This meeting may be filmed.*

Central Bedfordshire Health and Wellbeing Board

Agenda

Meeting Title:	Central Bedfordshire Health and Wellbeing Board
Date:	Wednesday, 27 July 2016
Time:	2.00 p.m.
Location:	Council Chamber, Priory House, Monks Walk, Shefford

1. **Apologies for Absence**

   Apologies for absence and notification of substitute members.

2. **Election of Vice-Chairman 2016/17**

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

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

4. **Minutes**

   To approve as a correct record the Minutes of the last meeting held on 6 April 2016 and note actions taken since that meeting.

5. **Members' Interests**

   To receive from Members any declarations of interest.

6. **Public Participation**

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

HEALTH AND WELLBEING STRATEGY

Item	Subject	Page Nos.	Lead
7.	**Enabling People to Stay Healthy for Longer - Reducing Premature Mortality from Cardiovascular Disease** To report back on what more could be done to increase the take up of health checks.	11 - 16	MS

8.	**Giving Every Child the Best Start in Life: School Readiness** To provide an update on the progress being made in respect of 'School Readiness'.	17 - 22	SH
9.	**Health and Wellbeing Scorecard** To consider the proposed scorecard for the Health and Wellbeing Board which will be used to assess progress in achieving the Joint Health and Wellbeing Strategy.	23 - 34	MS

OTHER BUSINESS

Item	Subject	Page Nos.	Lead
10.	**East of England Ambulance Service NHS Trust** To receive a presentation from the Area Clinical Lead on the Trust's new operational model.		MJ
11.	**Transforming Care - Transformation Plan** To approve the Transforming Care Plan.	35 - 124	MT
12.	**Sustainability and Transformation Plan 2016-2020** To receive an update on the Sustainability and Transformation Plan.	125 - 130	RC
13.	**Better Care Fund Plan 2016/17** To receive an update on the Better Care Plan.	131 - 204	JO/DD
14.	**Board Development and Work Plan 2016/2017** To consider and approve the work plan. A forward plan ensures that the Health and Wellbeing Board remains focused on key priorities, areas and activities to deliver improved outcomes for the people of Central Bedfordshire.	205 - 208	RC

To: Members of the Central Bedfordshire Health and Wellbeing Board

Ms D Blackmun	Chief Executive, Healthwatch Central Bedfordshire
Mr R Carr	Chief Executive, Central Bedfordshire Council
Cllr S Dixon	Executive Member for Education and Skills, Central Bedfordshire Council
Mr C Ford	Director of Finance, NHS Commissioning Board Area for Hertfordshire & South Midlands
Mr M Coiffait	Director of Community Services
Mrs S Harrison	Director of Children's Services, Central Bedfordshire Council
Cllr C Hegley	Executive Member for Social Care and Housing, Central Bedfordshire Council
Cllr M Jones	Deputy Leader and Executive Member for Health, Central Bedfordshire Council
Dr A Low	Chair, Bedfordshire Clinical Commissioning Group
Mrs J Ogley	Director of Social Care, Health and Housing, Central Bedfordshire Council
Mrs M Scott	Director of Public Health
Mr M Tait	Chief Accountable Officer, Bedfordshire Clinical Commissioning Group

please ask for	Sandra Hobbs
direct line	0300 300 5257
date published	14 July 2016

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CENTRAL BEDFORDSHIRE COUNCIL

At a meeting of the **HEALTH AND WELLBEING BOARD** held in Council Chamber, Priory House, Monks Walk, Shefford on Wednesday, 6 April 2016

PRESENT

Cllr M R Jones (Chairman)
Mr M Tait (Vice-Chairman)

Mrs D Blackmun	Chief Executive Officer, Healthwatch Central Bedfordshire
Mr R Carr	Chief Executive
Mrs S Harrison	Director of Children's Services
Cllr C Hegley	Executive Member for Social Care and Housing
Mrs A Lathwell	Interim Head of Strategy & Corporate Planning, Bedfordshire Clinical Commissioning Group
Dr A Low	Chair, Bedfordshire Clinical Commissioning Group
Mrs J Ogley	Director of Social Care, Health and Housing
Mrs M Scott	Director of Public Health
Cllr M A G Versallion	Executive Member for Education and Skills

Apologies for Absence: Mr M Coiffait
Mr C Ford

Members in Attendance: Cllrs E Ghent
P Hollick

Officers in Attendance:	Ms S Chakrabarti	– Assistant Director, Public Health
	Mrs P Coker	– Head of Service, Partnerships - Social Care, Health & Housing
	Mrs S Hobbs	– Committee Services Officer
	Mrs C Shohet	– Assistant Director of Public Health

HWB/15/33. **Chairman's Announcements and Communications**

Dr Judy Baxter had retired from the Board and Members took the opportunity to thank her for the help and guidance that she had provided the Board and wished her all the best for the future.

Dr Alvin Low would replace Dr Judy Baxter as a Bedfordshire Clinical Commissioning Group representative on the Board.

Agenda item 11, Transforming Care Plan, had been deferred to the next meeting on 27 July 2016.

HWB/15/34. **Minutes**

RESOLVED

that the minutes of the meeting of the Central Bedfordshire Health and Wellbeing Board held on 20 January 2016 be confirmed as a correct record and signed by the Chairman.

HWB/15/35. **Members' Interests**

None were declared.

HWB/15/36. **Public Participation**

There were no members of the public registered to speak.

HWB/15/37. **Joint Strategic Needs Assessment**

The Board considered a report that provided a summary of the health and wellbeing needs in Central Bedfordshire and the areas which required further focus. The Joint Strategic Needs Assessment (JSNA) had last been updated in the autumn of 2014 and there had been some significant changes which directly impacted upon or were an indicator of health and wellbeing.

A number of common themes had emerged from the JSNA:-

- The need to increase healthy life expectancy and promote independence by 'mainstreaming prevention'. This was important to both local residents and to the local health and care system that would need to fund the consequences if healthy life expectancy did not improve.
- The need to reduce inequalities in health which started from birth – so giving every child the best start in life was essential, as was minimising the impact of welfare reform.
- The need to give mental and physical health parity – there was no health without mental health.
- The need to be ambitious – whilst outcomes in Central Bedfordshire appeared better than average, they should be as it was a relatively affluent area, so the aim should to be among the best.

The key areas agreed to drive the Board's future focus were:-

- Educational attainment.
- Young People's emotional wellbeing and resilience.
- Mental Health.
- Reducing the proportion of life spent in poor health.
- Hypertension and diabetes.
- Alcohol abuse.

- Injuries due to falls.
- Welfare reform.

The Board agreed that at this stage the JSNA did not suggest the need for a complete refresh of the Health and Wellbeing Strategy. It was agreed that there may be a requirement to review the key issues within the strategy following the regular review of progress.

RESOLVED

1. **that the 2016 Executive Summary of the Joint Strategic Needs Assessment for Central Bedfordshire be endorsed; and**

2. **that the areas, set out above, required focus and action across the system and should be incorporated into the Health and Wellbeing Strategy at an appropriate point.**

HWB/15/38. **Ensuring Good Mental Health and Wellbeing at Every Age**

The Board considered a report that outlined the roadmap to ensuring young people had good mental health and wellbeing and identified what was being done and what success would look like. The report also provided more in-depth understanding of why mental health was a priority, including the reasons for young people in Central Bedfordshire reporting lower self-esteem.

Bedfordshire was part of a national Child and Adolescent Mental Health Services (CAMHS) school pilot which aimed to support health services and schools to work more closely to promote mental health wellbeing in schools. Teachers were being trained to identify mental health issues at an earlier stage. CAMHS clinicians were also providing clinics at the schools taking part in the pilot and were improving access to services for those young people experiencing mental health issues.

The Children's Trust Board were investigating why young people in Central Bedfordshire suffered from low self esteem, following an in-depth schools survey.

Currently there was no provision for over 10 year olds to be assessed for autism. SEPT and Bedfordshire Clinical Commissioning Group were working to have a robust pathway to provide capacity and resources to enable assessments to be carried out for older children. The reduction in waiting times for assessment in crisis and reduction in inpatient admissions was a key performance indicator.

The Board agreed that an update on ensuring good mental health and wellbeing at every age be provided at their meeting on 19 October 2016.

RESOLVED

1. **that the roadmap to ensure good mental health and wellbeing for children, young people and families across Central Bedfordshire be noted;**

2. **that the recommendations set out within the report be approved; and**

3. **that an update be provided to the Health and Wellbeing Board at their meeting on 19 October 2016.**

HWB/15/39. **Bedfordshire Clinical Commissioning Group's Emerging Operational Plan for 2016/17 (Bedfordshire Plan for Patients)**

The Board received a presentation that provided an overview of the Bedfordshire Clinical Commissioning Group's (BCCG) emerging operational plan for 2016/17 and an update on the requirements for a Sustainability and Transformation Plan (STP). The Plan would explain the development and transformation of primary care and set out the ambition for integration across health and social care.

The presentation highlighted the outcome headlines for:-

- maternity and early years;
- mental health;
- cancer;
- long term conditions;
- multimorbidity and frailty;
- carers; and
- alcohol and liver disease.

NOTED the presentation.

HWB/15/40. **Planning for the Better Care Fund Plan 2016/17**

The Board considered a report that provided an update on the Better Care Fund (BCF) Plan for 2016/17, set out the proposed priorities for 2016/17 and included the quarter 3 performance return that had been submitted to NHS England.

The 2016/17 BCF Plan would build on the work carried out in 2015/16 and demonstrate that local partners had reviewed progress in the first year of the BCF. The Plan would also be mindful of the linkages with the NHS Sustainability and Transformation Plans which NHS partners were required to produce in 2016.

Assurance of the 2016/17 Plans would be based on a high level BCF Planning Return detailing the technical elements of the plan, including funding contributions, a scheme level spending plan, national metric plans, as well as a narrative plan. The final submission of the BCF Plan 2016/17 had to be submitted to NHS England by 28 April 2016. A copy of the full submission would be provided to the Board at their next meeting on 27 July 2016.

RESOLVED

1. **that the first submission for the BCF Plan 2016/17 be noted;**

2. **to authorise the Director of Social Care, Health and Housing and the Bedfordshire Clinical Commissioning Group Lead Director, in consultation with the Chairman of the Health and Wellbeing Board, to sign off the BCF Plan 2016/17 and the Section 75 Agreement; and**

3. **that the quarter 3 return on the BCF Plan to NHS England be noted.**

HWB/15/41. **Young People's Vision of Current and Future Health and Wellbeing Services in Central Bedfordshire**

The Board considered a report that outlined details of Healthwatch Central Bedfordshire's (HCB) health and wellbeing engagement project. This had sought to empower and involve young people by asking them to share their experiences of health and wellbeing issues and concerns, including an exploration of their ideas for the future commissioning of services. The Board watched a short film where the young people highlighted their experiences of health and social care services.

A number of young people were interested in developing a Young Healthwatch for Central Bedfordshire that could be used to seek young peoples' views on future developments within health and wellbeing.

RESOLVED

1. **to recommend that the Children's Trust Board and Corporate Parenting Panel consider the report on the young people's vision of current and future health and wellbeing services in Central Bedfordshire.**

HWB/15/42. **Transforming Care Plan**

This item had been deferred to the Health and Wellbeing Board meeting on 27 July 2016.

HWB/15/43. **Health and Wellbeing Board Work Programme**

The Board considered the updated work programme of items for the Health and Wellbeing Board for 2016/17.

RESOLVED

that the work plan be approved, subject to the inclusion of the following items:-

- **ensuring good mental health and wellbeing at every age for the meeting on 19 October 2016; and**
- **transforming Care Plan for the meeting on 27 July 2016.**

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

Chairman …….……

Dated ……..

Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	**Enabling People to Stay Healthy for Longer - Reducing Premature Mortality from Cardiovascular Disease** An update on what more could be done to increase the take up of NHS Health Checks.
Meeting Date:	27 July 2016
Responsible Officer(s)	Muriel Scott, Director of Public Health
Presented by:	Martin Westerby, Head of Public Health

Action Required:

1. **The Health and Wellbeing Board is asked to endorse and support the delivery of the recommendations to facilitate greater uptake of an NHS Health Check by staff, patients, customers and stakeholders.**

Executive Summary	
1.	This report outlines the strategies to increase provision of the NHS Health Check programme, using an approach that targets those populations that will benefit greatest from having an NHS Health Check. Initially these will be delivered through the existing Primary Care route and subsequently through future commissioned community provision. It identifies how Central Bedfordshire Council (CBC) and Bedfordshire Clinical Commissioning Group (BCCG) can support further development of the NHS Health Check delivery by facilitating involvement from key stakeholders in those organisations.

Background	
2.	Cardiovascular disease (CVD) currently affects the lives of over 4 million people in England, causes 36% of deaths (170,000 a year in England) and is responsible for a fifth of all hospital admissions. It is the largest single cause of long-term ill health and disability, impairing the quality of life for many people.

3.	The NHS Health Check programme is a national initiative which systematically offers preventative checks to all those aged 40 - 74 years to assess their cardiovascular disease risk; this includes heart disease, stroke, diabetes and kidney disease. These diseases share a common set of risk factors: obesity, harmful alcohol intake, lack of physical activity, hypertension, smoking, disordered blood fat and/ or sugar levels.
4.	Early identification and management of these risk factors can potentially delay or prevent the onset of vascular disease, with subsequent, reductions in the potential burden on future health and social care.
5.	The NHS Health Check is currently primarily delivered by GP practices in Central Bedfordshire. Unfortunately only just over half of residents offered a health check actually attend for their check.
6.	The 6,712 NHS Health Checks delivered in CBC during 2015/16 represented 69.9% of the target. Performance varies between practices for many reasons including: • competing priorities • capacity of clinical and clerical staff • lack of clinic space • doubts over the evidence base • invitations to patients not being sent systematically or consistently.
7.	In 2015/16 only 1 CBC General Practice failed to deliver any NHS Health Checks, 1 GP achieved less than 25% of delivery target, with a further 6 delivering between 25% – 50% of target. 4 General Practices delivered in excess of their delivery target.
8.	In addition it is acknowledged nationally that a lack of awareness or campaigns around the NHS Health Check offer has had an impact on patient uptake.

Detailed Recommendation	
9.	To improve of the capacity for delivery of health checks and to increase uptake two commissioning actions are planned: • The procurement of community outreach provision which will increase capacity and improve access for those of working age whose availability to attend their GP practice during working hours may be limited. The provider will also deliver health checks in community venues and work places.

