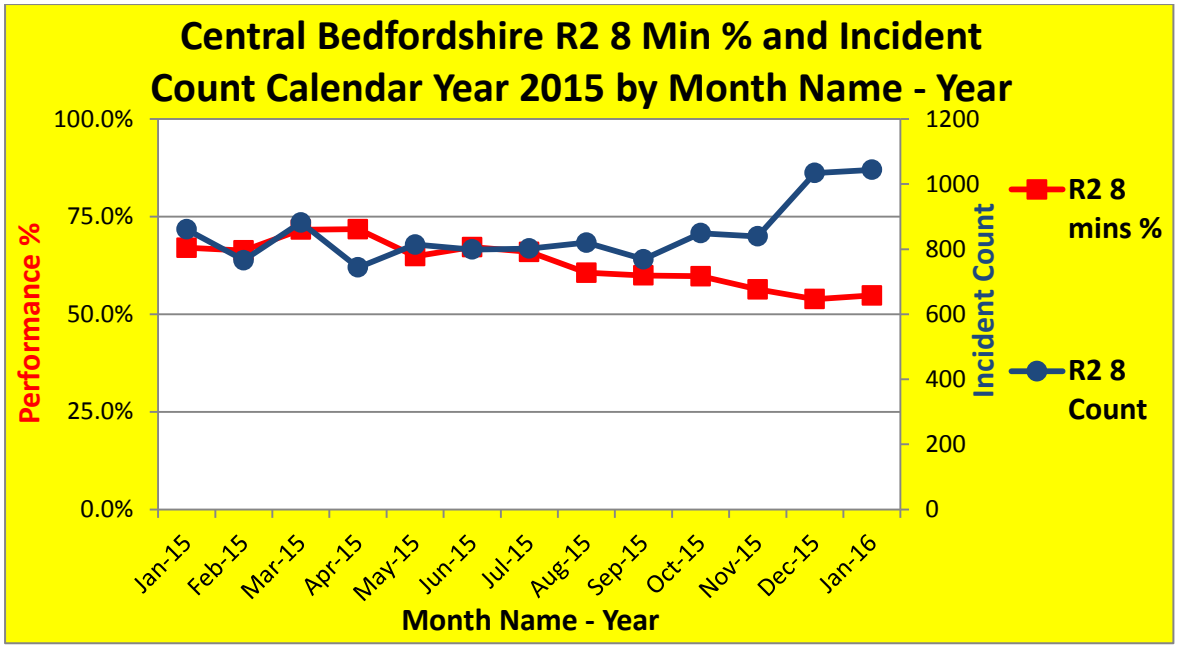
Performance

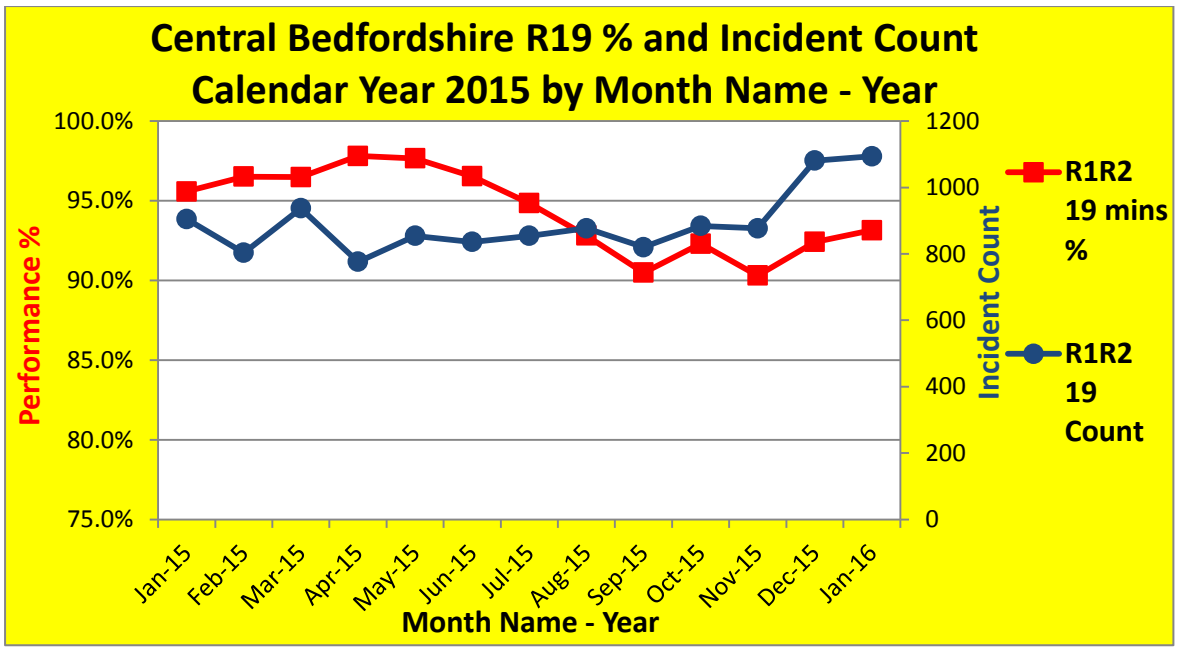
The charts below show performance in Central Bedfordshire against the three national ambulance targets – Red 1 (R1), Red 2 (R2) and Red 19 (R19). These show the growth in red demand (patients with potentially life threatening conditions).

The targets are as follows:

Red 1	Patients with potentially life threatening conditions; for example a cardiac arrest	An eight-minute response 75% of the time
Red 2	Patients with potentially life threatening conditions; for example a suspected stroke	An eight-minute response 75% of the time
Red 19	Patients requiring transport to hospital receive a vehicle able to transport them in a clinically safe manner.	A nineteen minute response 95% of the time.




Central Bedfordshire R2 8 Min % and Incident Count Calendar Year 2015 by Month Name - Year
Performance %
100.0%
75.0%
50.0%
25.0%
0.0%
Incident Count
1200
1000
800
600
400
200
0
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Month Name - Year
R2 8 mins %
R2 8 Count


Central Bedfordshire R19 % and Incident Count Calendar Year 2015 by Month Name - Year
Performance %
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
Incident Count
1200
1000
800
600
400
200
0
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Month Name - Year
R1R2 19 mins %
R1R2 19 Count

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Central Bedfordshire Council

SOCIAL CARE HEALTH AND HOUSING OVERVIEW AND SCRUTINY COMMITTEE

21 March 2016 2016

Primary Care Strategy

Presenting Officer: Alison Lathwell, Acting Director of Strategy and System Redesign Bedfordshire Clinical Commissioning Group. (Alison.Lathwell@bedfordshireccg.nhs.uk)

Advising Officers: Nikki Barnes, Locality Business Manager, BCCG; Tony Medwell, Primary Care Development Programme Lead, BCCG.

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1. The purpose of this report is to provide members of the Committee with an overview of the work underway to develop a Primary (Health) Care Strategy for Bedfordshire.
2. To provide a key opportunity for Members to feed into the strategic priorities and intentions for Bedfordshire Clinical Commissioning Group (BCCG) with regard to primary healthcare services, particularly general practice services.
3. To provide assurance to the Committee as to how the views of local service users and residents have helped to shape the draft Primary Care Strategy.

RECOMMENDATIONS

The Committee is asked to consider and comment on:-

- **The work underway to develop a Primary (Health) Care Strategy for Bedfordshire;**
- **the draft strategic priorities and intentions**
- **The efforts which have been taken to ensure that these priorities reflect the needs of local residents.**

Council Priorities

This report supports the following council priority

- Protecting the vulnerable, promoting well being

Corporate Implications

The Primary Care Strategy for Bedfordshire has been produced by Bedfordshire Clinical Commissioning Group and any corporate implications to the Council are detailed in the report.

Conclusion and next Steps

Members are requested to consider and comment on the information provided by the Bedfordshire Clinical Commissioning Group.

Appendices

Appendix A – The Primary Care Strategy for Bedfordshire Report.

Appendix A

Central Bedfordshire Council

SOCIAL CARE, HEALTH & HOUSING OVERVIEW AND SCRUTINY COMMITTEE

21 March 2016

Primary Care Strategy for Bedfordshire

Report of: Alison Lathwell, Director of Strategy & System Redesign (Acting), Bedfordshire Clinical Commissioning Group (BCCG)

Advising Officers: Nikki Barnes, Locality Business Manager, BCCG;
Tony Medwell, Primary Care Development Programme Lead, BCCG

This report relates to a non-Key Decision

Purpose of this report

1. To provide Members of the Committee with an overview of the work underway to develop a Primary (Health) Care Strategy for Bedfordshire.

2. To provide a key opportunity for Members to feed into the strategic priorities and intentions for Bedfordshire Clinical Commissioning Group (BCCG) with regard to primary healthcare services, particularly general practice services.

3. To provide assurance to the Committee as to how the views of local service users and residents have helped to shape the draft Primary Care Strategy.

RECOMMENDATIONS
The Committee is asked to:
1. **consider the work underway to develop a Primary (Health) Care Strategy for Bedfordshire**
2. **consider the draft strategic priorities and intentions**
3. consider the efforts which have been taken to ensure that these priorities reflect the needs of local residents.

Executive Summary

Bedfordshire CCG (BCCG) has identified the development of primary care as one of its seven strategic priorities. A programme to drive this workstream forward has been established and work is underway to produce a Primary Care Strategy to provide a clear framework for action.

The BCCG Primary Care Strategy will outline a set of practical initiatives to help ensure the ongoing sustainability of high quality primary care services across Bedfordshire, and will support the CCG to be effective in its new role as a co-commissioner of general medical services. Implementation of the Strategy will have an impact on how the CCG commissions services and how expenditure is prioritised. A number of key workstreams to support delivery of the Strategy are already underway.

The core of the Strategy is the development of new models of care where general practices, particularly groupings of practices, will be more effectively integrated with community services and social care and will act as the hub from which care packages for many of our most complex and vulnerable patients will be managed, delivering more proactive, preventative care with better health outcomes for local people. These new models will be enabled through the development of integrated health & social care hubs, and more joined up and effective IT systems. A range of workforce development initiatives will help to address some of the pressures around GP and nurse recruitment, and will support the development of new clinical roles within primary care. The implementation of the Strategy will be underpinned by a robust quality and performance framework.

Delivery of the strategy will be dependent on continuing to develop more integrated services across health and social care at locality/quadrant level, through continued closer working with both local authorities and community health services.