	• The introduction of a new payment system (as from October 2016) which will support a more targeted approach, incentivising practices to focus on those at highest cardiovascular risk. The payment structure will also positively encourage good quality and onward referral to weight management services.
10.	To promote the NHS Health Check and increase the proportion who take up the offer, a range of actions are proposed covering workforce, providers and customers. **Across Central Bedfordshire Council:** i. Positively promote the health check programme, display promotional materials in all CBC buildings; **For example**, leisure centres and libraries (currently promoted on CBC website, Twitter and staff newsletter); ii. CBC staff, who meet the eligibility criteria, should be encouraged to contact their GP and book their NHS Health Check. Managers to proactively encourage staff to take up the NHS Health Check offer from their GP (through staff development process); **For example**, facilitating staff to attend during the working day where they are not offered outside working hours, through agile working arrangements where appropriate; iii. All public facing departments to proactively promote the NHS Health Check programme to their service users/clients; **For example**, paid carers encourage and support clients to have a health check, where appropriate (supported by Public Health with training/resources); staff within the contact centre could also ask residents to take up the offer of a health check. iv. Incorporate the delivery of NHS Health Checks in existing contracts where providers have the opportunity provide to existing customers/clients; **For example**, identifying contracts where there are opportunities to oblige or encourage providers to promote health checks, and facilitate their clients to undertake a health check; v. Identify opportunities for CBC staff or contracted providers to deliver health checks, as an additional activity, where contact with customers allows; a. **For example;** Leisure Centre staff to deliver health checks as 'a community' provider for their clients as part of role in improving wellbeing;

vi. NHS Health Check lead to coordinate a small group of CBC volunteers to take blood pressure for employees on a monthly basis (free training and protocol to be provided by the Stroke Association) linking to 'know your numbers', 'One You', 'Heart Age Tool' and signposting to the NHS Health Check.

BCCG

vii. Positively promote the health check programme, display promotional materials in all BCCG buildings, share posts via website, social media and staff newsletters;

viii. Endorse the new contract and payment model developed by Public Health for primary care to provide Health Checks, and to support practices to take up delivery;

ix. Encourage staff, who meet the eligibility criteria, to contact their GP and book their NHS Health Check and managers to proactively encourage staff to take up the NHS Health Check offer from their GP;
For example, facilitating staff to attend during the working day where they are not offered outside working hours;

x. Incorporate raising the profile of the NHS Health Check where Provider contracts are in place,
For example, identifying opportunities to contractually oblige providers to promote health checks, and facilitate their clients to undertake a health check, where appropriate.

xi. CCG Locality leads to encourage GP Practices to take up the Public Health offer of quarterly performance reviews so that Public Health can offer support to GPs to help overcome barriers to delivery, share good practice solutions and improve performance.

Healthwatch Central Bedfordshire

i. Promote the delivery of NHS Health Checks to eligible populations whilst also seeking evidence from the local consumer community of their experience of the health check to establish how useful and beneficial they found it.

ii. Identify what more could be done to increase uptake, as part of their current GP Practice 'Enter & View' programme.

Issues	
Governance & Delivery	
11.	Invitation to and uptake of NHS Health Check is rigorously monitored and performance, reported on monthly basis through the people scorecard within CBC and will be a part of the emerging Health & Wellbeing Board Scorecard.
Financial	
12.	The financial implications of extending the offer for NHS Health Checks, as detailed in this proposal, are within existing Public Health budget.
Public Sector Equality Duty (PSED)	
13.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
	Are there any risks issues relating Public Sector Equality Duty No
	If yes – outline the risks and how these would be mitigated

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

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Presented by Martin Westerby

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Giving Every Child the Best Start in Life: School Readiness
Meeting Date:	27 July 2016
Responsible Officer(s)	Sue Harrison: Director of Children's Services
Presented by:	Deborah Pargeter

Recommendation(s)

1. **For the Health and Wellbeing Board to consider and comment on the progress made in giving every child the best start in life: school readiness.**

Purpose of Report	
1.	The report provides the Health and Wellbeing Board with an update on the progress being made in respect of 'School Readiness'.

Background	
2.	This item was last considered in detail by the Health and Wellbeing Board at its meeting on 7th October 2015.
3.	Work has been progressed through the School Readiness workstream of the Partnership Vision for Education Board.
4.	A detailed action plan exists which has been refined to expedite impact for children entering reception classes in Central Bedfordshire in September 2016. Current actions include: **Communications** • Presentations have been shared with, and delivered to parents and professionals, on the characteristics of school readiness and the detrimental impact of not preparing a child for school. • A leaflet detailing the characteristics of school readiness which provides parents with guidance on what they can do to support their child has been sent with all reception class offer letters. Posters have been distributed to promote the leaflet.

- Future actions include the development of a similar leaflet to support better school attendance.

- Social media links to a Central Bedfordshire Council video clip are being prepared - demonstrating the characteristics of school readiness for parents.

- All professionals aware of services available to support children, through an on-line directory.

Early Years Foundation Stage Data

- All Central Bedfordshire schools agreed to continue with Early Years Foundation Stage data collection using the profile currently adopted. (There is no requirement for schools to use a uniform assessment tool to record early years progress.)

Information Sharing

- Transition documents and assessment tools are being shared.

- School improvement, early years and health teams present as a collective unit and share information routinely (including at professionals briefings).

Lessons Learned

- Reflecting on lessons learned when things have gone wrong for a child.

Transition

- All 0 - 5 settings know their linked Early Years professional and Health visitor.

- Improving the handover between health visitors and school nurses.

- Settings and Central Bedfordshire Council are to be held accountable for the uptake of Early Years Pupil Premium and impact on learners.

- Linking health checks and 2-½ year checks to Early Years Foundation Stage progress and facilitating health checks in educational settings. The Partnership Pilot Programme (2015-16) between Early Years and The Health Visiting Service to implement an Integrated Health & Education Review at 2½ years has been extremely successful and has driven a significant increase in uptake of the review in the pilot areas of Biggleswade and Sandy. Face-to-face integrated reviews, including a social and emotional focus were offered in all early years settings in these areas.

	Parents reported having a more comprehensive understanding of the age appropriate social development of their children and identified - with the professionals - clear areas of work to support their child. Staff reported that opportunities and referrals for appropriate early interventions for children with additional needs were more effective and efficiently delivered, due to the collaborative approach. The Integrated 2½ year Review is now being rolled out across all of CBC in 2016-17 and the impact – particularly in relation to the outcomes of 'ready to learn' and 'ready for school' - will be monitored through Early Help/Early Years and Public Health. **Vulnerable Pupils** A pilot has started with high achieving settings with vulnerable pupils sharing good practice with less successful settings with a similar context.

Reasons for the Actions being taken by the Workstream Group	
4.	The expected outcome for every child leaving reception is that they achieve a 'Good Level of Development'. 2015 results show that in Central Bedfordshire 64% of children were classed as having a Good Level of Development – 2% below the national average. Indicative results for 2016 indicate that this level has risen by 4% to 68% of children having a Good Level of Development. This figure has yet to be moderated, and national and statistical neighbour figures are not yet available. The school readiness research carried out suggests that milestones that indicate a child's ability to reach a national expectation by the end of reception were not being shared or discussed between professionals as there was no medium for sharing information and good practice.
5.	Other reasons for the above actions include: • Parents and settings were not preparing children adequately enough to allow them to make rapid progress immediately on entry into a reception class. • Sharing good practice (Matching higher achieving settings with those less successful and share good practice.)

6.	Working towards the following outcomes: • Improved communication between early years settings and schools. • Parents and professionals aware of key contacts and how to access additional support for a child. • Shared best practice (Matching higher achieving settings with those less successful.) • Improved transition of information between professionals. • Up-take of health checks and educational checks continued increase. The latest data for 2½ year reviews in Central Bedfordshire indicate an increase from 55.3% (published data for Q3 2015-16) to 63.7% (May 2016), with a planned increase to 78% by October 2016. • Vulnerable children identified sooner and early intervention put in place to allow children to flourish. • Children's exit data for Early Years in the top quartile nationally.

Issues	
Governance & Delivery	
7.	'School Readiness' is a workstream of the Partnership Vision for Education Board. The Board oversees delivery of the Partnership Vision for Education 2015-19.
Financial	
8.	There is no budget allocated to this project and this is impacting on the impact of improvements.
Public Sector Equality Duty (PSED)	
9.	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
10.	Research complied by Ofsted (The Impact of Early Education as a Strategy in Countering Socio-Economic Disadvantage) indicates that early education for low income and ethnic minority children can contribute importantly to combating educational disadvantages if certain criteria are met.

11.	The plan is fully inclusive to the needs of adults and children within Central Bedfordshire and promotes equality of access for all children. The school readiness work stream is supporting the progress of all groups of children in Central Bedfordshire, including those born at different times of the year, from multi-ethnic groups, children known to social care, children with a special education need or disability and children eligible for free school meals. The work stream group is made up of professionals with direct experience of effectively supporting children in all of these groups.
12.	Are there any risks issues relating Public Sector Equality Duty No
	If yes – outline the risks and how these would be mitigated

Source Documents	**Location (including url where possible)**
Partnership Vision for Education	http://www.centralbedfordshire.gov.uk/Images/partnership-vision_tcm3-7593.pdf

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Presented by Sue Harrison

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Health and Wellbeing Scorecard
Meeting Date:	27 July 2016
Responsible Officer(s)	Muriel Scott, Director of Public Health
Presented by:	Celia Shohet, Assistant Director of Public Health

Action Required:

1. **To consider the proposed scorecard for the Health and Wellbeing Board which will be used to assess progress in delivering the Joint Health and Wellbeing Strategy.**
2. **To identify any additional key measures which the Board would wish to see included.**

Executive Summary	
1.	The Joint Health and Wellbeing Strategy has four cross cutting priorities where the Board wants to make the fastest progress: • Ensuring good mental health and wellbeing at every age. • Giving every child the best start in life. • Enabling people to stay healthy for longer. • Improving outcomes for frail older people. The scorecard proposed includes the key measures to provide an indication of progress and will be presented to the Board each quarter for review.

Background	
2.	The Joint Health and Wellbeing Strategy (JWHS) was agreed by the Board in April 2015. To date the update reports on progress for each priority have included measures of success and associated outcomes but they have not been brought together in one scorecard.
3.	The format of the scorecard builds on those currently in existence and that adopted by the Children's Trust has been identified as being best suited to the JHWS.

4.	The proposed scorecard includes a range of measures which have been chosen because they: • Directly measure the desired outcome or are a process measure when an outcome measure is not available e.g. access to care measures. • Are generally measures already in existence and therefore don't require additional resource to collect. • Represent a range in frequency of reporting from monthly to annual. • Are available at a CBC level and in some cases at either a locality, practice or ward level.
5.	To understand the size of the challenge the scorecards will include, where possible, the number of residents affected by the issues presented. For example 12,485 CBC residents have diagnosed diabetes (2014/15) and if progress is made to reduce some of the risk factors for diabetes, such as excess weight, then this figure should stabilise and reduce.
6.	The scorecard performance judgement for all scorecards is shown below

Performance Judgement		
Direction of travel (DoT)	RAG score (Standard scoring rules unless the indicator specifies alternative scoring arrangements)	
Performance is worsening	▲	Target missed by 10% or more
Performance remains unchanged	●	Target missed by less than 10%
Performance is improving	★	Target achieved

Detailed Recommendation	
7.	There is some tension between keeping the scorecard relatively simple and therefore high level, yet providing enough detail to ensure that the drivers of outcomes are seen in the broadest sense. The draft scorecards provide a range of measures and the ones which are recommended to form the final scorecard are highlighted.
8.	The Board wants to be ambitious in achieving outcomes for residents and therefore benchmarks and targets need to be correspondingly challenging. However it is unwise to set different targets for the same indicator which is reported in other forums e.g. Children's Trust. It is therefore recommended that where a target has already been set, that this is used for this scorecard, however in other areas, where new targets need to be established, challenging targets should be agreed.

Issues	
Governance & Delivery	
9.	The scorecard will be reported to the Health and Wellbeing Board on a quarterly basis.
Financial	
10.	There no financial implications directly associated with this proposal.
Public Sector Equality Duty (PSED)	
11.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
	Are there any risks issues relating Public Sector Equality Duty No
	If yes – outline the risks and how these would be mitigated

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

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Presented by Celia Shohet

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Giving Every Child the Best Start in Life

Outcomes

Babies have the best start in life	Parents or carers are equipped to nurture their child and are not affected by drug or alcohol misuse, domestic abuse or poor mental health	All children arrive at school in a great position to learn

Cross Cutting:
Reducing inequalities by tackling the wider determinants
Prevention and Early Intervention
Acting upon patient and customer experience
Safeguarding and ensuring high quality integrated services

On average 3,250 babies are born each year in Central Bedfordshire and by the time they reach school 2,200 are achieving a good level of development at the early years foundation. To give children the best start we need to ensure that they are not adversely affected by parental drug or alcohol misuses, mental health or domestic abuse and currently 230 people are in treatment for drugs and / or alcohol that are living with children and in approximately 40% of domestic abuse incidents a child is normally resident at the same location.

Draft

Proposed indicators:

- Smoking at the time of Delivery
- Breastfeeding rate 6-8 weeks
- Early Access to antenatal care
- Mothers who receive a maternal mood review by the time the infant is 8 weeks
- Successful completions (opiates) of clients who live with children
- Successful completions (alcohol) of clients who live with children
- Domestic Abuse Incidents Reported
- Children who received an integrated 2-2.5 year review
- Number of disadvantaged 2 year olds placed in early education / childcare
- School readiness - % of children achieving a good level of development at the Early years Foundation

Other indicators to consider:

- Under 18 conceptions (aged 15-17)
- Excess Weight - Year R (4-5 years)
- Excess Weight - Year 6 (10-11 years)
- Children in poverty (under 16)
- Children in care
- Population vaccination coverage-MMR for one dose (5 year old)
- Population vaccination coverage Dtap/IPV/Hib (1 year old)

		Latest Data	Latest Data	Target	Current Status
...	Smoking at the time of Delivery	Dec 15	10.1 %	13.0 %	
...	Breastfeeding rate 6-8 weeks	Mar 16	42.6 %	50.0 %	
	Early Access to antenatal care		?	?	
	Mothers who receive a maternal mood review by the time the infant is 8 weeks		?	?	
	Successful completions (opiates) of clients who live with children		?	?	
	Successful completions (alcohol) of clients who live with children		?	?	
...	Domestic Abuse incidents reported	May 16	276.0	?	
...	Children who received an integrated 2-2.5 year review	Mar 16	60.5 %	90.0 %	
...	Number of disadvantaged 2 year olds placed in early education/childcare	Mar 16	668	810	
...	School readiness - % of children achieving a good level of development at the Early Years Foundation	Sep 15	64 %	69 %	
...	Under 18 conceptions (aged 15-17)	Dec 14	18.8	23.2	
...	Excess Weight - Year R (4-5 years)	Jul 15	20.2 %	19.1 %	
...	Excess Weight - Year 6 (10-11 years)	Jul 15	26.8 %	27.9 %	
	Children in poverty (under 16)		?	?	
	Children in care		?	?	
	Population vaccination coverage-MMR for one dose (5 year old)		?	?	
	Population vaccination coverage Dtap/IPV/Hib (1 year old)		?	?	

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Enabling People to Stay Healthy Longer

Outcomes

Fewer people develop long term conditions as a result of unhealthy lifestyles	Fewer people have complications as a result of a long term condition

Cross Cutting:
Reducing inequalities by tackling the wider determinants
Prevention and Early Intervention
Acting upon patient and customer experience
Safeguarding and ensuring high quality integrated services

Of the 210,500 people aged 18 years and above living in Central Bedfordshire (2014) an estimated 37,000 smoke, 150,000 are above a healthy weight and 56,000 are inactive. These lifestyle behaviours contribute to the development of Long Term Conditions and those already diagnosed include 12,500 people with diabetes, 40,000 with high blood pressure, 8,500 with heart disease, 4,200 with stroke and 4,700 with a serious respiratory condition.

Draft

Proposed Indicators:

- Smoking Prevalence
- Adult excess weight
- Inactive adults
- Health Checks Delivered
- Recorded diabetes
- Premature mortality
- Percentage of people with diabetes meeting all 3 treatment targets (blood sugar, blood pressure and cholesterol)
- Premature mortality for cardiovascular disease
- Under 75 mortality rate from respiratory disease
- Under 75 mortality rate from liver disease

Other Indicators to consider:

- Adult skills: no qualifications
- People with LTC feeling supported to remain independent
- Successful completion of drug treatment-opiate users
- Successful completion of drug treatment-non opiate users
- Successful completion of alcohol treatment
- Mortality rate from causes considered preventable
- Percentage in long term unemployment-% of working age population
- Under 75 mortality rate from cancer

		Latest Data	Latest Data	Target	Current Status
...	Smoking prevalence 18+	Oct 15	17.5 %	?	!
...	Adult Excess Weight	Jul 14	69.1 %	68.1 %	n/a
...	Inactive adults	Jan 15	26 %	22 %	▲
...	Health Checks Delivered % of Target	Apr 16	36.80	100.00	▲
	Recorded diabetes		?	?	?
	Premature mortality		?	?	?
	% people with diabetes meeting all 3 treatment targets (blood sugar, blood pressure & cholesterol)		?	?	?
	Premature mortality for cardiovascular disease		?	?	?
	Under 75 mortality rate from respiratory disease		?	?	?
	Under 75 mortality rate from liver disease		?	?	?
...	Adult Skills: No Qualifications	Dec 15	6.9 %	?	n/a
...	People feeling support to manage (LTC)	Sep 15	60.7 %	68.2 %	▲
...	Successful completion of drug treatment-opiate users	Mar 16	7.1 %	10.3 %	▲
...	Successful completion of drug treatment-non opiate users	Mar 16	45.8 %	46.6 %	●
...	Successful completion of alcohol treatment	Mar 16	34.5 %	39.2 %	▲
	Mortality rate from causes considered preventable		?	?	?
	Percentage in long term unemployment - % of working age population		?	?	?
	Under 75 mortality rate from cancer		?	?	?

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Ensuring good mental health and wellbeing at every age

Outcomes

Children, Young People and Adults are emotionally resilient	Children, Young People and Adults with poor mental health recover quickly	People with poor mental health live as healthy and for as long as those with good mental health

Cross Cutting:
Reducing inequalities by tackling the wider determinants
Prevention and Early Intervention
Acting upon patient and customer experience
Safeguarding and ensuring high quality integrated services

There are estimated to be around 4,000 children and young people affected by a mental health problem and around 26,000 adults with a common mental health condition, affecting one in four people over their lifetime.

Draft

Proposed indicators:

- Proportion of people that enter treatment against the level of need in the general population (target 15%)
- CAMHs waiting for intervention for more than 18 weeks
- Admissions for mental health 0-17 years
- Admissions for self-harm 10-24 years
- Emotional wellbeing of looked after children
- Recovery rates for those completing psychological therapies
- Premature mortality (<75 years) in adults with serious mental illness
- Proportion of adults in contact with secondary mental health services in paid employment

Other indicators to consider:

- Self reported wellbeing (age 16+ with low score)
- Adults in contact with secondary mental health services in paid employment
- Adults in contact with secondary mental health services living independently, with or without support
- Mortality from suicide and injury undetermined
- People with mental health issues receiving IBA/ESA
- Excess under 75 mortality rate in adults with serious mental illness
- Social care mental health clients receiving services during the year
- New social care assessments per year for mental health clients aged 18-64
- Emergency hospital admissions for intentional self harm
- People with a mental illness in residential or nursing care (aged 18-64)
- People in contact with mental health services

		Latest Data	Latest Data	Target	Current Status
	Proportion of people that enter treatment against the level of need in the general population		?	15.0 %	?
	CAMHs waiting for intervention for more than 18 weeks		?	?	?
	Admissions for mental health 0-17 years		?	?	?
	Admissions for self-harm 10-24 years		?	?	?
	Emotional wellbeing of looked after children		?	?	?
	Recovery rates for those completing psychological therapies		?	?	?
	Premature mortality (<75 years) in adults with serious mental illness		?	?	?
	Proportion of adults in contact with secondary mental health services in paid employment		?	13.2 %	?
	Self reported wellbeing (age 16+ with low score)		?	?	?
	Adults in contact with secondary mental health services in paid employment		?	?	?
	Adults in contact with secondary mental health services living independently, with or without suppor		?	?	?
	Mortality from suicide and injury undetermined		?	?	?
	Excess under 75 mortality rate in adults with serious mental illness		?	?	?
	Social care mental health clients receiving services during the year		?	?	?
	New social care assessments per year for mental health clients aged 18-64		?	?	?
	Emergency hospital admissions for intentional self harm		?	?	?
	People with a mental illness in residential or nursing care (aged 18-64)		?	?	?
	People in contact with mental health services		?	?	?

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Improving outcomes for Frail Older People

Outcomes

Older People stay well at home longer	Older people with dementia and their carers feel supported to manage their dementia

Cross Cutting:
Reducing inequalities by tackling the wider determinants
Prevention and Early Intervention
Acting upon patient and customer experience
Safeguarding and ensuring high quality integrated services

There are around 20,000 people aged 75 years and above in Central Bedfordshire and approximately 1,500 are known to have dementia, thought to represent about 68% of the total number of people affected.

Draft

Proposed indicators:

- Total non-elective admissions in to hospital (general & acute)
- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Rate of emergency admissions for injuries due to falls in persons aged 65+
- Dementia diagnosis rate (all ages)
- Adult carers who have as much contact as they would like
- Delayed transfers of care from hospital, and those which are attributable to adult social care

Other indicators to consider:

- Older people (65+) supported by adult social care throughout the year
- The proportion of older people offered reablement services following discharge from hospital
- Number of customers supported within the community (currently by the village care schemes
- Number of volunteers engaged within the community (currently by the village care scheme)

		Latest Data	Latest Data	Target	Current Status
...	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	Mar 16	2,447.48	6,331.00	
...	Permanent admissions of older people (65+) to residential & nursing care homes	Feb 16	480.9	352.0	
...	Proportion of 65+ still at home 91 days after discharge from hospital	May 16	77.3	95.5	
...	Emergency hospital admissions due to falls (65+) per 100,000	Mar 15	2,016.00	?	
	Dementia diagnosis rate (all ages)		?	?	
	Adult carers who have as much contact as they would like		?	?	
	Delayed Transfers of Care cases (Social care per 100,000)		?	?	
	Older people (65+) supported by adult social care throughout the year		?	?	
	The proportion of older people offered reablement services following discharge from hospital		?	?	
...	Number of customers supported within the community (currently by the village care schemes)	Mar 16	703.00	915.00	
...	Number of volunteers engaged within the community (currently the village care schemes)	Mar 16	897.00	1,041.00	

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Transforming Care – Transformation Plan
Meeting Date:	27 July 2016
Responsible Officer(s)	Julie Ogley, Director of Social Care, Health & Housing Donna Derby, Director of Commissioning, Bedfordshire Clinical Commissioning Group
Presented by:	Julie Ogley, Director of Social Care, Health & Housing Donna Derby, Director of Commissioning, Bedfordshire Clinical Commissioning Group

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

1. Consider and approve the joint three year plan in principle as there will need to be an ability to flex the plans predicated on the outcome of the engagement work stream across the footprint during 2016/17; and

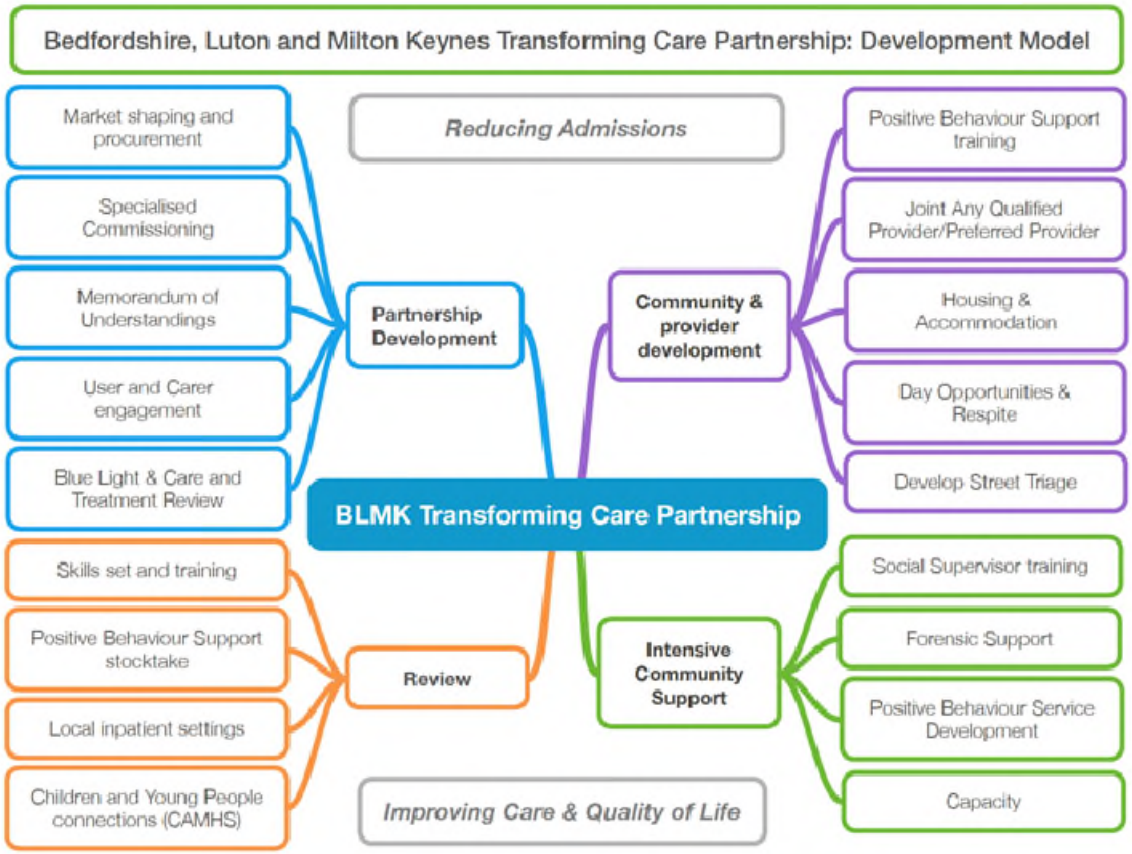
2. To note that this is a joint plan with Central Bedfordshire, Bedford Borough, Luton and Milton Keynes and therefore will be subject to approval and sign off through each of the organisational governance arrangements.

Purpose of Report	
1.	To update the Board on the development of the joint transformation plan across the footprint with Luton, Bedford Borough and Milton Keynes.
2.	For the Board to note the final submission of the transformation plan to NHS England on 11 April 2016.
3.	To inform the Board of the three year transformation plan for Transforming Care for children, young people and adults with learning disabilities and / or autism.
4.	To inform the Board of the three phases described within the transformation plan and to describe the vision of the Transforming Care Partnership (TCP).

Background	
5.	The 2012 investigation into criminal abuse at Winterbourne View Hospital initiated a national response known as “Transforming Care” to transform services for children, young people and adults with learning disabilities and/or autism who have mental health conditions or behaviours that are described as challenging.
6.	The purpose of this paper is to present the ‘joint transformation plan’ for Bedfordshire, Luton and Milton Keynes around Transforming Care. The plan was developed in partnership with the organisations identified within the new footprint area, this includes three Clinical Commissioning Groups (CCG) and four Local Authorities. The Senior Responsible Officer (SRO) is David Foord (Director of Quality & Clinical Governance) from Luton CCG.
7.	In October 2015 NHS England, the Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) published ‘building the right support’ and ‘a new service model’. Taken together these documents require Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England Specialised commissioners to come together to form Transforming Care Partnerships (TCPs).
8.	To achieve this systemic change, 49 Transforming Care Partnerships (TCP) (commissioning collaborations of CCGs, NHS England’s Specialised Commissioners and Local Authorities) were mobilised.
9.	The purpose of the TCP is to build up community capacity and reduce inpatient provision over the next three years for adults and children with a learning disability and/or autism who display behaviours that challenge, including behaviours that are attributable to a mental health condition.
10.	Bedfordshire forms part of a TCP which includes three CCGs (Milton Keynes, Luton and Bedfordshire) and four local authorities (Bedford Borough, Milton Keynes, Luton and Central Bedfordshire). The TCP was required to produce a joint three year transformation plan across the footprint, this plan was developed in partnership with the four local authorities and three CCG’s.
11.	NHS England described the allocation and set up of the footprint that would be responsible for developing the transformation plan for this area. This newly formed partnership developed the transformation plan that sets out and describes the high level principles that will be delivered over the next three years and that is broken down into three separate phases within the plan.
12.	The TCP was formed and produced the initial draft plans within a tight and challenging timescale. It should therefore be recognised that the principles described within the plan will need to be tested through local engagement with stakeholders and service users / family carers and there may be a requirement and ability to flex and amend the plans that will need to be agreed through the partnership. The engagement will commence in year 1 (2016/17).

13.	The final iteration of the transformation plan was submitted to NHS England on Monday 11 April 2016. The transformation plan is required to be signed off by the Health and Wellbeing Board no later than the 30 June 2016.
14.	During the development of the plan, Central Bedfordshire was represented on the local pan Bedfordshire Transforming Care steering group to ensure that the needs of the Central Bedfordshire population were considered and included within the three year plan. The pan Bedfordshire Transforming Care steering group includes colleagues from Bedford Borough Council, Central Bedfordshire Council and Bedfordshire CCG.
15.	The vision of the Transforming Care Partnership is to work with service users, their families and carers and other stakeholders to deliver a plan that: • reduces the numbers of in-patient admissions required for people with a learning disability and/or autism; • manages effective discharge and transition for people in hospital; and • builds resilient community capacity to support people to live as independently as possible in the most appropriate community setting.
16.	Transformation will mean redesigning services to enable them to meet a different range of complexity and individual need. Those in scope and who are likely to meet the definition and criteria for this area of work include children, young people and adults with a learning disability and / or autism who: ▪ Have a mental health condition such as severe anxiety, depression or a psychotic illness, and those people with personality disorders, which may result in them displaying behaviour that challenges. ▪ Display self-injurious or aggressive behaviour (not related to severe mental ill health), some of whom will have a specific neuro-developmental syndrome where there may be an increased likelihood of developing behaviour that challenges. ▪ Display risky behaviours which may put themselves or others at risk and which could lead to contact with the Criminal Justice System (this could include things like fire setting, abusive, aggressive or sexually inappropriate behaviour). ▪ Often have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance misuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the Criminal Justice System.
Central Bedfordshire data sets – Transforming Care	
17.	There are currently 3 Central Bedfordshire patients being supported within an inpatient setting and 4 patients being supported within a secure setting. In addition, there are currently 10 Central Bedfordshire residents placed in out of area specialist residential care homes or specialist educational placements predominately due to complex and challenging behaviours. The majority of this cohort of people were placed out of area as their needs could not be met locally.