The development of the Strategy has drawn upon the significant consultation with local people which has taken place over the last two years to support the Strategic Healthcare Review.

Primary Care Development

1.0 Introduction

Bedfordshire CCG (BCCG) has identified the development of primary care as one of its seven strategic priorities. A programme to drive this workstream forward has been established and work is underway to produce a Primary Care Strategy to provide a clear framework for action.

General practice is the bedrock within our healthcare system, and the CCG is proud that local practices offer high quality care and are highly valued by patients. However, the health system overall and general practices are under significant pressure, and the resilience of primary care services is at risk.

The BCCG Primary Care Strategy will outline a set of practical initiatives to help ensure the ongoing sustainability of high quality primary care services across Bedfordshire, and will support the CCG to be effective in its new role as a primary care co-commissioner.

The Strategy will:

- Support a sustainable GP practice base
- Support delivery of the wider CCG vision of closer integration between services, greater multi-disciplinary working within geographical clusters, and increased focus on prevention
- Provide practical approaches within co-commissioning to support development of premises, workforce and professional skills, and enabling IT to build that model
- Provide practical approaches to support collaborative working between practices
- Help the CCG and practices speed up progress towards delivering new models of care underpinned by more robust business management models.

Implementation of the Strategy will have an impact on how the CCG commissions services and how expenditure is prioritised, particularly once the CCG takes on more responsibility for commissioning general practice services under new joint commissioning arrangements with NHS England (co-commissioning). Delivery of the strategy will be dependent on continuing to develop more integrated services across health and social care at locality/quadrant level, through continued closer working with both local authorities and community health services.

This report provides a summary of how the Strategy is being developed and the key areas it will cover.

2.0 Developing the Strategy

The Primary Care Strategy is being produced by members of a Primary Care Working Group, with input from the five locality Chairs and Business Managers, other key CCG teams, the Local Medical Committee (LMC) and NHS England. An outline of the strategic direction has been discussed with all five Locality Boards, Healthwatch for both local authorities, the CCG's Patient Engagement Forum (PEF) and draws upon patient views already captured from Locality Patient Participation Networks and within the Strategic Healthcare Review. It is being developed alongside and interlinks with the other priority programmes within the CCG. A Communications & Engagement Plan has been developed to ensure that the Strategy is shared with key stakeholders before being finalised.

The feedback the CCG has received from consulting with hundreds of local people tells us that primary whole general practice services are highly valued. Priorities for enhancing/improving services going forward include:

- Reducing variation in access to GP surgeries, i.e. arrangements for booking an appointment and the time it takes to be seen
- Extending opening times for GP surgeries, especially for people with long term conditions to avoid missing time from work/education
- Maintaining a personalised service, with continuity of care
- GPs having more time to listen to patients and fully engage them in their care plans
- Developing more specialised services within primary care, particularly for children and older people with complex conditions
- Improving communication between services, especially liaison between GPs and hospitals, but also between GPs and community services and social care
- Providing more care closer to home
- Maintaining access to care for rural communities
- Increasing the use of technology to help make it easier to access services.

These priorities have helped to shape the draft Strategy, and engagement is underway with local patient groups to ensure that the initiatives being developed adequately reflect the needs and expectations of local people.

3.0 General Practice Business & Delivery Model

The main focus of the Primary Care Strategy will be around sustainability, both ensuring the sustainability of high quality general practice services across Bedfordshire, and the role primary care needs to play in ensuring the long-term sustainability of the local healthcare system.

The health system overall and general practices are under significant pressure, and it is unlikely that the current GP practice business model is fit for purpose in the longer term. The CCG aims to support local practices to develop a vibrant and sustainable general practice system, and enable practices to operate at the centre of new models of integrated health and social care delivery across Bedfordshire.

The demographics, health needs and expectations of the population are significantly changing, and in order to meet these, health and social care services will need to operate in a more integrated system, where clinicians work in flexible teams around the needs of the patients/service users with a clear focus on proactively managing care needs, away from hospital, in alternative home and community settings at a time and place that is convenient for patients.

The core of the Strategy is the development of new models of care where general practices, particularly groupings of practices, will be more effectively integrated with community services and social care and will act as the hub from which care packages for many of our most complex and vulnerable patients will be managed, delivering more proactive, preventative care with better health outcomes for local people.

To enable this to happen, the CCG will need to implement a range of initiatives and change how we commission services to: encourage and support practices to work more collaboratively together; redesign community services and co-locate with general practice where possible; and roll out new models of multi-disciplinary working and enhanced primary care across the county. A project has already commenced to scope the potential for delivering a Practice Manager Development Programme to help enhance strategic planning and change management skills.

Locally we intend to focus on developing new models of care within the following areas:

- The management of long term conditions, with a priority focus on diabetes and respiratory conditions in the first year

- The management of children with long term conditions, particularly children with asthma and other respiratory conditions
- Supporting people with complex conditions, particularly frail older people and people with multiple long term conditions
- How we organise home visiting arrangements and support to people residing in care homes
- How we organise services for people with urgent care needs, looking at new approaches to triage arrangements and same day appointments, particularly skill-mix within the delivery of this part of general practice activity
- Extending the hours that elements of primary care are available, including later into the evening and on weekends.

The aim of these new models of care will be to improve clinical outcomes and provide more care closer to home for local people, and also to develop more effective and sustainable systems for organising the delivery of care.

4.0 Workforce Development

Practices across Bedfordshire currently face significant workforce challenges. There is a need to simultaneously address the immediate pressures while improving recruitment and retention, supporting succession planning and developing enhanced roles for GPs, nurses, practice managers and other allied practice staff. Workforce planning needs to consider links to all health professionals within an integrated health and social care model including pharmacists and the wider community workforce.

Working in partnership with member practices, the LMC, Health Education England, NHS England, the GP Federation/s, the two Local Authorities and neighbouring CCGs, BCCG aims to tackle these challenges through a number of work streams, which include a mixture of short and long-term solutions to support practices right now, whilst also working towards creating a general practice workforce to support future models of care.

A Workforce Strategy group is already up and running with representation from the CCG, Health Education England, the LMC, the Horizon GP federation, practice nurses and practice managers. Key projects already underway include:

- GP Development and Practice Nurse Development Schemes in partnership with neighbouring CCGs
- Scoping the potential for establishing a Bedfordshire-specific GP Development Scheme
- Supporting the ongoing education and development of practice nurses
- Conducting a comprehensive workforce and education analysis
- Establishing an online education portal for practices.

5.0 IM&T

IM&T is essential to improving and supporting the patient experience and pathway within primary care. The BCCG Governing Body, supported by the Finance and IT Teams, has identified that improved IM&T support to practices is intrinsic to the delivery of the BCCG overall strategy, including the delivery of service reconfiguration within and across the local area.

The Primary Care Strategy will include a programme of work to:

- Improve IT support services
- Support the sustainability and quality of general practice by maximising functionality and making life easier for clinicians
- Ensure the new investment and focus on IT supports transformation and improvements in population health outcomes, e.g. through risk stratification

- Have a stronger focus on supporting integration and interoperability of IM&T with partners, i.e. primary, community, secondary and social care to support Multi-Disciplinary Team (MDT) working.
- Increase clinical efficiency and quality through the better use of IT and clinical support systems.

There is an active IM&T working group already in place, and an investment programme is being developed. The key priority of focus currently is improving operational support to GP practices.

6.0 Estates

The Primary Care Strategy will provide the outline for a CCG Estates Strategy to be developed by the end of June 2016. A key enabler for the new models of enhanced primary care and multi-disciplinary working will be the development of integrated health and social care hubs in main population centres, whilst also sustaining key premises within our rural communities. Work is already underway to explore the feasibility of developing hubs in Dunstable and Bedford,

Strategic planning around general practice premises, community services and social care estate has been very separate historically. It is the aim of the CCG to work towards using all health estate more efficiently, including encouraging collaborative use of premises between practices as appropriate and with community services, and also to work towards developing a joined-up estates plan with our Local Authority partners, including ensuring the appropriate infrastructure is developed to support housing growth. Work to develop the CCG Estates Strategy will also support the redesign of community services underway. An Estates & Premises Committee – with strong representation from both Local Authorities – has recently been established to ensure that opportunities for partnership working are maximised.

Key projects already underway include:

- Developing a comprehensive Estates Strategy
- Preparing outline business cases for the development of integrated hubs in Dunstable and Bedford, and preparing bids to access national transformation funding
- Establishing a project to review the utilisation and future requirement of community buildings across Bedfordshire
- Establishing projects to conduct options appraisals for responding to planned housing developments across Mid Bedfordshire and in the Houghton Regis area.

7.0 Quality & Performance

Practices in Bedfordshire CCG on the whole already provide a high standard of primary care. Quality is achieved by focusing on the three domains of quality: patient safety, clinical effectiveness and patient experience.

Quality will be the golden thread though each work stream of the Primary Care Strategy to ensure that we:

- Embed quality in design
- Ensure quality in delivery
- Provide quality assurance

It will build upon work of NHS England commissioners to provide the formative arm of quality improvement, looking to reduce variation, improve performance and support practices to undertake actions required to achieve high quality primary care.

Discussions have commenced with NHS England around developing a joint programme of practice visits, and a shared dashboard of quality indicators.

8.0 Co-commissioning

From April 2016 Bedfordshire will assume responsibility as a joint commissioner of General Practice with NHS England. This was agreed with NHS England as being the appropriate level of shared responsibility with potential to move to delegated commissioning at a future date. The advantages of Joint Commissioning with NHS England are to use the partnership arrangement to drive transformation across the system and enable the joint commissioning of both primary and secondary care. The CCG retains its formative development role in driving quality, improving outcomes for our communities and supporting sustainability of the sector.

The CCG's ambition is to work with NHS England to co-commission general practice in a manner that enables alignment of priorities, contractual flexibilities and incentives to support transformation of the sector and allow the scope and quality of service to continually develop to meet the changing needs and expectations of our communities.

The CCG is already managing conflicts of interest as part of our day to day work. However, engaging in co-commissioning will significantly increase both the frequency and scale of potential conflicts of interests for BCCG. We have reviewed our Conflicts of Interest Policy to minimise this and embed NHS England statutory guidance on conflicts of interest for CCGs.

9.0 Conclusion

The Committee is asked to:

1. consider the work underway to develop a Primary (Health) Care Strategy for Bedfordshire
2. consider the draft strategic priorities and intentions
3. consider the efforts which have been taken to ensure that these priorities reflect the needs of local residents.