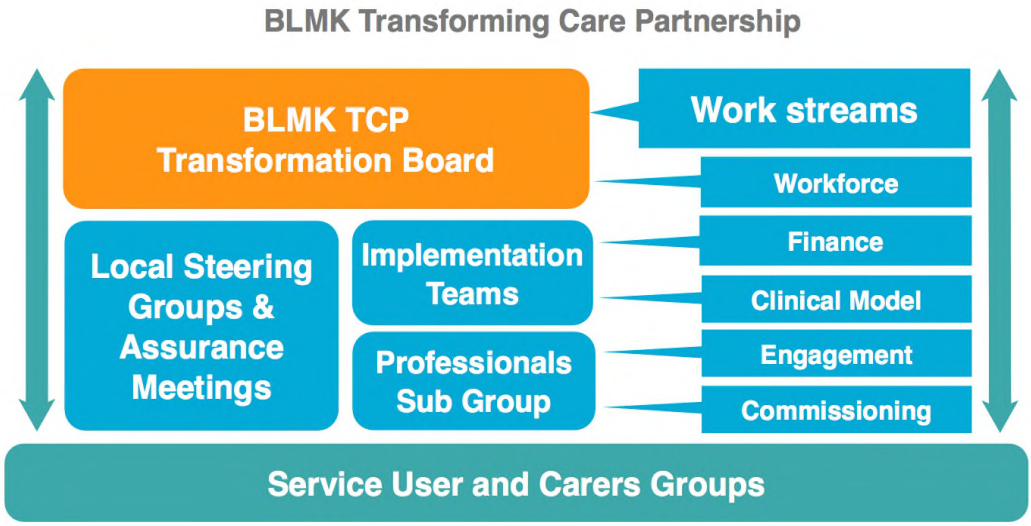
18.	There are 2 Central Bedfordshire young people approaching adulthood who are likely to meet the Transforming Care definition and are at risk of admission. This data was taken on 01.06.2016.
19.	It should be acknowledged that whilst these figures are low, the complexity and risk that these patients may and are likely to present with are significant and will require a specialist and highly skilled workforce / service to meet their needs in a community setting and to prevent admission back into hospital. These community packages of care are likely to be high cost placements that will reflect the specialism required to meet individual needs in the community.
20.	The plan describes the importance of tracking and understanding the presenting need of children and young people who are likely to be at risk of admission to enable commissioners to plan and commission services that are able to meet their needs locally and prevent admission into hospital or being placed out of area in large specialist residential / education placements often miles away from their family, friends and local care team.
National Model	
21.	The national model of care aims to: • change services for people with a learning disability and autism away from institutional models of care; • close inpatient provision; and • strengthen the support available to individuals in their local areas.
22.	National policy documents, *'Supporting People with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition' Oct 2015 and the national plan 'Building the Right Support' Oct 2015,* set out expectations to transform care. These expectations include a national service model based on the principles of reducing the numbers of in-patient admissions for people with a learning disability and/or autism, and building resilient community capacity to support people to live in the most appropriate community setting.
23.	The Bedfordshire, Milton Keynes and Luton Joint Transformation Plan has been based on these principles and includes the development and strengthening of service provision in the following areas: • Healthcare • Preventative Services • Advocacy • Carer support • Universal welfare • Education and training

	Service Model
24.	
25.	The plan has three key phases to deliver this model over the next three years, phase 1 (2016/17) is summarised as follows: **Phase 1 – 2016/17** ▪ Establish the foundations of a joint approach to transforming care; this will include establishing a formal agreement across the three Health Commissioning Authorities and four Local Authorities. The purpose of the agreement is to formalise a memorandum of understanding on how the areas will work together in a way that enhances services and improves the offer available. ▪ Development of a stakeholder engagement and communications strategy that will incorporate: o Further engagement with the two Autism Partnership Boards, four Learning Disability Partnership Boards and four Carers Partnership Boards to ensure that we are all working together on this agenda, and that we have appropriate representation at both reference group and Transforming Care Board.

	o A review of the approach as to how we are involving people and their family carers in the design and development of the local service model to ensure we have ways of including everyone which is meaningful. o Working with Children's services (including transitions) to establish how this piece of work should be led, and how the partnership will work together towards the all age approach that is required. o A joint approach will include sharing systems for working and commissioning providers, such as a joint Preferred Providers List (PPL) / Any Qualified Provider (AQP). The partnership will jointly scope the market position and the viability of an enhanced supported living scheme across the footprint for those aged 16-25 years. This scoping will include Continuing Health Care (CHC), out of area placements including those people who have behaviour described as challenging. o Further work on identifying the number of current and future patients likely to require forensic support. The formulation of a TCP footprint approach to this group also provides wider opportunities to understand and enhance day opportunities and respite for at risk groups. o Development of a cross-needs housing strategy for vulnerable adults considering Adult Social Care and Health and including those with a learning disability and/or autism who may present with behaviour described as challenging. o During this phase the partnership will implement a process to share information, intelligence and quality data on the various providers of support and hospital admissions. o Robustly work on the data to ensure its validity and aid accurate and effective planning for Phase 2 and 3 to inform any regional commissioning outside of this partnership. o The partnership will look to extend the scope of the PPL/AQP to include social care across the TCP footprint.
26.	**Phase 2 – 2017/18** ▪ The partnership will understand, plan and cost a community based forensic solution focused on reducing the offending and reoffending rate of people with a learning disability and / or autism. ▪ The partnership will scope out the unmet needs of individuals who have autism but not a significant learning disability to map out gaps in service provision and how the care pathway can be improved for this cohort.

	▪ The partnership will scope out the factors leading to 52-week out of area placements for children and young people under 18, and start to map out how the care pathway and models of support can be improved for this cohort. ▪ The partnership will model the TCP footprint inpatient requirement assuming a reduction in out of area placements of 75%. ➢ building up our community services - more providers providing better quality support accommodation ➢ up skilling of our community workforce – preventing admission / reducing potential for people to escalate to a crisis situation ➢ more robust service specification and monitoring of providers ➢ increased provision of respite services ➢ Improved transition plans for people returning to area.
27.	**Phase 3 – 2018/19** ▪ The partnership will aim to build the capacity and capability of the market for community services, potentially commissioning a TCP forensic service working together across the footprint if appropriate. ▪ The partnership will jointly provide an inpatient learning disability /autism solution across the TCP footprint, with a reduction in the average length of stay. Delivering a service model across the footprint that draws on a shared understanding of positive behavioural support, an emphasis on support being provided where the patient is, and available 24 hours a day seven days a week. ▪ The partnership will start to explore an “all age integrated” approach for care, support and financial planning for the cohorts covered in this plan Governance.
28.	In reducing the inpatient capacity there will need to be an increase in community provision that provides person centred support and services to people and their carers that achieves the following: • improved quality of life; • services that support people to take positive risks whilst ensuring that they are protected from potential harm; • choice and control - working with people in their decisions about their health and care services decision must be made in their best interests involving them as much as possible and those who know them well; • support and interventions provided in the least restrictive manner; and • equitable outcomes, comparable with the general population, by addressing the determinants of health inequalities outlined in the Health Equalities Framework.

	Governance Structure
29.	The work of the Bedfordshire, Luton and Milton Keynes Transforming Care Partnership is overseen by a joint transformation board. The governance structure for the delivery of the plan is shown below -



Resource Implications	
30.	The Transformation Plan requires the partnership to complete a finance and activity schedule for each area across both the health and social care arena. NHS England have confirmed that there will be monies available for both transformation and capital for partnerships to bid for over the next three years. There is an expectation that any successful bids will be match funded by the local commissioning teams. The risk around the financial position for the local authorities and CCG's has been flagged at the TCP board and with NHS England.
31.	The transformation plan is a three year plan and will require dedicated resource across both children and adults services through the health and social care arena.
32.	NHS England congratulated the partnership in pulling together a robust plan within challenging timescales and asked the partnership if the BLMK plan could be shared as good practice to support other areas in developing their plans.
Environmental Implications	
33.	The Transforming Care transformation plan will link in with the accommodation consultation within Central Bedfordshire Council to ensure that the principles and needs of the local population are recognised within both areas of work and to ensure that the interface is clear.

34.	One consideration for the TCP is whether the partnership would consider that local people placed within the geographical footprint for BLMK would be considered as being placed in area, whether this would be in a person's own home or a supported living scheme.
35.	This could offer benefits around economies of scale and may create an appetite among good high quality community providers to invest in the local area. This will be developed as part of the engagement plan with the market through 2016/17.
Patient/Service user experience	
36.	The implementation team, which comprises local commissioners, has been instrumental in putting together the transformation plan. It has based the key principles and proposed model of service on relevant engagement with stakeholders, review and analysis of national and local strategy and an evaluation of current provision, unmet need and the current market.
37.	The local Learning Disability Partnership Boards and Autism Partnership Boards will be kept informed and where appropriate involved in the development of this plan over the next three years.
38.	The TCP has identified patients with lived experience of transforming care and has started to work with them on how best to engage those in the process that is meaningful and person centred to the individual.
39.	Luton CCG are leading on developing a Communication Strategy for the partnership that will describe the engagement work that is being rolled out both locally and across the wider partnership throughout 2016 / 17.
40.	The pan Bedfordshire Transforming Care steering group discussed the engagement approach for the local population within Central Bedfordshire and describing the challenges with engaging the people who do not necessarily attend board meetings or voice groups. A plan was compiled as to how the local voice would be heard and encouraged to speak up about what is important for young people and adults who are either at risk of admission, in hospital or who have recently been discharged from hospital. It is vital that the voice of the carer and family members are also captured during this process.
41.	The engagement work stream will continue to run through 2016 / 17 and will include key stakeholders, service users, family carers, providers and community teams.

	Financial Summary
42.	The Transforming Care Partnership submitted a finance and activity template with the transformation plan to NHS England detailing the current spend across the health and social care arena for those meeting the criteria. A three year trajectory of activity and spend was identified taking into account the anticipated discharges from inpatient units into community placements. The care pathway for those patients currently detained in hospital or secure settings is not known at this time so a high level approach was taken to produce this anticipated trajectory.
43.	A financial risk has been identified and escalated to the board in relation to the patients currently detained in secure services. There are currently 4 Central Bedfordshire known patients detained in secure settings. When these patients are discharged, depending on their care pathway and assessed need, these are likely to be high cost placements and the money does not currently move with the patient from NHS England. Therefore these patients are being tracked by Bedfordshire CCG as to the likely and anticipated timescales and appropriate placements for discharge, to enable the commissioning authorities to monitor and plan for commissioning services that are high quality and cost effective.
44.	The concept of a dowry payment is focused on providing financial support for social care costs for eligible dowry patients (five years continuous in patient). Dowry funding will be assessed only at the point of discharge and will be agreed locally through the TCP. A dowry will only apply to those patients discharged on or after 1st April 2016 and will only be considered for those patients who have been in inpatient care for five years or more on 1st April 2016. The concept around the dowry payment needs to be discussed locally through the partnership and local arrangements need to be agreed.
45.	The transformation and capital bid monies available over the next three years need to be considered and scoped carefully as the funding will not be recurrent and therefore the schemes need to reflect that the partnership has considered this and the need to ensure that the schemes are sustainable following the three year plan.
	Conclusion
46.	The partnership has developed an ambitious three year transformation plan which aims to further progress the personalisation agenda providing local people with a learning disability and / or autism with high quality individualised support in the community and enable them to live ordinary lives and to reach their full potential.
47.	The partnership will develop the market place, build on existing good practice, continue to advance preventative support and build sustainable person centred solutions. It will also ensure that individuals have access to effective clinical support at time of crisis and acute mental ill health.

48.	The partnership expects to move towards a seamless pathway that will ensure a smooth transition for those preparing for adulthood that provides local solutions for people that not only reduce the reliance on inpatient care but enable people to live and receive support closer to home.
49.	The Transforming Care Partnership will carefully monitor and review the progress of the plan to ensure that the partnership is making progress and delivering successful health and wellbeing outcomes for the individuals covered in the plan.

Reasons for the Action Proposed	
50.	The Health and Wellbeing Board (HWB) has a statutory duty to promote integration and is seen as a valuable forum for stakeholders to come together to review performance of the transformation plan. The expectation is that HWBs will continue to oversee the strategic direction of the plan and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners.
51.	NHS England guidance requires Transforming Care Partnerships to submit their plans to the Health and Wellbeing Boards no later than 30.06.2016. It is required that the plans are signed off by the relevant board members before NHS England are able to feedback the position in relation to the transformation plan and subsequent bids that have been submitted with the plan.
	Next steps
52.	• Continue to develop the BLMK Communication Strategy • Implement the phase 1 (2016 / 17) engagement work stream across Bedfordshire • Implement a programme framework for delivery of phase 2 & 3 that aligns with other key programmes across health and social care

Issues	
Governance & Delivery	
53.	Within the plan the Transforming Care Partnership was asked to complete a trajectory of the number of inpatient beds required for the footprint, demonstrating a reduction in bed usage and in line with the national recommendation per one million GP population. The partnership has completed this piece of work and this was submitted with the plan. However it has been recognised that Bedfordshire are currently tracking 7 patients (4 out of the 7 are Central Bedfordshire patients) who are placed in secure services commissioned through the Specialist Commissioning Group, both in and out of area and who present with complex and risky behaviours.

	Predicated on when these patients are stepped down through their care pathway, they are likely to require a lengthy period in locked rehabilitation and therefore would need to form part of the bed allocation for the footprint. There is a risk that the partnership will not work within the bed allocation for the footprint because when the patients are stepped down from secure they are likely to remain in inpatient provision for longer periods of time before consideration can be given to progress people further and into community placements, resulting in the bed usage for Bedfordshire being higher than reported in the plan. This risk has been raised and discussed at the TCP board with NHS England. The financial impact has also been flagged with the Executive team in the CCG as the money will not be moving with these patients and therefore the CCG will inherit these high cost placements as they step down into locked rehabilitation provision.
Financial	
54.	Whilst a commitment in principle has been made in the plan, the financial position for the Local Authorities and Clinical Commissioning Group remains challenging and therefore over the course of the 3 years the position could change predicated on the financial landscape going forward. It was felt important to highlight this from the beginning as this could impact on the plan over the course of the next three years which could result in a change of the proposed model.
Public Sector Equality Duty (PSED)	
55.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between and in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
	Are there any risks issues relating Public Sector Equality Duty **No**
56.	Luton is the lead organisation for the Transforming Care Partnership and the transformation plan has been through their equality and diversity process which has been signed off and agreed by Bedfordshire CCG equality lead. It is anticipated that when the transformation plan develops into individual projects, that these will need to go through the local equality and diversity assurance process within Bedfordshire CCG and Central Bedfordshire Council.

57.	The cohort of people affected by the implementation of the service model will include: • Those currently living in the community, supporting them to lead independent lives including crisis prevention and management; • Those currently in in-patient and secure settings; and • Those in residential placements out of area who are able to be successfully transition back to their local community

Source Documents	**Location (including url where possible)**
Transforming Care transformation plan	Appendix 1

_____

Presented by Julie Ogley, Director of Social Care, Health & Housing
Donna Derby, Director of Commissioning, Bedfordshire Clinical Commissioning Group

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Joint transformation planning template

Introduction

- **Purpose**

This document provides the template and key guidance notes for the completion of local plans aimed at transforming services for people of all ages with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, in line with *Building the Right Support – a national plan to develop community services and close inpatient facilities* (NHS England, LGA, ADASS, 2015). These plans should cover 2016/17, 2017/18 and 2018/19.