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Central Bedfordshire Council

SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE

Monday, 21 March 2016

Excess Weight Strategy

Report of Cllr Maurice jones, Executive Member for Health
(cllr.maurice.jones@centralbedfordshire.gov.uk)

Advising Officers:
Celia Shohet, Assistant Director of Public Health,
celia.shohet@centralbedfordshire.gov.uk

This report relates to a non-Key Decision

Purpose of this report:

1. **To report allows Members the opportunity to review the Excess Weight Strategy which has been developed with partners to tackle this important public health issue.**

RECOMMENDATIONS
The Committee is asked to:

1. consider and comment on the Central Bedfordshire Excess Weight Strategy 2015-2019.

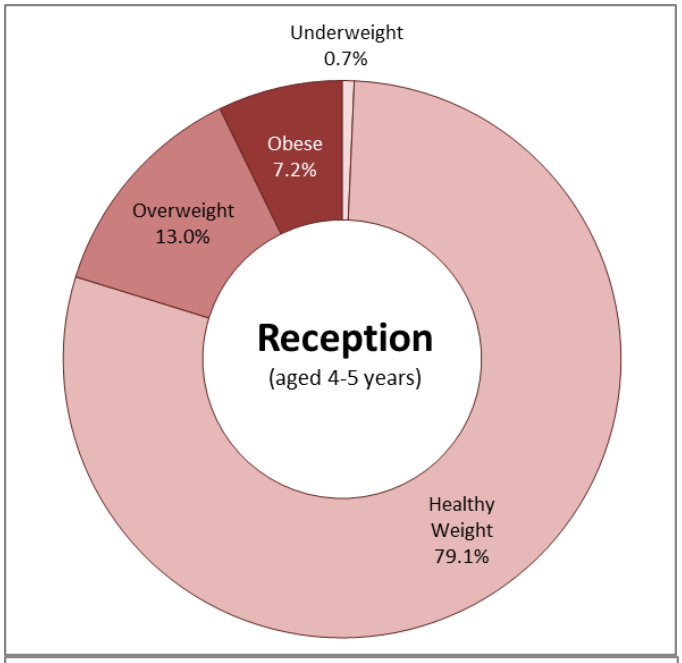
Issues

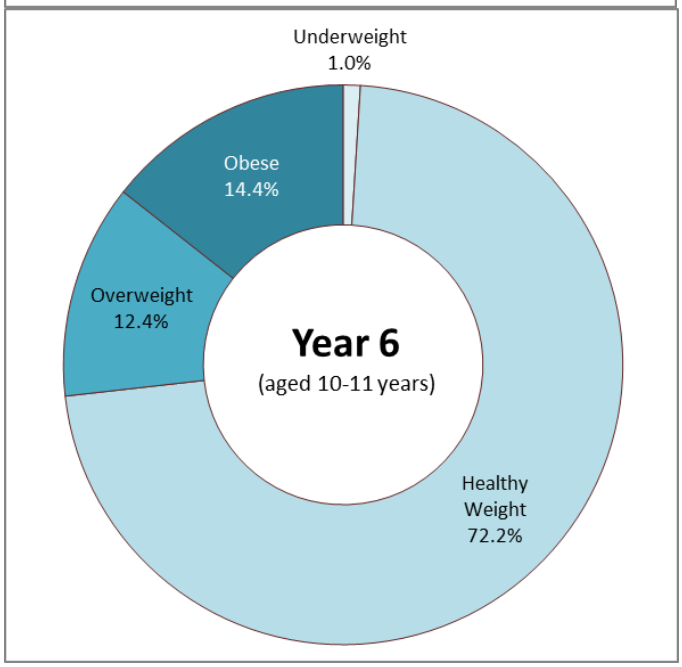
Prevalence of Excess Weight

The prevalence of overweight and obesity is increasing in virtually every country in the world and among virtually all age groups. Obesity rates in England have more than doubled in the last 25 years with almost two thirds of the adult population now overweight or obese. Central Bedfordshire is no exception.

The detailed location picture and trends is outlined in the strategy attached but in summary 69% (145,000 adults) in Central Bedfordshire are estimated to be either overweight or obese.

The latest position for children (academic year 2014/15) is illustrated in the figures over page. Detailed ward level data is shown in Appendix A.





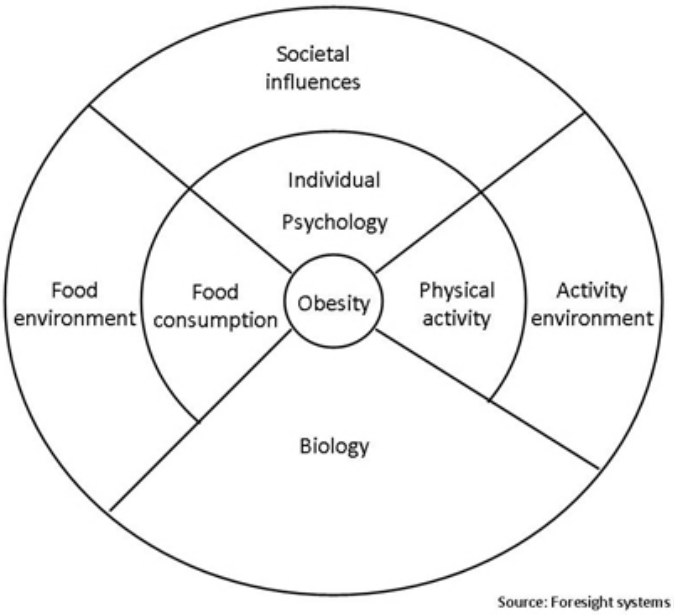
Whilst the cost to the wider community has not yet been established at Local Authority level, in 2008 obesity cost NHS Bedfordshire £98.8 million, and this is predicted to have risen to £136 million by 2015.

How are we tackling Excess Weight in Central Bedfordshire?

There are a number of programmes in place and the contract for excess weight was re-commissioned in 2015, the new provider, Bee Zee Bodies commenced in September 2015.

However a wider partnership approach is also required because the causes of excess weight are complex and multifactorial, and wider determinants including the so-called ‘obesogenic environment’ must also be addressed.

The following diagram below broadly identifies the issues surrounding weight:



Source: Foresight systems map, 2007

Tackling excess weight requires a 'whole systems' approach, creating strong links with other directorates, and internal and external services such as Environmental Health, Planning, Transport, the 0-19 team and the voluntary sector; and developing a shared strategy for tackling the causes of excess weight is essential. These plans have been formalised in the Excess Weight Partnership Strategy 2015-2019. The priorities identified in the strategy are:

1. Creating environments which actively promote and encourage a healthy weight.

2. Giving all children and families the best start in life and supporting them in achieving a healthy weight and lifestyle.

3. Empowering adults and older people to attain and maintain a healthy weight.

4. Enabling practitioners working in Central Bedfordshire to have a meaningful discussion about weight in a confident and effective manner.

Council Priorities

2. The proposed action supports the following Council's priorities:

- Enhancing Central Bedfordshire – Creating positive environments which actively promote and encourage a healthy weight.

- Protecting the vulnerable; improving wellbeing – Develop programmes to support families and communities most at risk of excess weight.

Corporate Implications

Legal Implications

3. None

Financial and Risk Implications

4. The current programme is funded through the ring fenced public health grant. However central government has made significant cuts to the public health allocation putting at risk future funding of public health prevention programmes. Therefore all programmes are being reviewed to ensure that the best outcomes are achieved with the resource available.

Equalities Implications

5. Central Bedfordshire Council has a statutory duty to promote equality of opportunity, eliminate unlawful discrimination, harassment and victimisation and foster good relations 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.
6. The Government's Call to Action on Obesity equality analysis emphasises that particular attention needs to be given to specific socioeconomic and ethnic groups and to disabled people and people with mental health needs.
7. The Central Bedfordshire Strategy has identified a need to engage with and support vulnerable groups including men, pregnant women, and BME groups .