- **Aims of the plan**

Plans should demonstrate how areas plan to fully implement the national service model by March 2019 and close inpatient beds, starting with the national planning assumptions set out in *Building the Right Support.* These planning assumptions are that no area should need more inpatient capacity than is necessary at any one time to cater to[1]:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

These planning assumptions are exactly what the term implies – assumptions for local commissioners to use as they enter into a detailed process of planning. Local planning needs to be creative and ambitious based on a strong understanding of the needs and aspirations of people with a learning disability and/or autism, their families and carers, and on expert advice from clinicians, providers and others. In some local areas, use of beds will be lower than these planning assumptions, but areas are still encouraged to see if they can go still further in supporting people out of hospital settings above and beyond these initial planning assumptions.

- **National principles**

Transforming care partnerships should tailor their plans to the local system's health and care needs and as such individual plans may vary given provider landscape, demographics and the system-wide health and social care context.

[1]The rates per population will be based on GP registered population aged 18 and over as at 2014/15

However local plans should be consistent with the following principles and actively seek to evidence and reinforce these:

a. **Plans should be consistent** with **Building the right support** and the **national service model** developed by NHS England, the LGA and ADASS, published on Friday 30th October 2015.

b. **This is about a shift in power.** People with a learning disability and/or autism are citizens with rights, who should expect to lead active lives in the community and live in their own homes just as other citizens expect to. We need to build the right community based services to support them to lead those lives, thereby enabling us to close all but the essential inpatient provision.

   To do this people with a learning disability and/or autism and their families/carers should be supported to co-produce transformation plans, and plans should give people more choice as well as control over their own health and care services. An important part of this, is through the expansion of personal budgets, personal health budgets and integrated budgets

c. **Strong stakeholder engagement:** providers of all types (inpatient and community-based; public, private and voluntary sector) should be involved in the development of the plan, and there should be one coherent plan across both providers and commissioners. Stakeholders beyond health and social care should be engaged in the process (e.g. public protection unit, probation, education, housing) including people with direct experience of using inpatient services.

Summary of the planning template

The Bedfordshire, Luton & Milton Keynes Transforming Care Partnership:

Plan for transforming the care of children and adults with a learning disability and/or autism who display challenging behaviour

Executive Summary

Quote from service user following repatriation after a 2-year period in hospital out of area

"I have a lot more freedom here, as now I have left hospital I'm doing a lot of things myself, and I don't need a lot of help from anybody really"

"In the past I needed a lot of support, I'm pretty independent now"

The vision of this partnership is that we will work with service users, their families and carers and other stakeholders to deliver a plan that

- reduces the numbers of in-patient admissions required for people with a learning disability and/or autism
- manages effective discharge and transition for people in hospital
- builds resilient community services to support people to live as independently as possible in the most appropriate community setting.

1. Introduction

The 2012 investigation into criminal abuse at Winterbourne View Hospital initiated a national response known as "Transforming Care" to transform services for people with learning disabilities and/or autism who have mental health conditions or behaviours that are challenging. This national model of care aims to

- change services for people with a learning disability and autism away from institutional models of care
- close some inpatient provision
- strengthen the support available to individuals in their local areas.

To achieve this systemic change, 49 transforming care partnerships (commissioning collaborations of CCGs, NHS England's specialised commissioners and local authorities) are mobilising now. They will work with people who have lived experience of these services, their families and carers, as well as key stakeholders to agree robust implementation plans by April 2016 and then deliver on them over three years.

Throughout this summary and the attached plan, the term 'people' will refer to children and adults with learning disability and/or autism and challenging behaviours, including those with a mental health condition.

2. Context

2.1 National

Following the publication of the Department of Health's report 'Transforming Care: A national response to Winterbourne View Hospital' in December 2012, a significant amount of work has been undertaken to make improvements in the care and services available for children and adults with learning disabilities and/or autism spectrum disorders.

However, subsequent reports including 'Transforming Care for People with Learning Disabilities – Next Steps' in January 2015 recognised more needs to be done. Simon Stevens, Chief Executive of NHS England, identified in June 2015: "We need a closure programme for long stay institutions, with more power in the hands of families."

Further national policy documents, 'Supporting People with a Learning Disability and/or autism who display behaviour that challenges, including those with a mental health condition' Oct 2015 and the national plan 'Building the Right Support' Oct 2015, set out expectations to transform care.

Transforming Care relates to the transformation of services for people with a learning disability and/or autism and challenging behaviours, including those with a mental health condition. The programme of work is designed to strengthen community services, reduce reliance on in-patient beds (non-secure, low and medium secure) and close some in-patient facilities.

NHS England (NHSE) has asked Local Authorities, Clinical Commissioning Groups (CCGs) and NHSE specialised commissioners to come together to form Transforming Care Partnerships (TCPs) to build up community services and close unnecessary inpatient provisions over the next 3 years and by March 2019. TCPs should allow for areas to commission at sufficient scale to manage risk, develop commissioning expertise and commission strategically for the relatively small number of individuals whose packages of care can be very expensive.

2.2 Local

The Bedfordshire, Luton and Milton Keynes (BLMK) Transforming Care Partnership (TCP) is a newly formed arrangement set up to transform care for people with a learning disability and/or autism across Bedfordshire, Luton and Milton Keynes. It covers four local authorities and three Clinical Commissioning Groups (CCG) in central eastern England.

Two of the local authorities in the partnership area have coterminous CCGs' (Luton and Milton Keynes). Bedford Borough and Central Bedfordshire are served by Bedfordshire CCG.

In line with NHSE requirements BLMK TCP has been required to produce a joint transformation plan for the next three years (this document.) On the 22nd March NHSE awarded this plan the status of "met" and the BLMK TCP has worked on final enhancements in preparation for the final submission on the 11th April prior to formal approval and sign off through partners' governance arrangements. Work is now beginning on mobilisation of the plan.

Across the partnership all three CCG areas have patients placed in secure inpatient settings that are either funded by the CCGs or via specialist commissioning, funded via NHS

England. In addition, there are a range of independent, voluntary and statutory sector providers that provide community support, supported living, residential care and education to people with a learning disability and /or autism. Much of this care and support is spot purchased or provided through small block contacts by the individual CCG's and councils across the partnership area and more widely across the country when need cannot be met locally.

The numbers of in-patients across this partnership are relatively low compared to other areas in eastern and central England. At the end of January 2016 there were 32 people in an in-patient environment (this includes those funded by the CCGs and by specialised commissioning)

Across the area there is a strong commitment to improve health and wellbeing outcomes for people with a learning disability and/or autism. This Transforming Care Partnership is aligned to the developing Sustainability and Transformation Planning footprint for Bedfordshire, Luton and Milton Keynes; reflecting the strategic goals of all partner organisations. The aims and approach of this plan through the Transforming Care Partnership will also be incorporated into the Sustainability and Transformation Plan as it emerges in June 2016.

3. The Solution

The guidance documents from NHSE set out the expectations of the Transforming Care programme. These expectations include the implementation of a national service model.

The proposed BLMK solution has been articulated in the attached submission, the key elements of which are based on the national service model principles of

- reducing the numbers of in-patient admissions required for people with a learning disability and/or autism
- managing effective discharge and transition for people in hospital
- building resilient community services to support people to live as independently as possible in the most appropriate community setting.

In reducing the inpatient capacity there will need to be an increase in community provision that provides person centred support and services to people and their carers that achieve

- improved quality of life
- services that support people to take positive risks whilst ensuring that they are protected from potential harm
- choice and control - working with people in their decisions about their health and care services decision must be made in their best interests involving them as much as possible and those who know them well
- support and interventions provided in the least restrictive manner
- equitable outcomes, comparable with the general population, by addressing the determinants of health inequalities outlined in the Health Equalities Framework.

The cohort of people affected by the implementation of the service model will include

- those currently living in the community, supporting them to lead independent lives including crisis prevention and management
- those currently in in-patient and residential placements out of area who are able to be successfully transitioned back to the community.

The plans include the development and/or strengthening of service provision in the areas of

- Healthcare
- Social Care
- Preventative Services
- Advocacy
- Carer support
- Universal welfare
- Education and training

4. Conclusion and recommendations

The partnership has developed an ambitious three-year transformation plan which aims to further progress the personalisation agenda providing local people with a learning disability and / or autism with high quality individualised support in the community and enable to them to live ordinary lives and meet their full potential. The Partnership will develop the care market, build on existing good practice, continue to advance preventative support and build sustainable person centred solutions. It will also ensure that individuals have access to effective clinical support at time of crisis and acute mental ill health.

The partnership expects to move towards a seamless “all age” pathway that provides local solutions for people that not only reduce the reliance on inpatient care but enable people to live and receive support closer to home. The Transforming Care Board will carefully monitor and review the progress of the plan to ensure that the partnership is making progress and delivering successful health and wellbeing outcomes for the individuals covered in the plan

Bedfordshire, Luton and Milton Keynes Planning template

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

Background

In 2012, following an investigation into criminal abuse at Winterbourne View Hospital, the Department of Health initiated a national response known as “Transforming Care” to transform services for people with learning disabilities and/or autism who have mental health conditions or behaviours that are challenging. Transforming care aims to change services for people with a learning disability and autism away from institutional models of care, closing some inpatient provision and strengthening the support available to individuals in their local areas.

The Bedfordshire, Luton and Milton Keynes (BLMK) Transforming Care Partnership

The BLMK Transforming Care Partnership (TCP) is a newly formed arrangement set up to transform care for people with a learning disability and/or autism across Bedfordshire, Luton and Milton Keynes. It covers four unitary local authorities and three Clinical Commissioning Groups (CCG) in central eastern England.

Chart 1.01 Map showing Bedfordshire, Luton and Milton Keynes CCG Boundaries – area covered by the Bedfordshire, Luton and Milton Keynes (BLMK) Transforming Care Partnership. Source: https://www.england.nhs.uk/resources/ccg-maps/

Two of the local authorities in the partnership area have coterminous CCGs' (Luton and Milton Keynes). Bedford Borough and Central Bedfordshire are served by Bedfordshire CCG.

Bedfordshire and Luton CCGs contract with East London Foundation Trust (ELFT) for learning disability and mental health services. Specialist Learning Disability Community Services (SPLD) are shared across Bedfordshire and Luton (including learning disability inpatient beds). Milton Keynes CCG commissions Central North West London Foundation Trust (CNWL) to provide Mental Health and Learning Disability Services. There is no collaborative commissioning between Milton Keynes CCG, Bedfordshire and Luton CCGs at the present time. The TCP is a newly formed partnership between the four Local Authority areas, predicated on this new arrangement, relationships between the different organisations and directorates will need to be formed and built upon particularly at this initial planning phase. The importance of getting this right from the start has been identified and described throughout the plan.

Table 1.01 Local Authority, CCG and Key Mental Health and Learning Disability Providers across the BLMK TCP Area.

CCG	Local Authority	Mental Health and Learning Disability Provider
Bedfordshire	Bedford Borough	East London Foundation Trust (ELFT)
	Central Bedfordshire	
Luton	Luton Borough	
Milton Keynes	Milton Keynes	Central North West London Foundation Trust (CNWL)

All three CCG areas have patients placed in secure inpatient settings commissioned though specialist commissioning and funded via NHS England. In addition, there are a range of independent, voluntary and statutory sector providers that provide community support, supported living, residential care and education to people with a learning disability and /or autism. There are also a small number of placements in independent hospitals. Much of this care and support is spot purchased or provided through small block contacts by the individual CCG's across the partnership area and more widely across the country when need cannot be met locally.

Partners work with many independent and voluntary sector providers often on a spot purchase basis and some of these are: Turning Point, Care Services (MK) CIC, MacIntyre, Dimensions, Philori Care, Consensus Support and Social Care Solutions (provide residential care and community support); POWHER and Talkback provides advocacy and engagement support.

Healthwatch is the independent consumer champion for local health and social care services – public engagement – including children and young people. Members from Healthwatch sit on local partnership boards, health and wellbeing boards and programme boards.

Across the area there is a strong commitment to improve health and wellbeing outcomes for people with a learning disability and/or autism. This Transforming Care Partnership is aligned to the developing Sustainability and Transformation Planning footprint for Bedfordshire, Luton and Milton Keynes; reflecting the strategic goals of all partner organisations. The aims and approach of this plan through the Transforming Care Partnership will also be incorporated into the Sustainability and Transformation Plan as it emerges in June 2016.

Describe governance arrangements for this transformation programme

The work of the BLMK Transforming Care Partnership is overseen and governed by a Programme Board. A robust governance structure is being implemented; this is overseeing the development of the plan and will oversee its delivery.

As mentioned earlier the partnership encompasses three CCGs and four unitary local authorities all of which are represented on the programme board in addition to other partners and stakeholders.

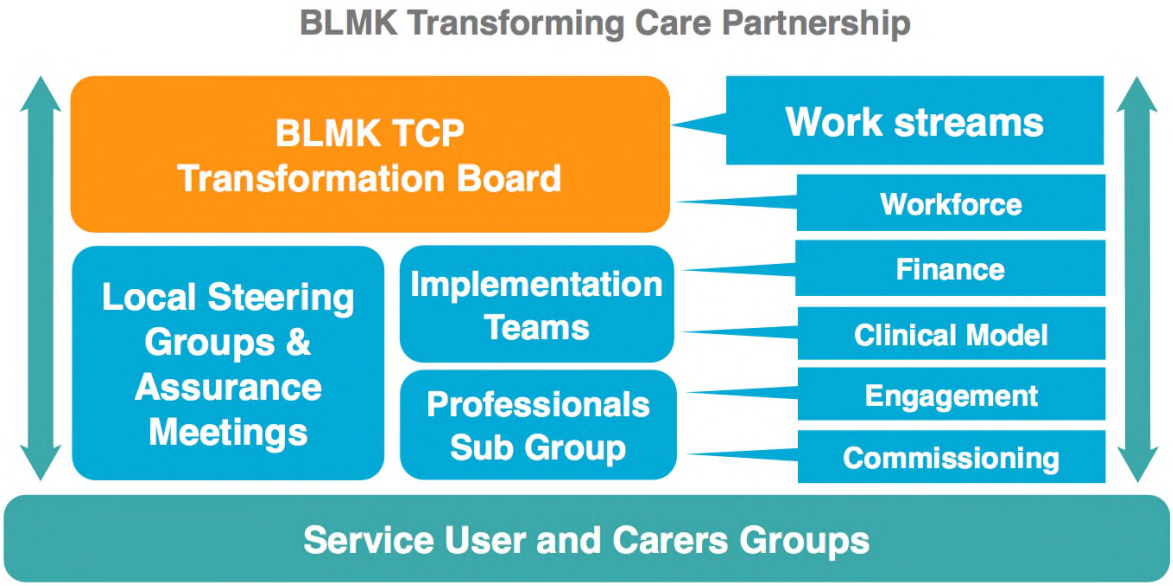
The current membership of the programme board is set out below and the terms of reference are included in the appendices to this plan. Further information about the names of the members of the Professionals subgroup and the service users and carers' groups can be made available.

Table 1.02 Transforming Care Partnership Board Membership

Organisation/Role	**Person and Job Title**
Luton CCG and **Senior Responsible Officer (SRO)**	David Foord (Director of Quality and Clinical Governance), Liz Cox (Deputy Chief Financial Officer)
Bedfordshire CCG	Anne Murray (Director of Nursing and Quality) Kaysie Conroy (Head of Mental Health and Learning Disability)
Milton Keynes CCG	Jill Wilkinson (Director of Nursing and Quality) David Pennington (Safeguarding Adults; Mental Health and Learning Disability Lead) Andrew Law (Senior Finance Manager)
Luton Borough Council	Pam Garraway (Director of Adult Social Care) Maud O'Leary (Service Director Adult Social Care) Bridget Moffat (Joint Commissioner Manager leading on Learning Disabilities) Vacant post (Learning Disabilities and Autism Service Manager) Lisa Levy (Communications Manager)
Milton Keynes Council	Michael Bracey (Corporate Director People) Mary Clifton (Director of Adult Social Care) Robin Goold (Joint Commissioner Milton Keynes CCG & Council) Amanda Griffiths (Head of Joint Learning Disability Services)
Bedford Borough Council and **Deputy SRO**	Kevin Crompton (Director of Children and Adult Services) Kate Walker (Assistant Director Adult Social Care)
Central Bedfordshire Council	Julie Ogley (Director of Adult Social Care) Stuart Mitchelmore (Assistant Director of Social Care) Nikki Kynoch (Head of Integrated Services Adult Social Care)
NHS England	Charmaine Cleaver (Specialised Commissioning East of England Transforming Care Lead) Transforming Care Lead Midland and East partnership NHS England Nerea Uriarte (Transforming Care Case Manager Regional Specialised Commissioning NHS England – Midlands and East (East of England)) Jenny Butler (Transforming Care Lead)

A graphical representation of the programme structure is shown in chart 1.02 below.

Chart 1.02 Bedfordshire, Luton and Milton Keynes Transforming Care Partnership Programme Structure



This programme will report into the BLMK TCP Transformation Board which in turn reports into the Joint Commissioning Boards, Change Programme Boards, Patient Safety and Quality Committee's and the Health and Wellbeing Boards for each area. Additionally, there will be highlight reporting to the Transforming Care programme team for NHS England. This will initially be on a monthly basis. The programme sits within the overall governance structure as illustrated in chart 1.03 below.

The sign off time frames for the plan are as detailed in table 1.03 below.

Table 1.03 Sign off time table for the Bedfordshire, Luton and Milton Keynes Transforming Care Partnership plan

Governing Body/Group	When	Comment	RAG for 30/06/2016
Bedford Health & Wellbeing Board	15/06/2016	On agenda.	ON TARGET
Central Bedfordshire Health & Wellbeing Board	By 30/06/2016	Virtual sign off by board in advance of next meeting 27/07/2016.	ON TARGET
Luton Health & Wellbeing Board	07/06/2016	On agenda. Date of board is provisional, but expected to go ahead.	ON TARGET
Milton Keynes Health & Wellbeing Board	09/03/2016	Sign off delegated to the chair of the H&WB Board. Signed off by Cllr Peter Marler, Leader Milton Keynes Council. COMPLETED.	COMPLETE

Note: RAG = Red/Amber/Green rating. Green on target or complete. Amber at risk of being

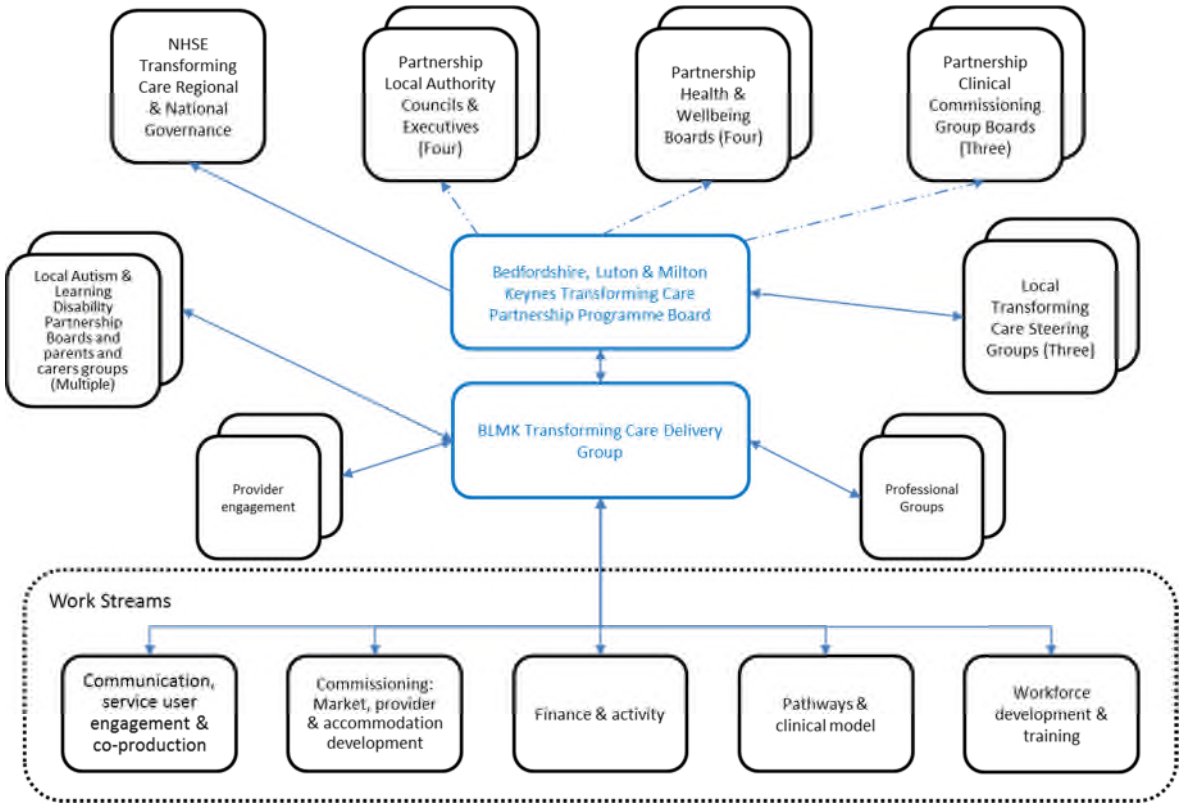
missed. Red will be missed.

Luton CCG is the lead authority for the Transforming Care Partnership. Our Senior Responsible Officer (SRO) is David Foord (Director of Quality and Clinical Governance, Luton CCG. Our deputy SRO is Kevin Crompton (director of Children and Adult Services Bedford Borough).

Additional assignments include:

- Programme Manager (reporting into the board) – Andrée Mitchell (Interim).
- Finance Lead – Liz Cox (Deputy Head of Finance, Luton CCG)
- Communications Lead – Lisa Levy (Communications Manager, Luton Borough Council)

Chart 1.03 Bedfordshire, Luton and Milton Keynes Transforming Care Partnership Board Governance Structure



Describe stakeholder engagement arrangements

The TCP programme board held its first meeting on 20th January 2016 and is now meeting monthly having published meeting dates for the following six months.

The implementation team, which comprises local commissioners, has been instrumental in putting together the BLMK Transforming Care draft plan. It has based the key principles and proposed model of service on relevant consultation with stakeholders, review and analysis of national and local strategy and an evaluation of current provision, unmet need, and the

current market.

Note: When any data or description is referred to as "current" throughout this draft plan this relates to the situation as of 11th April 2016.

The partnership has been, and continues to consult fully on this plan involving all relevant stakeholders that include:

- Service users of all ages, families and carers
- Providers
- Health care professionals
- Police
- NHS England Team for Learning Disabilities (including Court Liaison and Diversion)

There is agreement in principle for a provider to support coproduction and consultation and this element is further described in the bid within this plan. In addition to this the partnership is utilising provider representation provided through the NHS-England Transforming Care programme. The NHS Service users and carers will be supported to work with the TCP in relation to the development of the transformation plans going forward.

The local Learning Disability and Autism Partnership Boards within each of the Local Authority areas will contribute to the local Transforming Care plans and the draft plans have already been discussed at a number of board meetings.

The TCP has identified patients with a lived experience of transforming care and has started working with them on how best to engage them in this process in a meaningful patient centred way. We have been using our community services and voluntary sector self-advocacy experts to assist us with this.

- Talkback is a user-led engagement and self-advocacy group which works with the partnership and has been asked to work with us to support people with learning disabilities and/or autism and their carers to be involved in the Transforming care Partnership; to ensure that the authentic voices of people with those conditions and their carers are heard at every stage of planning and implementation.

- Service users are engaged within their own locality partnership boards where the plans are being discussed on an ongoing basis, for example transforming care has been raised in the Autism MK Partnership board in January and is agenda for the 18th April, and has been discussed at the last three monthly learning disability partnership boards.

- Joe has a lived experience of being in hospital and being supported to return to the community. Joe attends the steering group in Milton Keynes as an expert by experience. The BLMK wide plan has been shared with Joe and he has been able to contribute to discussions through his lived experiences. He will continue to attend the meetings in the immediate future as well as being supported with one to one discussions with commissioners across the partnership where appropriate. Joe has raised a number of issues and two particular issues, which are of importance to him:
  - How do we effectively share the information about the plans across the partnership area?
    - *We will develop a communications strategy and plan for the programme which will detail the ways in which we will:*
      - *Share information with our service users through a number of engagement events. These will be ongoing across the three years of*

the programme
- *Consult with the people who use services and work together with them from the start to the end of the programme*

- How do we ensure providers involve service users in the recruitment of staff?
  - *Commissioners will specify this as a requirement in the revised specifications for our community providers*

- In June 2015 a provider awareness and engagement event was held across by the partnership. This was to give an overview of the transforming care needs in the area. This event was well attended by care and housing providers and has generated a lot of interest across the care market.

- Commissioners within the partnership area are actively engaged in informal discussions with current and potential providers. This includes providers with a particular interest in the area of transition from children to adulthood; including the provision of intensive supported living services.

One of the identified work-streams in the diagram in the section above is engagement and managing and delivering the right stakeholder engagement will be a critical success factor in achieving the agreed ambitions of the partnership. This engagement will deliver both the right voice and influence for service users and their families / carers; and will also deliver the right processes and channels for professionals and providers within the broadest system to provide their own views as well as receive feedback and guidance about what is being changed, what it means for them and how changed processes and system behaviours will be supported and reported.

The following provides a snapshot overview of the progress to date:

- All three of the CCGs have been briefed and approved the draft project plans through their Clinical Executives

- Plans are in place to fully brief the Health and Wellbeing Boards on the final plan following submission on 11th April 2016. And this process is ongoing with Milton Keynes Health and Wellbeing Board giving its full support to the plan 9th March 2016.

- Briefings have been completed with the lead members in all four local authorities.

The TCP partnership engaged with the 'National Development Team for inclusion' (NDTi) to provide support on a number of key areas including how we can improve our engagement across the partnership. This workshop took place on 23rd March 2016 and its outcomes will be incorporated into the communications and engagement work stream moving forward.

POhWER (the local advocacy provider for the partnership providing both statutory and non-statutory issue based advocacy) have been involved in care and treatment reviews and are well sighted on the Transforming Care agenda. They have taken on issue based advocacy case management where service users and family members have required support and will continue to both support people with a learning disability and their carers in this way and also to engage meaningfully with the partnership.

The above areas demonstrate the commitment that the TCP has made to working in partnership and the progress to date; at the same time, the partnership recognises

that the challenges go far beyond this initial engagement. A detailed communications plan is currently being prepared and will be finalised and shared with NHS England when it has been approved by the TCP programme board. As a part of the communications and stakeholder engagement strategy for the programme the partnership will look to stage launch events and also raise the profile of the programme especially at during World Autism Awareness week in April (a press release has recently gone out) and Learning Disability week in June.

Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

The Board recognises that to successfully deliver the transformation plan there will be significant changes in the way services are provided and increased partnership working across the BLMK area.

A scope of the current engagement work currently taking place across the TCP footprint will be taken forward in the first year that will include the CAMHS transformation plans.

- Parental engagement activities are continuing. On behalf of the Partnership Milton Keynes are involved in regular engagement meetings with the Parents and Children's Alliance (PACA) to share emerging thinking and plans regarding Transforming Care. We are consulting with PACA on the best way to engage with them regarding these plans and PACA is currently working to identify a service user to specifically work with us on the Transforming Care Programme. In addition, Luton and Bedfordshire are consulting with local charities and groups that are in touch with children, young people and family carers (e.g. the FLAG group and specific services run by Autism Bedfordshire). This will ensure we are engaging with parents and carers who are more difficult to reach.

- Talkback is a user-led engagement and self-advocacy group which works with the partnership (see the previous section.)

- Service user Joe is attending his local steering group in Milton Keynes. The whole plan was discussed with Joe and he was able to contribute to the discussions through his lived experiences (See the previous section.)

Our next steps are to:

- Further engage with the two Autism Partnership Boards, three Learning Disability Partnership Boards, and four Carers Partnership Boards to ensure that we are all working together on this agenda, and that we have appropriate representation at both reference group and Transforming Care Board levels.

- Review the way we are involving people from all five cohorts in the design and development of the local service model to ensure we have ways of including all of them in ways that are meaningful to them.

- Establish with Children's and Transitions Services how they wish to lead on this aspect of work, and how we will work together towards the all age approach that is required

POhWER (the local advocacy provider for the partnership providing both statutory and non-statutory issue based advocacy) have been involved in care and treatment reviews and are

well sighted on the Transforming Care agenda (see previous section.)

The partnership has an ambition to involve more local people with lived experience of hospital as paid "experts by experience" in Care and Treatment Reviews, and to meaningfully involve Service Users and Carers in any partnership procurement exercises undertaken. We also plan to include Service Users in monitoring, as well as in the implementation of this plan. We will coproduce an "easy read" version of the plan. Part of our funding bid which accompanies this plan focuses on coproduction to help enable this work to happen.

It is also the TCP's ambition to develop further and work in partnership with people with autism and/ or a learning disability, their carers, families, and other stakeholders in the implementation of this plan. At the partnership's workshop with NDTi on 23rd March a major focus was the area of stakeholder engagement and coproduction and the outcomes of this will be incorporated into the communications and engagement work stream moving forward. During the early stages of the project a communications and stakeholder management strategies and plans will be developed and agreed. In addition to established channels, the work streams will consider evidence based approaches to co-production and stakeholder engagement, and the programme will look at current examples of best practice. Engagement will extend to universal services with a view to how they might best engage with this cohort.

Please go to the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack) and select the CCG areas covered by your Transforming Care Partnership

We have attached an activity and finance template for the three CCG areas; this includes the current inpatient projections as of 11th April 2016.

2.Understanding the status quo

Baseline assessment of needs and services

Provide detail of the population / demographics

Transforming Care Partnership (TCP) Geographic Footprint – Bedfordshire, Luton and Milton Keynes (BLMK)

The TCP for Bedford Borough, Central Bedfordshire, Milton Keynes and Luton is a newly formed arrangement. As mentioned earlier, it covers four local authority areas and three Clinical Commissioning Group areas within Central Eastern England.