Implications for Work Programming

8. None

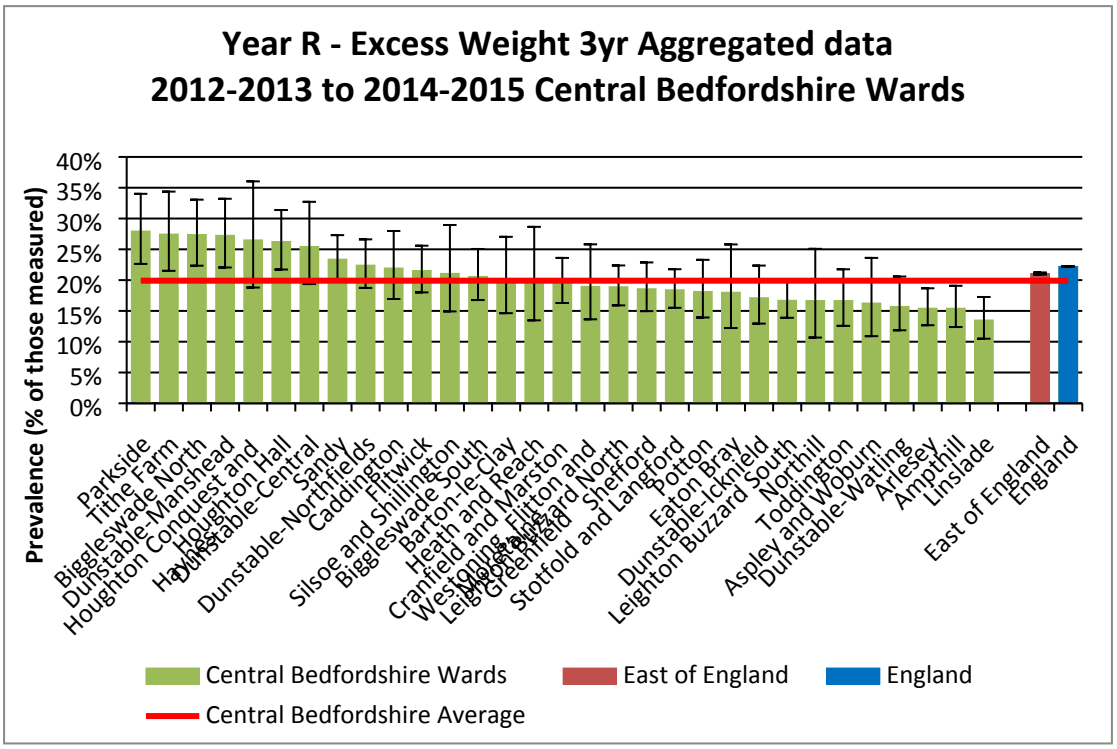
Conclusion and next Steps

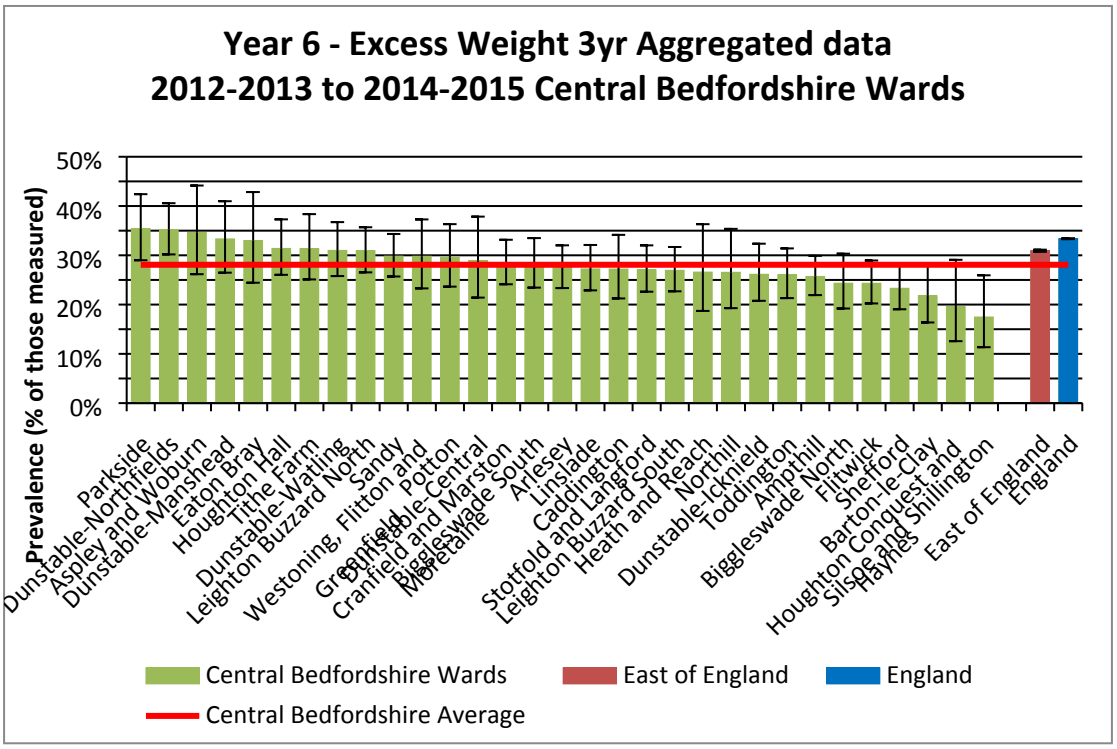
9. Tackling Excess Weight is a key priority due to the health, social and economic costs associated with being overweight and obese. However, the scale of the challenge should not be underestimated. Good foundations are in place, but a partnership approach is required if we are to have the population impact on levels of excess weight. Excess weight is 'everybody's business'.

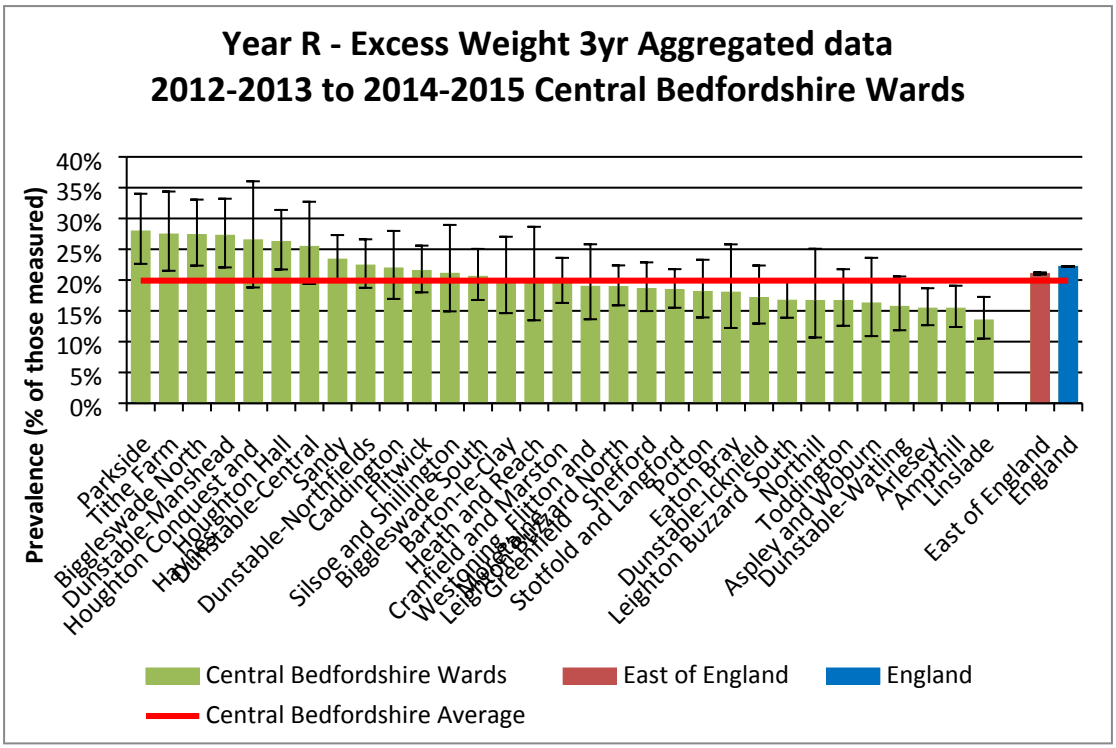
Appendices

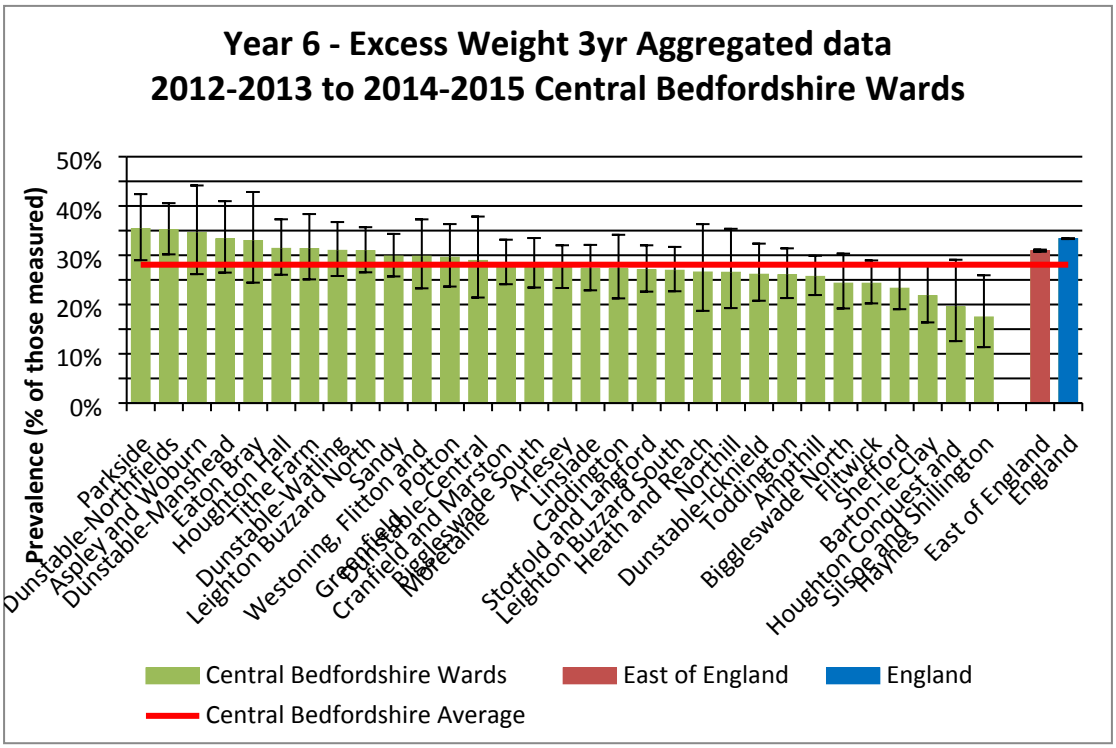
Appendix A - National Child Measurement Ward level data 2014/15
Appendix B – Excess Weight Partnership Strategy 2015-19

Appendix A: National Child Measurement Ward level data 2014/15






Year R - Excess Weight 3yr Aggregated data
2012-2013 to 2014-2015 Central Bedfordshire Wards
Prevalence (% of those measured)
40%
35%
30%
25%
20%
15%
10%
5%
0%
Parkside
Tithe Farm
Biggleswade North
Dunstable-Manshead
Houghton Conquest and
Houghton Hall
Dunstable-Central
Sandy
Dunstable-Northfields
Caddington
Flitwick
Silsoe and Shillington
Biggleswade South
Barton-le-Clay
Heath and Reach
Cranfield and Marston
Westoning, Flitton and
Leighton Buzzard North
Shefford
Stotfold and Langford
Potton
Eaton Bray
Dunstable-Icknield
Leighton Buzzard South
Northill
Toddington
Aspley and Woburn
Dunstable-Watling
Arlesey
Ampthill
Linslade
East of England
England
Central Bedfordshire Wards
East of England
England
Central Bedfordshire Average


Year 6 - Excess Weight 3yr Aggregated data
2012-2013 to 2014-2015 Central Bedfordshire Wards
Prevalence (% of those measured)
50%
40%
30%
20%
10%
0%
Parkside
Dunstable-Northfields
Aspley and Woburn
Dunstable-Manshead
Eaton Bray
Houghton Hall
Tithe Farm
Dunstable-Watling
Leighton Buzzard North
Sandy
Westoning, Flitton and
Greenfield
Potton
Dunstable-Central
Cranfield and Marston
Biggleswade South
Arlesey
Linslade
Caddington
Stotfold and Langford
Leighton Buzzard South
Heath and Reach
Dunstable-Icknield
Northill
Toddington
Biggleswade North
Ampthill
Flitwick
Shefford
Barton-le-Clay
Houghton Conquest and
Silsoe and Shillington
Haynes
East of England
England
Central Bedfordshire Wards
East of England
England
Central Bedfordshire Average

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Appendix B

Excess Weight Partnership Strategy

2015-19

Foreword

There are many things that affect our health, but for many people trying to achieve or stay a healthy weight is a challenge.