The area covers a mix of rural and densely populated urban districts, it has good transport links and a rapidly growing population, with population increase estimates in some parts of the partnership area being 20% over 20 years. In 2015 the total population for the partnership area was estimated by the Office for National Statistics (ONS) at 912,759.

Table 2.01 Office for National Statistics (ONS) Total Population Estimates published 2014

Local Authority	Population Estimate (all ages)			Predicted population increase (all ages) from 2015 estimate	
	2015	2019	2030	2019	2030
Bedford	164,397	171,360	188,990	4.24%	14.96%
Central Bedfordshire	269,600	283,084	316,059	5.00%	17.23%
Luton	213,696	223,936	246,885	4.79%	15.53%
Milton Keynes	263,051	277,293	309,133	5.41%	17.52%
Total	**912,759**	**957,692**	**1,063,097**	**4.92%**	**16.47%**

Remit of the Plan

The population that is in scope of this plan are children or adults with a learning disability and/or autism who have/display:

- A mental health problem, such as severe anxiety, depression or a psychotic illness which may result in them displaying behaviours that challenge
- Self-injurious or aggressive behaviour, not related to severe mental ill-health, some of whom will have a specific neurodevelopmental syndrome with often complex life-long health needs and where there may be an increase likelihood of behaviour that challenges
- 'Risky' behaviour which may put themselves or others at risk (this could include fire-setting, abusive, aggressive or sexually inappropriate behaviour) and which could lead to contact with the criminal justice system
- Lower level health or social care needs and disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family background), who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system
- A mental health condition or whose behaviour challenges who have been in inpatient care for a very long period of time, having not been discharged when NHS

campuses or long-stay hospitals were closed

This comprises an extremely diverse group of people and often the care and support required will often be highly individualised. This plan applies to all those who are the responsibility of Health and/or local authorities within the Transforming Care footprint.

Where somebody lives in one social care area (e.g. Northampton) but are registered with a GP within the BLMK partnership area they will receive health care services from our local LD team, whilst social care will be provided by their own local authority. Further guidance on this can be found in 'Who Pays'.

Out of scope for this plan

- People with a learning disability and/or autism who are placed in hospital for the treatment of physical conditions
- People at risk of admission as a result of their physical health needs

Definitions of "learning disability" and "autism"

The White Paper, Valuing People, defines a learning disability as: a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); along with a reduced ability to cope independently (impaired social functioning). Certain conditions such as dyslexia are not considered to be learning disabilities, as while they make tasks such as reading or writing difficult they do not affect intellect; instead they are considered to be learning difficulties. Similarly, while learning disabilities are linked to mental health issues, poor mental health is not considered to be a learning disability in itself, as it can affect anyone, at any time and can usually be overcome with treatment and support (Department of Health, 2001).

Learning disabilities can be grouped into four main levels of severity:

- Likely to result in some learning difficulties at school. At this level, many adults will be able to work, maintain good relationships and contribute to society.
- Likely to result in marked developmental delays in childhood but most can learn to develop some degree of independence in self-care and acquire adequate communication and academic skills. Adults are likely to require varying degrees of support in order to live and work in the community.
- Likely to result in severe developmental delays and a continuous need for support throughout the life course.
- Likely to result in severe limitations in self-care, continence, communication and mobility. Requires a high level of constant care and support (Department of Health, 2001)

The National Autistic Society defines Autism in the following way:

> "Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. It is a spectrum condition, which means that, while all people with autism share certain difficulties, their condition will affect them in different ways. Some people with autism are able to live relatively independent lives but others may have accompanying learning disabilities and need a lifetime of specialist support. People with autism may also experience over- or under-sensitivity to sounds, touch, tastes, smells, light or colours. Asperger syndrome is a form of autism. People with Asperger syndrome are often of average or above average intelligence. They have fewer problems with speech but may still have difficulties with understanding and processing language."

(From: What is autism? National Autistic Society)

Prevalence – Adults

At a national level there is no definitive record of the number of people with learning disabilities and/ or Autism in England. Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Services Information (PANSI), web-based tools for use by commissioners, supported by the Institute of Public Health, projected that the number of adults living in England with a learning disability totalled 1,013,065 in 2015 and that the number of adults with an autistic spectrum condition totalled 422,164 in the same year.

It is estimated that there were a total of 16,427 adults with a learning disability within the partnership area in 2015. The breakdown of estimated and projected prevalence of learning disability, autistic spectrum conditions for adults is provided below (table 2.02), along with projected figures for 2030 (table 2.03).

There will be increases in the number of people with a moderate or severe learning disability, behaviours that challenge and autistic spectrum conditions over the next 15 years (table 2.04).

Table 2.02 Prevalence Estimates for 2015 (Source: POPPI and PANSI)

Area	Learning Disability Baseline (18 years and above)	Autistic Spectrum Conditions (ASCs) (18 years and above)	Challenging Behaviour (18- 64 yrs. only)
Bedford	3,003	1,246	45
Central Bedfordshire	4,956	2,078	74
Milton Keynes	4,664	1,935	73
Luton	3,804	1,597	60
Total	**16,427**	**6,856**	**252**

Table 2.03 Projected population in 2030 (Source POPPI and PANSI)

Area	Learning Disability Baseline (18 years and above)	Autistic Spectrum Conditions ASCs) (18 years and above)	Challenging Behaviour (18- 64 yrs. only
Bedford	3,456	1,451	48
Central Bedfordshire	5,796	2,446	80
Milton Keynes	5,541	2,312	80
Luton	4,410	1,892	67
Total	**19,203**	**8,101**	**275**

Table 2.04 Predicted percentage increase in estimated cohort between 2015 and 2030. (Source – based on POPPI and PANSI data)

Area	Learning Disability Baseline (18 years and above)	Autistic Spectrum Conditions ASCs) (18 years and above)	Challenging Behaviour (18- 64 yrs. only
Bedford	15.08%	16.45%	6.67%
Central Bedfordshire	16.95%	17.71%	8.11%
Milton Keynes	18.80%	19.48%	9.59%
Luton	15.93%	18.47%	11.67%
Total	**16.90%**	**18.16%**	**9.13%**

Services report higher levels of prevalence of challenging behaviour e.g. Milton Keynes' register for people with behaviour that challenges include 136 people.

What can we predict about adults with learning disabilities who display behaviours that challenge services?

Challenging behaviour usually begins in childhood or young adulthood and without effective intervention is highly persistent; around 30 per cent of young children (aged zero to three years) and 10-15% of adults with learning disabilities display behaviour difficulties (Emerson and Milton Keynes, 2011) or 0.045% of the population aged five or over based on the study "Challenging behaviours: Prevalence and Topographies, (Lowe et al (2007) Journal of Intellectual Disability Research, Volume 51)". Not all of these people will have a moderate, severe or profound disability and hence not all of them will be in receipt of learning disability services. Many of these people will be at risk of offending and will have come into contact with the criminal justice system, substance misuse services or mental health services. Interestingly though a study in 2007 indicated that of those in receipt of services, it tended to be the abler people with learning disability and challenging behaviour who experienced placement breakdown and eventually more secure settings (Broadhurst and Mansell, 2007).

The number of people with a learning disability registered as having a Learning Disability diagnosis by GPs provided by the Quality and Outcomes Framework (QOF). The estimated population with a learning disability that are currently accessing services is not necessarily the same as those registered on the QOF.

Table 2.05 QOF LD Register 2014/2015 - showing numbers of people on Learning Disability register and prevalence by CCG.

BLMK CCGs	Size of List	Number of people on LD register	Prevalence
Bedfordshire CCG	457,600	1,895	0.41%
Luton CCG	223,266	880	0.39%
Milton Keynes CCG	279,399	940	0.34%
Total	**960,265**	**3,715**	**0.39%**

As the QOF Register prevalence levels are lower than expected this might indicate further work is required with primary care across the partnership. Also the QOF list size for 2014/15 at 960,265 for the area is nearly 50,000 people higher than the estimated population for the area based upon ONS estimates for 2015. We recognise that there will be differences in the many different data sources for general and LD/autism population numbers and we will use a data-driven approach to ensure that we fully understand these differences. This also requires us to ensure that within individual localities and across the partnership area we have effective systems and processes in place to ensure that these differences in data do not lead to individuals failing to be identified and to be supported effectively.

Table 2.06 Number of adults with a learning disability known to services (Jan 2016)

Area	Number of adults with learning disability and/or autism known to Local Authority
Bedford	573
Central Bedfordshire	655
Milton Keynes	681
Luton	550
Total	**2,459**

Prevalence – Children

There are approximately 3,800 young people with some form of learning difficulty in the partnership area. One of the best sources of information around children and young people with Special Educational Needs and disability (SEND) is data from the School Census. This provides pupil level information for all pupils in the partnership area detailing their level of need and their primary type of SEN. As of January 2015 the number of pupils with their primary need being a learning difficulty was 3,802 for the total partnership area, with Milton Keynes and Luton having the highest number of pupils in this category.

Table 2.07 Special Needs and Disability Data from the School Census January 2015

Area	Specific Learning Difficulty	Moderate Learning Difficulty	Severe Learning Difficulty	Profound and Multiple Learning Difficulty	Total
Bedford	178	343	13	0	534
Central Bedfordshire	173	541	14	8	728
Milton Keynes	196	1,087	11	8	1,302
Luton	235	958	37	0	1,238
Total	782	2,929	75	16	3,802

Table 2.08 Out of area residential/ educational placements – all ages (as at 31st January 2016)

Area	**Under 18**	**18-25**	**Over 25**	**Total**
Bedford	5	11	2	18
Central Bedfordshire	5	6	4	15
Milton Keynes	10	2	51	63
Luton	15	10	28	53
Total	35	29	85	149

Note: *The data set described in the table above for Bedfordshire has been taken from the Phase 2 register 'out of area residential and / or educational placements for people with a learning disability and / or autism who have been placed out of area due to behaviour described as challenging' the data sets will be subject to validation across Bedfordshire CCG (including CHC), Central Bedfordshire and Bedford Borough Council.*

Local Population Issues

Milton Keynes is a growing population both in size and diversity. Milton Keynes CCG largely works to the same boundaries as Milton Keynes Council. In 2013 the population of Milton Keynes was 255,700. Between 2003 and 2013 Milton Keynes increased by 38,100 people (+17.5%).

The Population Bulletin 2013/14 outlines that the high population growth is expected to continue into the future. The population is forecast to grow to 302,100 people by 2026. This is an increase of 49,700 people or 19.7% between 2012 and 2026.The Milton Keynes (MK) population is getting older, the median age rose from 34 in 2001 to 35 in 2011 and by 2026 this is expected to be 40. However, the MK population remains young: 21% of the MK population were aged under 15 years compared with 17.7% in England.

The ethnic diversity of the total Milton Keynes population has increased more than that for England as a whole. In 2001, 13.2% of the total population in England were from an ethnic group other than 'white British'. In Milton Keynes the comparable figure was 13.2%. By

2011, 20% of the population of England was estimated to have an ethnic group other than white British while the comparable group in Milton Keynes has risen to 26%.

Milton Keynes' local authority is ranked 211th out of 326 unitary and district authorities in England, where first is the most deprived.

Milton Keynes has four dedicated special needs secondary school for 11-19 year olds with a further one planned.

The current population of Central Bedfordshire is 269,100 (2014). Central Bedfordshire is the 15th largest unitary council in England by population size.

The area of Central Bedfordshire is 716 square kilometres. Central Bedfordshire is the 11th largest unitary council in England by area. It is classified as 'largely rural', with 58% of residents living in rural areas. This includes 'hub towns', which are towns with populations of 10,000 to 30,000 that play an important role in providing services, employment and businesses to the rural areas around them. It is forecasted that Central Bedfordshire population will increase to 287,300 in 2021.

Central Bedfordshire is less diverse than England as a whole, and has a greater proportion of people who are White British. The biggest ethnic groups within Central Bedfordshire were 'White Other' (7,040 people, 2.8% of the population), 'White Irish' (3,150 people, 1.2%), and 'Indian' (2,530 people, 1.0%).

The population profile of Central Bedfordshire will change by 2021, with people aged 65 and over representing 19% of all people, compared to 16% in 2011. This is the result of a higher rate of growth in the number of older people compared to other age groups – 35% between 2011 and 2021.

Overall levels of deprivation in Central Bedfordshire are relatively low, with many areas being among the least deprived in England.

Bedford Borough covers an area of 476 sq. km and is home to an estimated 163,900 people (2014). Almost two-thirds of the population (64%) lives in the urban area of Bedford and Kempston, and 36% in the surrounding rural area which comprises 45 parishes. The Borough's population rose from 148,100 in mid-2001 to 163,900 in mid-2014, an average annual increase of approximately 0.7%.

Bedford Borough has a similar age profile to England, with the same median age of 39.7 (2014), but has a much younger profile than the East of England which has a median age of 41.3. The proportion of older people in the Borough is also lower, with 17.0% of the population aged 65+ in 2014 compared to 17.6% in England and 19.0% in the region. Further information will be included in the April 2016 plan submission.

Prior to 2014/15, the national data indicated that Bedford Borough supported a very "typical" number of people in relation to its population size - and reduced the numbers in a typical way over time.

In 2014/15 Bedford Borough experienced an unusual surge in demand – resulting in sudden growth in the number of people receiving home care – although not in the number admitted to residential/nursing homes. This is confirmed by the fact that the rate of new people admitted to Bedford Borough's Adult Social Care system in 2014/15 was relatively high – although only around 5% higher than the comparator average, and 2% higher than the national average. By the end of that year, 38% of people receiving support in Bedford

Borough were “new to its system” (compared with a national average of 31%).

As a result, Bedford Borough’s position in relation to other councils changed very dramatically. The new figures suggest that Bedford Borough now provides long-term support to rather high numbers of people (both in the <65 and 65+ age ranges). In the current year, this situation has largely been contained. The number of client packages increased by 2.8% (between April and September). This is consistent with demographic growth - and especially with the fact that the number of people aged 85+ is rising by 4% per annum.

Luton is the most densely populated local authority area in the eastern region of England. The borough’s population is projected to grow significantly with the latest forecast estimating a 20% overall increase over the next 20 years, with the school age population rising by 23% in this timeframe. The population is ethnically diverse with approximately 55% being from Black and Minority Origin (BME). The ethnic composition of Luton fits a model known as “super diversity” in which there are an increasing number of BME communities within the population each with its own needs and cultures. Luton is landlocked and has a significant problem with homelessness and there are currently over 160 families who are homeless or living in temporary accommodation, several wards within the borough fall within the top 10% of the most deprived areas within the country.

In 2014 there were 457 children and young people on Luton’s disability register and the children with disability team provided support to 407 children. According to the most recent Joint Strategic Needs Assessment (JSNA) for 2013/14 Luton has a significantly high number of children known to schools with a severe learning difficulty (7.09 per 1000 pupils compared to 3.73 – average for England). Woodlands, the borough’s main special needs secondary school for 11-19 year olds will be the largest secondary school of its kind in the country by 2017.

Analysis of inpatient usage by people from Transforming Care Partnership

Overall Picture:

The BLMK partnership area has relatively low usage of inpatient beds, compared to many other areas in Eastern and Central England. As of 31st January 2016 the partnership was reporting on 17 adults in inpatient settings (see table 2.09). It has been projected that by April 2016 eight of these patients will have been discharged or have a confirmed discharge date. The partnership is therefore confident that it will be able to meet the planning assumptions set out in “Building the Right Support” within a reasonable timescale through ongoing work and timely discharge planning and should be in a strong position to reduce inpatient levels further through effective collaborative working.