In Central Bedfordshire, one in five 4-5 year olds and 3 out of 5 adults are overweight or obese. Being overweight or obese in childhood is associated with poor educational attainment and a range of health problems including childhood diabetes. Overweight and Obesity in Adults is associated with a range of health problems including type 2 diabetes, heart disease and cancer.

However, the size of the challenge should not be underestimated. The causes of overweight and obesity are a complex mix of individual, societal and environmental factors: we live in a society where high-energy foods are readily available, and modern life encourages us to be less and less active. While it is important that national government takes action, and we look forward to the new national strategy; individuals, families, communities, schools, businesses, health services and the Council all have a part to play in tackling obesity.

Central Bedfordshire's Excess Weight Partnership Strategy has been developed to support the National ambition to turn things around and achieve a downward trend in levels of excess weight in children and adults by 2020[1]. The strategy supports a coordinated approach to providing a healthier environment that encourages and supports children and adults to be more active and eat healthily. It is ambitious, but by working in partnership, we will tackle excess weight across the population of Central Bedfordshire.

Cllr Maurice Jones
Executive Member for Health

[1] Department of Health (2011) Healthy Lives, Healthy People; A Call to Action on Obesity.

Introduction

i) Why do we need to tackle excess weight?

In Central Bedfordshire, levels of excess weight (overweight and obesity combined) in both children and adults are a concern for health and social care professionals:

Being overweight or obese in childhood can lead to lower self-esteem, poor educational attainment and a range of health problems including childhood diabetes. Overweight and obese children and young people are also more likely to become obese adults. Overweight or obese adults are at a much greater risk of developing health problems including heart disease, cancer and type II diabetes and require more intensive social care support in older age. In 2015, the estimated cost of obesity to NHS Bedfordshire was £136 million. The costs of obesity to families, social care and the wider economy are substantial but hard to quantify.

The complex mix of causes and the potential impact on society make tackling excess weight 'everybody's business'.

A whole-system response is required in order to reduce the current levels seen across Central Bedfordshire; everyone has a part to play.

ii) What we want to achieve

The aim of the strategy is to bring together, coordinate and focus the contributions of all Local Authority departments and partner organisations. By aligning our efforts we will work to create an environment across Central Bedfordshire which supports every child, young person, adult and older person to achieve and maintain a healthy weight.

iii) Our Priorities

Our four priorities for tackling excess weight are:

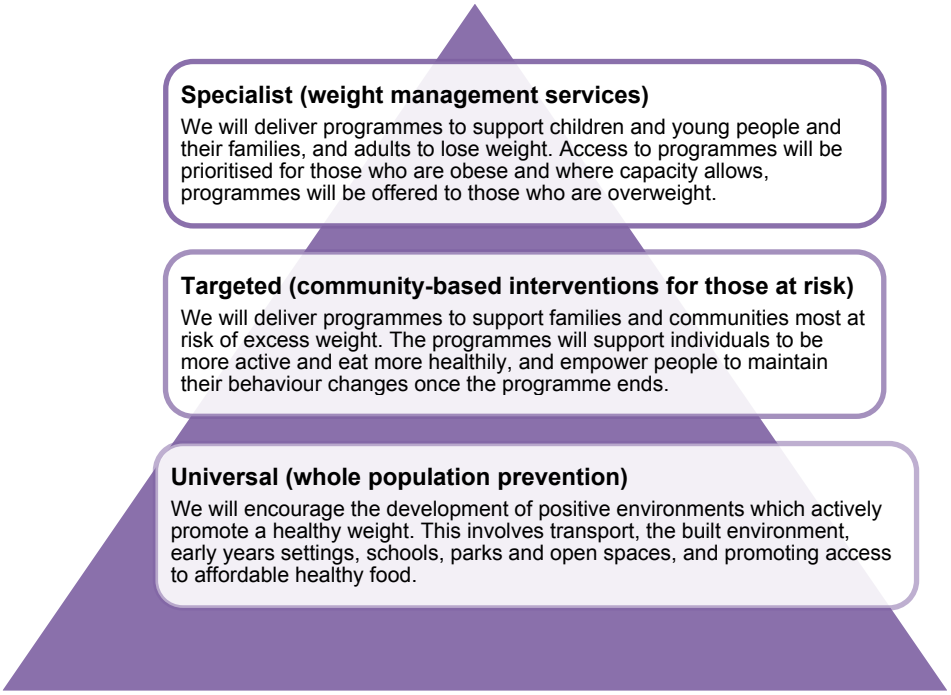
1. Creating positive environments which actively promote and encourage a healthy weight.

2. Giving all children and families the best start in life and supporting them in achieving a healthy weight and lifestyle.

3. Empowering adults and older people to attain and maintain a healthy weight.

4. Enabling practitioners working in Central Bedfordshire to have a meaningful discussion about weight in a confident and effective manner.

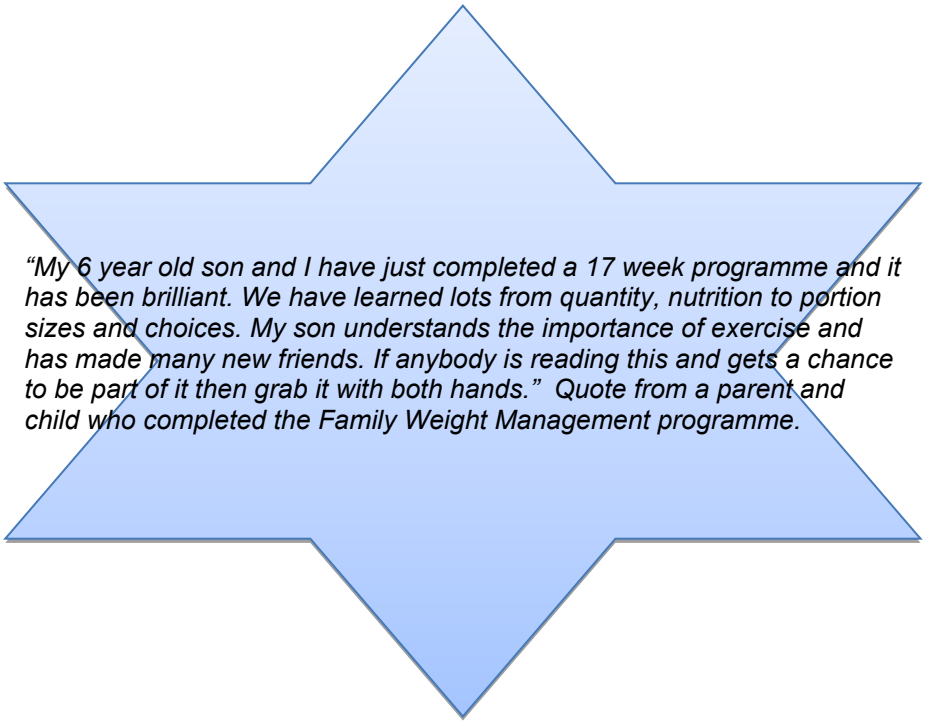
Actions to address the priorities will be taken at three levels:



To ensure a smooth transition between programmes and services we will develop a single pathway for preventing and managing excess weight in children, young people, families and adults in accordance with the aims of this strategy.

iv) What will success look like?

As well as being able to demonstrate success for the individuals and families enrolled in our targeted and specialist prevention and management programmes, a successful Excess Weight Partnership Strategy will deliver sustained reductions in population levels of excess weight in children, young people and adults.



The Healthy Weight Strategic Group will continue to steer the implementation and evaluation of the strategy and action plan. Progress against actions will be monitored by the Health and Wellbeing Board.

The Four Priority Areas

1. Creating positive environments which actively promote and encourage a healthy weight

Why it's important:

- The Environment in which we live has been shown to have a significant impact on our health. By improving the environment in which residents live, work and play, we can make the healthy choice the easy choice;
- The Government released a briefing in 2014 which outlined the importance of action on obesity, with a specific focus on fast food takeaways, and outlined the regulatory and other approaches that can be taken at a local level;
- Personal responsibility for diet and physical activity levels plays a crucial part in weight gain, so does the 'obesogenic' environment in which we live, with its abundance of energy dense food, motorised transport and sedentary lifestyles (Foresight 2007).

Key challenges	What We Will Do in Partnership
1. Building new housing developments which promote health, leisure and active transport.	Ensure the new local plan includes planning policies which identify and prioritise the inclusion of the key principles of Healthy Environments in the design of new developments, i.e. provision of open space, physical activity opportunities, ensuring accessibility to local services and creating opportunities for active travel.
2. Quality and choice of food in food establishments.	Engage with food businesses to support the development of healthy food choices in new and existing environments, for example, Environmental Health working with businesses to encourage healthier food options in hot food takeaways and restaurants.
3. Provision of safe and aesthetically pleasing environments which encourage physical activity.	Encourage partnership working between a range of departments and agencies including highways, parks, leisure, rights of way, to ensure environments are conducive to encouraging physical activity.
	Encourage employers to create aesthetically pleasing, safe opportunities for physical activity and accessing healthy food choices, for example, through senior level endorsement of walking meetings, the provision of standing work areas and healthier food options in work canteens.
	Ensure that sustainable travel choices that are accessible and actively encouraged across communities and in workplaces by providing secure cycle racks, information and cycle route maps.

What will success look like?

1. Increased access to healthier food establishments, particularly around schools and workplaces.
2. All local planning and policy decisions have a focus on preserving and creating healthier environments which provide opportunities for physical activity and healthier food choices.
3. An increase in the provision of healthier food options in new and existing food establishments, for example, premises, workplaces, and leisure facilities.
4. An increase in the use of sustainable modes of travel including walking and cycling, both for leisure and commuting.

Baselines to be established in 2016/17.

How will we know if we are starting to make a difference?

1. Working groups developed to take forward actions, establish baselines and report progress.

2. Giving all children and families the best start in life and supporting them in achieving a healthy weight and lifestyle

Why it's important:

- The early years lay down the foundations for future health and wellbeing, promoting a child's physical, emotional, cognitive and social development to ensure all children have a fair chance to succeed at school and in later life
- Early intervention is key to ensuring that all children have the best start in life and in addressing the inequalities in health and life chances that exist between children living in disadvantaged circumstances and those living in better off families.
- Parents of young children are more likely to be receptive to healthy weight and lifestyle behaviour changes when they are delivered through Health professionals or an evidence based programme like HENRY.
- Achieving the best start in life also benefits educational achievement and economic status later in life.

Key challenges	What We Will Do in Partnership
1. Lifestyle choices in pregnancy:- obese pregnant women have an increased risk of complications at birth, and their children are often overweight also.	• Ensure that the discussion of excess weight and signposting to appropriate services is part of the core offer of midwives and health visitors.
2. Sharing data at the 2 ½ year check across professional groups including Commissioned Services.	• Develop data sharing agreements to ensure a smooth transfer of patient data for families who need support from a number of professionals.
3. There is an upward trend in very overweight rates in children aged 10-11 years (school year 6) as shown in National Child Measurement Programme (NCMP) 13/14 figures.	• Target interventions to the areas of greatest need using the ward level data.

What will success look like?

1. A reduction in the number of pregnant women at booking with i) a BMI > 30 and ii) 25-29.9 from a baseline of approximately 200.
2. A reduction in the number of children starting school who fall into the excess weight category, from a baseline of 20.2% (NCMP 2014/15)
3. A reduction in the prevalence of excess weight in school-aged children and young people, from a baseline of 26.8% (NCMP 2014/15)
4. An increase in the number of families walking and cycling to work/school and for leisure, walking, tracked using 'Bike It' data and data from Travel hub.

How will we know if we are starting to make a difference?

1. Data sharing agreements in place.
2. Interventions in place in targeted areas.
3. Training schedule for professionals to ‘Raise the issue of weight’ agreed.

3. Empowering adults and older people to attain and maintain a healthy weight

Why it's important:

- Life expectancy in Central Bedfordshire is increasing, but we need to ensure that those extra years are lived in good health;
- The best way to help people live longer and healthier lives is to prevent illness in the first place, through action on common risk factors including diet and physical inactivity.
- Overweight and obesity in adults is predicted to reach 70% nationally by 2034 (NOO, 2015); based on modelled estimates local levels have already reached 69%.
- There are significant financial implications for CBC due to the additional costs associated with housing adaptations which may be required for obese adults; additional care costs linked to support that may be required in the home including shopping, cleaning and cooking due to mobility restrictions.

Key challenges	What We Will Do in Partnership
1. 69% of adults in Central Bedfordshire are overweight or obese, which is higher than the England average.	• Ensure the provision of consistent information regarding healthy weight by promoting 'Change4life', 'One You' and commissioned services to professionals who work with adults.
2. Engaging with and supporting vulnerable groups including men, pregnant women, and BME groups.	• Ensure all partners with access to target groups are engaged with and contribute to the development of the action plan.

What will success look like?

1. A reduction of 1% in the prevalence of excess weight in all adults from a baseline of 69.1%
2. A reduction in the prevalence of excess weight in specific groups of vulnerable adults (BME, men, pregnant women).

How will we know if we are starting to make a difference?

1. An increase in the number of safe and accessible opportunities to be active and eat healthily.
2. Healthy weight and lifestyle advice and communications are consistent and accurate.

4. Ensure Excess Weight is everybody's business by working in partnership, and by developing a workforce which is confident and competent in addressing excess weight.

Why it's important:

- Studies have shown that after receiving appropriate training, practitioners feel more confident in raising the issue of weight and signposting to the appropriate services.

Key Challenges	What We Will Do in Partnership
1. Changing the culture. Senior buy in – 'Everyone's business'	• Engage senior managers across the Local Authority to act as workplace champions to inspire colleagues to be active during their working day and to support them in making healthy eating choices through, for example, the encouragement/participation in walking/standing meetings; healthier food choices in staff restaurants and removing high fat, high sugar produce from till points.
2. Varied skills and abilities in engaging and active listening of professionals who have contact with children, young people and their families including older adults.	• Training for professionals to raise the issue of weight. • Evaluate the impact of the Lifestyle Hub in Dunstable focusing on Physical activity and Healthy eating. • Ensure that all professionals who have contact with children, young people and their families have access to training on 'Raising the issue of weight' and can signpost/refer as appropriate.

What will success look like?

1. A healthier active workforce, with fewer sickness absences.
2. An increase in the workforce who are competent and confident to raise the issue of weight.

Baselines established in 2016/17 for each success measure

How will we know if we are starting to make a difference?

1. Senior managers are engaged as workplace champions and participate in workplace initiatives to encourage physical activity and healthy eating.
2. Employees are supported by their workplace to make positive changes to improve their health and wellbeing.

Appendix 1: Current Partnership Activity across the 4 Priority Areas

1. Creating positive environments which actively promote and encourage a healthy weight

Prevention

- 400 metre zone opening time restriction on Hot Food Takeaways near Upper Schools (previously included in Development Framework – plans to include in the new document)
- Consultation in place between Public Health and Environmental health department regarding HFTs in areas of high obesity levels
- 25% healthy snack options to be introduced in all vending machines in all 6 LCs from 2015.
- PH representation on Leisure Strategy/PA Network
- Change4Life. One *You* national social marketing campaigns

2. Giving all children and families the best start in life and supporting them in achieving a healthy weight and lifestyle

Prevention

- HENRY healthy lifestyle programme run in children's centres;
- Change 4 Life Sports Club pilot (5 schools in CB) for Year 5 and 6.
- School games and physical activity - run through the County Sports Partnership
- Change4Life and Start4Life
- Whole School Review for schools to maintain their Health in Education status and identify their provision and any gaps in Health and Wellbeing across the school and in the wider community.

Management

- Beezee Bodies as provider of all lifestyle weight management programmes.
- Bike IT' delivered in 27 schools across CBC to pupils and for family leisure and travel, commissioned by Public Health.

3. Empowering adults and older people to attain and maintain a healthy weight

Prevention

- Walk 4 Health – led by PH Team/Sustrans across CB – Leisure Strategy
- Change4Life
- Health and Wellbeing SWAP (Staff and Wellbeing Action Programme) - led by HR with cross departmental support. Next 12 months includes Health Checks/Health Walks/Yoga, Mental health and wellbeing and advice on Non-sedentary working practices.
- Heartbeat Award (healthy eating) in Leisure Centre cafes - joint programme between Public Health and Leisure Services. Public Protection is keen to promote this with restaurants and HFT.

- Pride in Days – Community initiative in areas identified with specific issues. i.e. excess weight, high levels of smoking, drinking, youth crime etc.
- Healthy eating workshops to support programmes run by The Stroke Association, Carers Association and by the Workplace Health team.

Management

- BeeZee Bodies CIC: HENRY, Gutless, BeeZee Bumps, BZ Chat and Believe.
- Lifestyle Hub
- Maternal Obesity programmes: BHT and L&D delivered by BeeZeeBodies.

4. Enabling practitioners working in Central Bedfordshire to have a meaningful discussion about weight in a confident and effective manner

Prevention

- ‘Making the Most of Me’ – 'Train the Trainers' course, run and commissioned by Public Health
- Training 0-19 team and support to SNs via SN Forum meetings
- Excess Weight Resource Packs – for SNs/Pupils/PSHE body
- BZB as provider will support 0-19 teams by training in ‘raising the issue of weight’.

Appendix 2: Detailed Local Excess Weight Picture

i) Definition

'Excess weight' is used to describe an individual's body weight which is above the healthy range and encompasses both overweight and obese. Above the healthy weight range there are increasingly adverse effects on health and wellbeing. Weight gain can occur gradually over time when energy intake from food and drink is greater than energy used through the body's metabolism and physical activity.

ii) Measurement of 'Excess Weight'

a) Adults

The recommended measure of both overweight and obesity in adults is body mass index (BMI). BMI is calculated by dividing body weight (kilograms) by height (metres) squared.

Having a higher than recommended BMI in adulthood, increases the risk of chronic diseases.

Table 1: BMI classification for Adults

BMI range (KG/m2)	Classification
<18.5	Underweight
18.5-24.9 18.5-23	Healthy weight (white European) Healthy weight (Asian)
25-29.9 23-27.5	Overweight (white European) Overweight (Asian)
30-34.9 27.5+	Obesity I (white European) Obesity I (Asian)
35.9-39.9	Obesity II
>40	Obesity III (Morbidly obese)

The measurement of waist circumference in adults is also important, especially for those with a BMI of <35kg/m2, due to the association between intra-abdominal fat (on the waist) and diabetes, raised blood lipids and raised blood pressure. Levels of risk associated with waist circumference are identified in the table below:

Table 2: Waist circumference measurement and risk of co-morbidities

	Increased risk	Substantial risk
Men (white European) Men (Asian)	Greater than 94cms (37")	Greater than 102cms (40") Greater than 90cms (35")
Women (white	Greater than 80 cms	Greater than 88cms

European) Women (Asian)	(32")	(35") Greater then 80cms (31.5")

b) Children and Young People

In children BMI is adjusted for age and gender and referred to as a BMI centile[2] .

Table 3: UK National BMI percentile classification for population monitoring[3] of Children and Young People

Classification	BMI Centile
Very underweight	≤0.4th centile
Low weight	≤2nd centile
Healthy weight	>2 but <85th centile
Overweight	≥85th but <95th centile
Obese	≥95th centile

iii) Prevalence of 'Excess Weight'

The prevalence of overweight and obesity is increasing in virtually every country in the world and among virtually all age groups. Obesity rates in England have more than doubled in the last 25 years with almost two thirds of the adult population now overweight or obese.

Trends in child obesity are a particular cause for concern. Obesity has been rising rapidly in children in England over the past 20 years: the proportion of children classified as obese has nearly doubled for children aged 4-5 years and increased more than threefold for children aged 10-11 years. However this increase may be starting to level off, as the rate of increase in child obesity has slowed compared to the increases observed between 1995 and 2004.

Local prevalence data for children and young people and adults is shown below:

a) Prevalence: Children and Young People

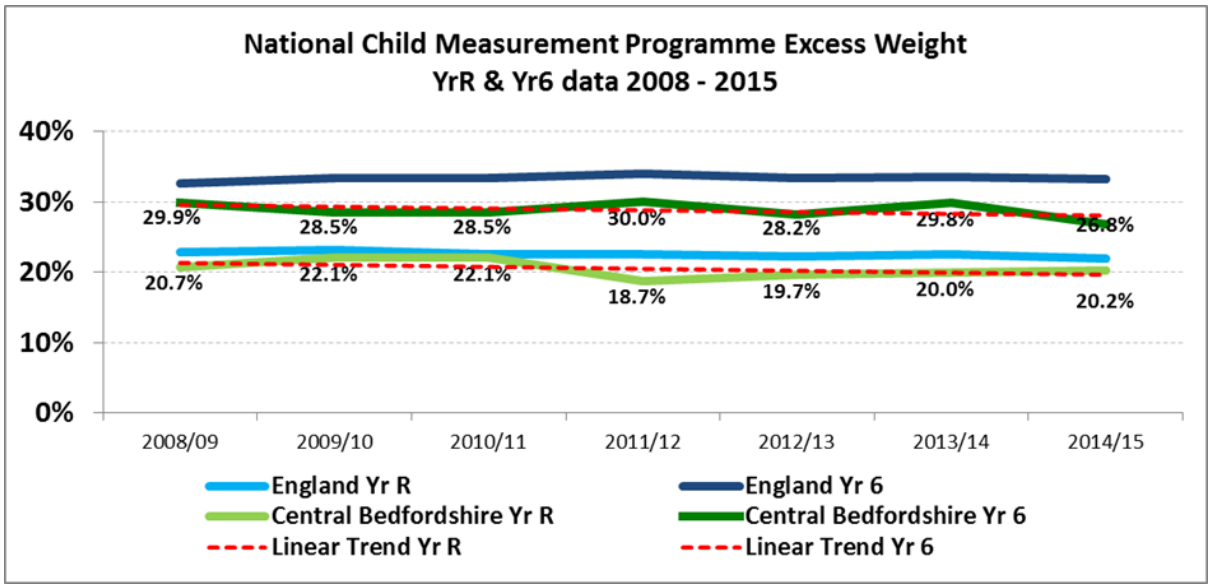
The latest NCMP data (14/15)[4] is shown in the table below:

Categories	Age	Central Bedfordshire	East of England	England
Very Overweight (Obese)	Year R	7.2%	8.2%	9.1%
	Year 6	14.4%	16.9%	19.1%

[2] This is a complex calculation based on height, weight, and appropriate age and sex reference charts. In England, the British 1990 (UK90) growth reference charts are used to determine the weight status of an individual child and population of children.
[3] The thresholds identified in Table 3 are population monitoring, they are not the same as those used in a clinical setting for individuals (where overweight is defined as a BMI of ≥91st but >98th centile and obese is defined as a BMI ≥ 98th centile).
[4] based on postcode of residence

Overweight	Year R	13.0%	12.4%	12.8%
	Year 6	12.4%	13.8%	14.2%
Excess Weight (Very Overweight & Overweight combined)	Year R	20.2%	20.7%	21.9%
	Year 6	26.8%	30.7%	33.2%
Healthy Weight	Year R	79.1%	78.5%	77.2%
	Year 6	72.2%	68.0%	65.3%
Underweight	Year R	0.7%	0.8%	1.0%
	Year 6	1.0%	1.4%	1.4%

Trend data over a 7-year period from 2008 shows a downward trend for Year R and Year 6 for excess weight as shown below:



The current ward data available (2014/15) shows the wards with the highest levels of excess weight are:

Year R:- Parkside, Houghton Conquest/Haynes, Dunstable Central.
Year 6:- Manshead, Northill, Aspley/Woburn.

b) Prevalence: Adults

The latest data, based on the Active People Survey (2012), is shown in the table below:

Categories	Central Bedfordshire	East of England	England
Obesity	23.7%	23.2%	23.0%
Overweight	45.3%	41.9%	40.8%
Excess Weight (Overweight & Obesity combined)	69.0%	65.1%	63.8%
Healthy Weight	30.0%	33.8%	35.0%
Underweight	0.7%	1.0%	1.2%

In terms of excess weight, this equates to approximately **145,000** adults in Central Bedfordshire.

Ward level data is available for 'obesity' only, based on modelled estimates. The five wards in Central Bedfordshire with the highest prevalence are as follows; with clear similarities to the ward level data for children and young people:

	Ward of residence	% Obese
1.	Parkside	28.9%
2.	Tithe Farm	28.4%
3.	Houghton Hall	27.4%
4.	Dunstable Icknield	27.3%
5.	Dunstable Northfields	27.0%

Prevalence of obesity in pregnancy is also a significant issue. For women in the first trimester, 37% of pregnant women are obese (BMI ≥ 30) (BHT-17%; L&D-20%).

iv) Causes of Excess Weight

Physiological, psychological, social and environmental factors all contribute to overweight and obesity in individuals, communities and wider society. Although personal responsibility in relation to diet and physical activity levels, plays a crucial part in weight gain, so does the 'obesogenic'[5]environment in which we live, with its abundance of energy dense food, motorised transport and sedentary lifestyles (Foresight, 2007).

v) Risks associated with 'Excess Weight'

a) Children and Young People

Being overweight or obese in childhood has consequences for their health and emotional well-being, in both the short and long term. Type 2 diabetes, previously considered an adult disease, has increased dramatically in overweight children as young as five, and referred to as 'diabesity'[6]. Raised blood pressure and cholesterol can also be identified in obese children and adolescents. In addition, overweight and obese children and young people are more likely to become obese adults. The emotional and psychological effects of being overweight including teasing and discrimination by peers; low self-esteem; anxiety and depression. Obese children may also suffer disturbed sleep and fatigue.

b) Adults

Overweight and Obesity are associated with a range of health problems including type 2 diabetes, heart disease and cancer. The risk of type 2 diabetes for obese women is 13 times greater and 5 times greater for obese men compared to those who are not obese (HSCIC, 2011). There is also an increased risk of other diseases, including angina, gall bladder disease, liver disease, osteoarthritis and stroke. One third of obese adults in England have a limiting long-term illness compared to a quarter of adults in the general population. It is estimated that life expectancy is reduced by an average of 2 to 4 years for those with a BMI of 30 to 35 kg/m2 and 8 to 10 years for those with a BMI of 40 to 50 kg/m2 (NOO, 2010).

In both men and women, BMI generally increases with age althought the patterns of obesity differ amongst ethnic groups. Although there are people in all population groups who are overweight or obese, obesity is related to social disadvantage.

[5] obesity promoting
[6] (http://www.noo.org.uk/NOO_about_obesity/child_obesity/Health_risks)

A systematic review of the childhood predictors of adult obesity showed that maternal obesity and weight gain during pregnancy are related to higher BMI in childhood and subsequent obesity in adulthood. Women who have diabetes during pregnancy are likely to have obese offspring[7].

[7] independent of genetic factors

Central Bedfordshire

A great place to live and work

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on the web: www.centralbedfordshire.gov.uk
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Monks Walk, Chicksands, Shefford, Bedfordshire SG17 5TQ

Social Care Health and Housing Overview and Scrutiny Committee
Monday 21st March 2016

Budget Monitoring 2015/16 Quarter 3

SCHH General Fund Revenue Quarter 3 2015/16

The forecast outturn for 2015/16 is £65.113m after use of reserves – an over spend of £0.468m (1%).

Key Variances and Indicators

Over spends on:

- OPPD placements and packages - £1.5m (after BCF contribution and use of reserves) partially offset by additional customer income from charges - £1.2m
- Learning Disability services - £0.4m (Mid Life Transitions/Carer Breakdown, Clinical Treatment Reviews, Pathway to my Place)
- Older Persons Homes - £0.358m (assimilation to CBC terms and conditions of service and shortfall in other local authority income)
- Housing Solutions £0.3M pressure on temporary accommodation

Offset by under spends on:

- Dementia premium - £0.175m (uptake below target)
- Vacancy savings - £0.3m
- Housing General Fund - £0.1m reduced recharges from Landlord Services
- Risks and Opportunities - NHS dowry income £0.13m risk & withdrawal of Continued Health Funding re: Financial situation at the CCG £0.4m

SCHH Quarter 3 Net Revenue Forecast 2015/16

Social Care Health and Housing General Fund Revenue Outturn 2015/16						
Service Area	**Approved Budget**	**Forecast Outturn**	**Outturn Variance**	**Use of Earmarked reserves**	**Outturn Variance after use of earmarked reserves.**	**Outturn as % of Budget**
Director	197	464	267	-241	26	6%
Housing Solutions	1,198	1,632	434	-269	165	10%
Older People and Physical Disabilities	37,332	40,079	2,747	-1,086	1,661	4%
Learning Disabilities and Mental Health	23,481	23,880	399	-30	369	2%
Commissioning	10,363	10,038	-325	171	-154	-2%
Resources	-7,926	-9,258	-1,332	-267	-1,599	17%
TOTAL	64,645	66,835	2,190	-1,722	468	1%

General Fund Revenue SCHH

Residential and nursing placement approvals for the period 1st April to 31st December 2015/16 for Older People

Admitted From	Quarter 1 2015/16	Quarter 2 2015/16	Quarter 3 2015/16	TOTAL	%
Hospital	45	57	41	143	56
Own Home	7	6	10	23	9
Rehabilitation	3	3	2	8	3
Respite	20	19	25	64	25
Other	1	1	16	18	7
TOTAL	76	86	94	256	100

- The number of approvals for quarters 1, 2 and 3 of 2015/16 at 256 is higher than the equivalent to the period in 2014/15 - 226. There were 119 deaths during quarters 1, 2 and 3 of 2015/16 (153 during the equivalent period of 2014/15).
- The ongoing residential placement efficiency is particularly challenging but was achieved for 2014/15. The no. of residential placements stood at 502 at the end of December 2015 (541 at the end of December 2014) with 212 residential block beds being used and 290 spot contract beds.

SCHH Capital 2015/16 Quarter 3 Forecast

Outturn gross spend = £3.49M (Budget = £7.77M) – £4.28M under spend offset by deferred gross income of £3.42M resulting in a net under spend of £0.86M

Housing General Fund

- Disabled Facility Grants – outturn gross forecast of £2.4M (under spend of £0.35M); additional external income of £0.155M from increased grant/client contributions – forecast net under spend £0.51M. 271 adaptations to date (280 to Q3 2014/15).
- Empty Homes – budget of £0.3M, outturn forecast £0.24M with slippage requested
- Renewals Assistance – forecast net spend of £0.19M (over spend £0.09M) – extra demand from Warm Homes campaign. 32 works completed (43 to Q3 2014/15)
- G&T sites – outturn forecast of £0.19M (under spend of £0.39M) as a result of slippage of 11 plot Potton extension

Adult Social Care

- Campus Closure – Steppingstones scheme in Dunstable opened in Jan 2015, Beech Close, Dunstable re-provision subject to release of £0.7m capital receipts by NHS
- ICT projects – gross expenditure budget £0.3m – zero spend – Care Act implementation will determine use/likely spend in 2015/16
- Review of Accommodation/Day Support gross expenditure budget £2.0m – forecast £0.15m spend – will support the Transformation programme and prioritised capital works at the Older People Care Homes

Landlord Services Capital Quarter 3 2015/16

- Capital expenditure forecast net spend of £17.842M – under spend of £1.525M and slippage of £1.587M to be requested - against a budget of £20.954M
- Variance relates to delay in procurement of Croft Green development, slippage in some of the development programme and other minor under spends
- £8.134M forecast spend at Priory View – on budget and funded by Independent Living Development Reserve. Due to complete March 2016.
- 31 RtB sales to Q3 (28 total for 2014/15) – forecast full year yield of £2.0M of retained capital receipts

Landlord Services Business Plan/HRA Revenue

- Forecast revenue surplus of £6.067M - £0.442M lower than budget – due to a reduction in income of £1.1M (delayed opening of Priory View, increased void loss and reduced recharges to General Fund), and increased corporate recharges of £0.3M, offset by reduced maintenance costs (£0.9M) and reduced debt interest costs (£0.1M)
- Year end reserves forecast to be £16.2M, a reduction of £4.4M - £10.5M drawn down for Priory View and other projects (e.g. Creasey Park) offset by £6.1M contribution
- Tenant debt of £1.004M – current tenants £0.534M (1.80% of total rent debit of £29.688m). £0.015M of arrears written off to December 2015. 56% of income received via Housing Benefit payments.

Public Health Highlights

- The service is led by the Director of Public Health (DPH) who is supported by a Central Bedfordshire Council (CBC) public health team and a core public health team within Bedford Borough Council (BBC) working across both Unitary Authorities leading on health protection and population healthcare.

- The CBC public health team is responsible for commissioning the Drugs and Alcohol services and the Healthy Child Programme (5-19 and 0-5 from 1/10/15) on behalf of both CBC and BBC.

- The Bedford Borough Team commission Sexual Health across both Unitary Authorities and the Core Team commission Excess Weight services and Health Checks.

Overall

- The full year forecast position for 2015/16 as at the end of the third quarter is a balanced budget, following a proposed use of earmarked reserves of £463k (ringfenced). This will bring the total of the reserve to £1,033k at the end of 2015/16.

Public Health Highlights

Service financials

- **Drugs & Alcohol** – a forecast saving of £163k on the Drugs and Alcohol service due to the retender of the contract which has resulted in budget savings, £97k relating to CBC. The recommissioned service commenced in September with an annual value of £3.6m across BBC and CBC. In addition to this there are savings relating to the Support, Advocacy, Mentoring and Advice Service (SAMAS) - £13k relating to CBC.

- **0 – 19 Healthy Child Programme (HCP)** – the 5-19 SEPT contract is currently forecasting an underspend of £50k due to 3 vacant school nurse posts, with £30k relating to CBC. The annual value of the SEPT contract is £1.2m. The HCP 0-5 service transferred to the council on 1st October 2015, its value is £3.2m in 2015/16 across BBC and CBC, with a forecast saving of £16k on commissioning with £8k relating to CBC.

- **Sexual Health** – a forecast saving of £183k (CBC share) due to reduced activity in the Bedford Hospital GUM contract. The annual value of the various contracts total £3.6m, for both CBC and BBC.

- **Payroll** – saving forecast for the service on vacant posts/maternity leave is £100k.

- **Adults & Older People** - Emergency Planning service – a forecast saving of £11k. The Health Checks and Stop Smoking shared services are reporting savings of £81k and £43k respectively. The CBC Stop Smoking service is overspending by £8k.

Public Health Highlights

- There are committed proposals to spend part of the Public Health earmarked reserve, these total £275k in 2015/16 and £239k in 2016/17. Any other proposed use of reserves which are uncommitted are currently on hold.

- The £110k D&A saving, £38k 0-19 saving, £183k Sexual Health saving, £127k saving on Adults & Older People, combined with the £100k payroll savings offset by the £275k additional spend proposals and the £746k grant reduction total the £463k overspend forecast overall.

Overheads

- CBC corporate budget includes £639k contribution to overheads from Public Health.
- The contribution of the Public Health grant to other directorates was £582k in 2014/15. This has increased to £991k in 2015/16.

- As part of wider government action on deficit reduction, the Department of Health (DH) was asked to deliver savings of £200m in 2015/16 through reductions to the Public Health Grant. On 4th November 2015 the DH published its response to the consultation. The response confirms the Government's initial proposal to reduce each local authority's public health allocation for 2015-16 by 6.2%. This resulted in a clawback of £746k from Central Bedfordshire's 2015/16 Public Health Grant. After taking this and the value of the committed proposals for 2015/16 and 2016/17 into account, this will leave £794k remaining in the Public Health earmarked reserve.

Public Health Financials

Month: December 2015	Year to date				Year					
Director	**Budget**	**Actual**	**Use of Reserves**	**Variance**	**Approved Budget**	**Forecast Outturn**	**Forecast Variance**	**Proposed transfer to reserves**	**Proposed use of Earmarked reserves**	**Forecast Variance after use of earmarked reserves.**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Director of Public Health (incl contribution to corporate overheads)	473	466	0	-7	630	630	0	0	0	0
Assistant Director Public Health (incl contributions to other Directorates, Doolittle Mill, payroll for management team and costs of Shared team led by BBC)	1,374	1,398	0	25	1,832	1,874	42	0	-42	0
Children, Young People and Health Inequalities	4,043	3,427	0	-615	5,390	5,349	-41	41	0	0
Older People and Adults	960	833	0	-127	1,280	1,118	-162	162	0	0
Drugs and Alcohol	2,193	2,092	0	-101	2,924	2,802	-122	122	0	0
Less Government Grant	-9,039	-8,004	0	1,035	-12,052	-11,306	746	0	-746	0
Total	**3**	**213**	**0**	**210**	**4**	**468**	**463**	**325**	**-788**	**0**

Central Bedfordshire Council

SOCIAL CARE HEALTH AND HOUSING OVERVIEW AND SCRUTINY COMMITTEE

21 March 2016

Work Programme 2015-2016 & Executive Forward Plan

Report Author: Richard Carr, Chief Executive

Advising Officer: Paula Everitt (paula.everitt@centralbedfordshire.gov.uk)

Purpose of this report

1. The report provides Members with details of the currently drafted Committee work programme and the latest Executive Forward Plan.

RECOMMENDATIONS

The Committee is asked to:

1. Consider and approve the work programme attached, subject to any further amendments it may wish to make;

2. Consider the Executive Forward Plan; and

3. Consider whether it wishes to add any further items to the work programme and/or establish any Task Forces to assist it in review specific items.

Overview and Scrutiny Work Programme

2. The attached is the currently drafted work programme for the Committee.

3. The Committee is now requested to consider the work programme attached and amend or add to it as necessary.

Overview and Scrutiny Task Forces

4. In addition to consideration of the work programme, Members may also wish to consider how each item will be reviewed, i.e. by the Committee itself (over one or a number of Committee meetings) or by establishing a Member Task Force to review an item in greater depth and report back its findings.

Executive Forward Plan

5. Listed below are those items relating specifically to this Committee's terms of reference contained in the latest version of the Executive Forward Plan to ensure Members are fully aware of the key issues Executive Members will be taking decisions upon in the coming months. The full Executive Forward Plan can be viewed on the Council's website at the link at the end of this report.

Issue	**Indicative Exec Meeting date**
Central Bedfordshire's Policy for Housing Assistance 2016 - 2020	02 August 2016
Non Key Decisions	Indicative Exec Meeting date
Q3 Performance Monitoring	05 April 2016
2015/16 Revenue Outturn Report	07 June 2016
2015/16 Capital Outturn Report	07 June 2016
2015/16 Housing Revenue Account Financial Outturn Report	07 June 2016
Budget Strategy and MTFP	02 August 2016
Q1 2016/17 Revenue, Capital and HRA Budget Monitoring	11 October 2016

Corporate Implications

6. The work programme of the Social Care Health and Housing Overview & Scrutiny Committee will contribute indirectly to all 6 Council priorities. Whilst there are no direct implications arising from this report the implications of proposals will be details in full in each report submitted to the Committee.

Conclusion and next Steps

7. Members are requested to consider and agree the attached work programme, subject to any further amendment/additions they may wish to make and highlight those items within it where they may wish to establish a Task Force to assist the Committee in its work. This will allow officers to plan accordingly but will not preclude further items being added during the course of the year if Members so wish and capacity exists.

Appendices

Appendix A – Social Care Health and Housing Overview and Scrutiny Work Programme.

Background Papers

Executive Forward Plan (can be viewed at any time on the Council's website) at the following link:-
http://www.centralbedfordshire.gov.uk/modgov/mgListPlans.aspx?RPId=577&RD=0

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Appendix A **DRAFT**

Social Care, Health and Housing OSC Work Programme (2016/17)

OSC date	Report Title	Description
27 June 2016	Community Health Services Engagement	To highlight the engagement activities that are planned for the on-going redesign work for this serivce.
27 June 2016	Winter Resilience Planning 2015/16	BCCG report as to the effectiveness of the Winter Resilience Plan 15/16
27 June 2016	BCCG Plan for Patients 2016/17	To scrutinise the proposals outlined in the Plan for Patients 2016/17 and challenge the assumptions where applicable.
27 June 2016	Central Bedfordshire's Policy for Housing Assistance 2016-2020	To adopt the Council's Policy for Housing Assistance 2016 – 2020 for providing households with financial assistance to improve the homes of the most vulnerable households.
27 June 2016	Q3 Performance Report	To review and comment on the Q3 Performance Report
27 June 2016	Q4 Budget Monitoring	To review and comment on the Q4 Budget Monitoring Report
27 June 2016	The proposed development of integrated health and care hubs in Central Bedfordshire.	To scrutinise the proposals outlined in the Strategy and provide feedback to the Executive Member.
27 June 2016	Homelessness Services requested update	A requested item to update the Committee on the Strategy and forward plan for the service.

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