Reporting on inpatients across the Partnership (as of 31 January 2016)

Table 2.09 CCG Commissioned Inpatient Care

CCG area	Original “Winterbourne” Cohort admitted before March 2014	Patients admitted since March2014	Total
Bedfordshire	2	2	4
Milton Keynes	3	6	9
Luton	2	2	4
Total	**7**	**10**	**17**

Table 2.10 NHS England Specialised Commissioning (as of 31 March 2016)

CCG area	NHS specialised commissioning
Bedfordshire	9
Milton Keynes	3
Luton	2
Total	**14**

Note: These figures for specialised commissioning are to be validated, and may be subject to an increase as medium and high secure patients are identified during the Specialised Commissioning Care and Treatment Review process

Planning assumptions are that no area should need more inpatient capacity than is necessary at any one time to cater to:

- 10-15 inpatients in CCG commissioned beds per million of the population
- 20-25 inpatients in NHS England commissioned beds per million of the population

Picture at local level

Milton Keynes CCG currently reports on nine patients who are in inpatient settings supported by CCG funding. Three of these patients are from the original transforming care cohort. Two of these Two of these people will be shortly returned to Milton Keynes.

There have been six admissions since June 2014, three from the community and three transferred to Milton Keynes CCG from specialised commissioning. Over the same period, we have discharged four patients back into the community.

Of the three people currently reported on by Specialised Commissioning, one is likely to be transferred to Milton Keynes imminently. Our understanding from our community team is that two people are not going to be transferred back to Milton Keynes in the near future. The remaining three people are “disputed” and subject to confirmation that they originate from Milton Keynes.

Bedfordshire Clinical Commissioning Group is currently reporting four inpatients. Two of the four reported patients were inherited from Specialist Commissioning Group following their transfer from secure to specialised learning disability acute beds out of the Bedfordshire area and in independent hospitals. These patients form the original 2014 Winterbourne cohort.

The other two patients being reported were admitted into The Coppice (Bedfordshire and Luton inpatient provision) and plans are currently being developed to plan for discharge. These two admissions took place in December 2015 and January 2016 and therefore do not form part of the original Winterbourne cohort.

Luton CCG currently reports on four individuals who are in patient settings. This includes the two people who were in the original “Winterbourne” cohort and four people who have been admitted since March 2014 (one of the individuals was placed in hospital by children’s services and has turned 18 since being in hospital). In addition, NHS Specialised commissioning report on two people in secure settings. Of this total of six patients it is anticipated that four individuals will either have left hospital or have confirmed discharge dates by April 2016. Locally there is a transforming care action plan and steering group which oversees the progression of patients of through care pathways and their transition back into the community. The average length of stay at the local Crisis intervention inpatient service is 49 days; however, there have been three delayed transfers of care at the unit in

the last year due to breakdown in care arrangements and the need to source alternative accommodation in borough.

It is important to note at this stage that this data and information relates to people the CCGs know about. We understand there is small complex cohort of patients currently funded by specialised commissioning that are not yet allocated to a CCG. There is therefore a risk associated with any assumptions regarding funding requirements going forward.

Describe the current system

How we currently serve people covered by this plan

Within the partnership boundaries the four local authorities, three CCGs and NHS England are responsible for commissioning care for people who live in the area, care is provided by a range of providers including the NHS East London Foundation Trust (ELFT) for Bedfordshire and also for Luton. Milton Keynes is a joint health and social care service via a pooled budget arrangement between Milton Keynes CCG and Milton Keynes Council. Health professionals are employed by Central North West London NHS Foundation Trust (CNWL).

There is already a strong focus on delivering community based services and personalised support across the partnership and commissioning bodies across the area have taken significant steps to reduce reliance on inpatient care with the closure of the local NHS Assessment and Treatment Unit for adults with a learning disability in Bedfordshire and Luton. Other inpatient based services and campuses have also closed over the last 10 years, with only a residual crisis inpatient service in place currently accessed by Bedfordshire and Luton patients.

Milton Keynes also closed its inpatient facility in 2013 (the Oakwood unit) and in its place developed the Community Support Intervention Team focused on preventing hospital admission.

At present the three CCGs commission inpatient and specialist services separately although Bedfordshire CCG currently hosts the contract for Specialist Learning Disability Services on behalf of Luton CCG and these services are shared across Bedfordshire and Luton. There are currently seven NHS block contracted beds for adults with a learning disability across the whole partnership utilised by Bedfordshire and Luton patients. Milton Keynes has no NHS contracted beds for adults with a learning disability.

In Milton Keynes there is a local protocol with Adult Mental Health Services for access to an inpatient bed within the local mental health inpatient service. However this is often not considered to be clinically appropriate and inpatient beds are commissioned from a variety of NHS Trust and independent provision. Where a need for inpatient services is identified, the Community Learning Disability Team is involved in planning the admission, monitoring progress and planning and supporting the person's discharge from the in-patient service.

How We Serve adults

Current state: Adults

Details of the current inpatient population as of 4th April 2016 are detailed in the tables below for both within the TCP footprint (table 2.11) and out of area (table 2.12). Locations have been anonymised in order to maintain confidentiality.

Table 2.11 TCP inpatient population in beds in footprint

Unit (NHS)	Unit (Non NHS)	CCG or NHSE?	Type of bed	No of beds	No of beds commissioned / contracted by TCP	No of beds currently in use by TCP
NHS Unit 1		CCG	Crisis	7	7	6 (4/4/16)
	Non NHS Unit 1	CCG	Locked Rehab	53	0	4*
NHS Unit 2		NHS E	Low secure	UK**	Unknown	4

*Note that for Non NHS Unit 1, all beds are spot purchased.
** Unknown

Table 2.12 TCP inpatient population in beds outside footprint (out of area)

Unit (NHS)	Unit (non NHS)	CCG or NHSE?	Type of bed	No of beds currently in use by TCP
	Non NHS Unit 2	CCG	Locked rehab	3
	Non NHS Unit 3	NHSE	Secure	2
	Non NHS Unit 4	NHSE	Secure	2
	Non NHS Unit 5	CCG	Locked rehab	1
	Non NHS Unit 6	NHSE	Secure	2
	Non NHS Unit 7	CCG	Locked rehab	1
	Non NHS Unit 8	CCG	Locked rehab	1
	Non NHS Unit 9	CCG	Locked rehab	2
	Non NHS Unit 10	CCG	Locked rehab	1
	Non NHS Unit 11	NHSE	Secure	1
	Non NHS Unit 12	NHSE	Secure	1
	Non NHS Unit 13	CCG	Locked rehab	1

Specialist Learning Disability Services – SPLD (Bedfordshire and Luton)

The community SPLD is hosted by Bedfordshire CCG on behalf of Luton CCG. The community SPLD services include the following service areas:

- Occupational Therapy
- Specialist Medical
- Psychology
- Primary Health Facilitation
- Acute Health Facilitation
- Speech and Language Therapy
- Sensory Nurses
- Arts and Drama Psychotherapy
- Intensive Support Team
- The Coppice (seven bed short term acute crisis intervention**)**

NHS Acute Crisis Service – the Coppice (Bedfordshire and Luton)

The Coppice is a seven bedded acute crisis unit covering Bedfordshire and Luton. It is AIMS-LD accredited (Accreditation of Inpatient Mental Health Services – Learning

Disability). The focus of this service is different to that of a traditional "assessment and treatment" unit as it fully integrates with the areas' Intensive Support Team (IST), sharing a staff support and a Multi-Disciplinary Team (MDT). It provides seamless care to patients who need short term inpatient care because it is not safe or appropriate to provide interventions in a community setting, or there is a risk to safety or wellbeing. Discharge planning usually starts soon after admission. The average inpatient length of stay per admission is seven weeks.

The Intensive Support Team – IST (Bedfordshire and Luton)

The Intensive Support Team (IST) has a pivotal role and works across Bedfordshire and Luton with people with a learning disability who are experiencing a crisis in relation to a behaviour which is challenging or experiencing a mental health need whilst living in the community. It provides assessment, treatment and support to individuals in a safe and least restrictive environment. Interventions are person centred, intended to be time and goal specific, focus on the safety, empowerment and wellbeing of the patient and any carers involved, as well as minimising the need for admission to inpatient care.

The average caseload of the IST team is 60-80 patients at any one time across Bedfordshire and Luton. In the event of an admission to the Coppice, or any other hospital or inpatient unit IST will aim to facilitate a timely discharge and support the individual back into the community as soon as the individual is fit for discharge. IST are also able to work closely with adults with a learning disability who have been admitted to mainstream acute mental health inpatient unit or independent hospitals to facilitate timely discharge and smooth transition back into the community.

Patients with a learning disability across Bedfordshire and Luton and supported by IST to access local acute mainstream mental health inpatient units when appropriate and IST have supported six such admissions over the last year 2015/16.

Case study: How the Intensive Support Team and Crisis Intervention Service work in an integrated way to meet individual need, ensure inpatient stays are appropriate and for the minimum required time

Please note all personal information including the name of the patient has been changed in order to maintain confidentiality.

Dave was referred to the Intensive Support Team (IST) by his Care Co-ordinator for support with low mood, and psycho-education around treatment. Dave had a history of depression and substance misuse. He lived on his own with a few hours of support a week from paid carers to help him with everyday tasks.

IST completed an assessment the day after his referral. On assessment he was found to be very low in mood, experiencing sleep disturbances and a loss of appetite. He was not experiencing suicidal ideation but he had experienced this in the past. IST completed a depression rating scale which further demonstrated his low mood. Dave put his presentation down to recent bereavements and that he struggled to remember to take his anti-depressant medication.

He was allocated a named nurse who arranged a medical appointment with the IST consultant the next day. A plan was put in place to visit Dave every day to remind him to take his medication, monitor his mental health and work through his issues. Physical observations were also completed during visits to ensure that there were no underlying physical reasons for his presentation and that he was side-effect free. In addition to this IST rang Dave every evening to remind him to take his tablets. A referral was submitted for

psychological input for bereavement and his named nurse liaised closely with his care manager throughout.

Whilst this seemed to have an initial positive impact after around three weeks Dave's mood dipped. During one visit he stated that he was experiencing active suicidal thoughts and did not feel safe to be left alone. The nurse was concerned and decided to make enquiries about additional support, liaising with the IST senior nurse and IST Consultant. The local commissioner was also consulted and various options considered. It was agreed that a short admission to the crisis intervention service "The Coppice" would be the best course of action, to keep Dave safe and enable stabilisation of his mental state. David was fully informed of the discussions and felt that he would benefit from a short voluntary admission as he may act on his suicidal ideation.

The nurse supported Dave with his admission there and then. His named nurse remained the same throughout his admission and the staff team that visited him at home were familiar to him in The Coppice as the team are the same. Dave remained in The Coppice for three weeks. During this time his anti-depressant medication was increased and coping strategies/ a relapse prevention plan was developed with him. Dave also felt that much of his low mood had been due to boredom. He was assessed by an Occupational Therapist and an activity plan put in place. This then informed his care Co-ordinator who put in place extra support and activities for Dave on discharge.

Following discharge from The Coppice, IST visited Dave every day for the first seven days, again his named nurse remained the same. He was much more stable on discharge with an increase in medication and increased social support; he was also referred to advocacy services. IST remained involved with Dave but gradually reduced visits until he was well enough to manage. This was reviewed weekly by IST Multi-Disciplinary Team including the Consultant Psychiatrist.

Dave was discharged after a further four weeks to the locality Consultant Psychiatrist for his area and he remained on the waiting list for psychological input. Dave has the IST number as part of his relapse prevention plan. He is able to call this number on any day at any time for support and advice. He can also access crisis support including a home visit 24 hours a day seven days a week

Care management (Bedfordshire and Luton)

The care management function is delegated to Local Authorities (Bedford Borough, Central Bedfordshire and Luton) where the teams are made up of Social Workers, Community Nurses, Community Care Workers, Support Workers and Administrators.

Community Support Intervention Team (CSiT) (Milton Keynes)

Following the closure of Oakwood inpatient service in 2013 Milton Keynes CCG released additional funding into the pooled budget for a small specialist team focussed on preventing admissions to hospital. The Community Support Intervention Team of two nurses and three support workers work across during the day/evening seven days per week. This team works closely with the Behaviour Support Team, and the wider multi-disciplinary team based with Milton Keynes' Community Team for Adults with a Learning Disability.

Case study: How the Community Support Intervention Team (CSiT) work with individuals and providers to reduce or delay inpatient admissions.

Please note all personal information including the name of the patient has been changed in

order to maintain confidentiality.

John was living in his own flat in Milton Keynes supported by a local provider. His package was fully funded by Milton Keynes CCG. John has experienced several inpatient admissions during his adult life but he had settled well into his flat with the support of a staff team who knew him well.

Following the death of his father, John's mental and physical heath started to deteriorate with non-concordance with medication, verbal aggression, threats of physical aggression along with sleep disturbance. A 'Blue Light' Care and Treatment Review (CTR) was arranged as staff were indicating that a hospital admission might be required.

As an outcome of the 'blue light CTR' the Community Support Intervention Team (CSiT) were allocated to carry out an assessment and provide support to John and his support staff. This support was initially focussed on medication concordance but developed into providing support staff with coaching and support with their interventions. The CSiT has Outreach Community Nurses and support workers and intensive support was arranged for an initial period of seven days. In addition, the Community Team for Adults with a Learning Disability (CTALD) has a 24/7 on call system and the provider staff were encouraged to make use of this if they had any concerns about John.

The CSiT team worked closely with the CTALD to monitor John's presentation and several multi-disciplinary meetings were held to review John's plan and support. The inpatient admission was avoided at this time although John continued to present as 'unsettled'. The CSiT liaised with the CTALD consultant psychiatrist and John's medication was reviewed. Two further 'blue light' meetings were held and increased support was provided by the CSiT with community outreach nurses and support workers allocated to provide additional support to John and his staff team.

Community Team for Adults with a Learning Disability (CTALD) (Milton Keynes)

The 44-strong joint team is made up of a range of Health and Social Care professionals. This includes psychiatry, psychology and therapists, who assess needs, diagnose and deliver treatments. The team is funded via a pooled budget between Milton Keynes CCG and Milton Keynes Council.

As well as undertaking Care Assessments for new service users, and having responsibility for Care Act or Care Programme Approach reviews the team undertakes Safeguarding Vulnerable Adults investigations, assessments under the Deprivation of Liberty Safeguards and Continuing Healthcare reviews for service users who are in receipt of health funding. The Health Action Team aims to improve health outcomes for people with a learning disability by working out into mainstream health services to improve their effectiveness with people with a learning disability.

The team has a dedicated Behaviour Support Team aligned with both the Psychologists (two FTE) and the Mental Health and LD team of nurses and social workers.

Following assessment or review, the Brokerage Team works with individuals in a person centred way to plan services to meet their needs within their indicative budget.

In summary the CTALD includes the following functions:

- Occupational Therapy

- Psychiatry
- Psychology
- Health Action Team (health facilitation for primary and secondary care)
- Dietetics
- Speech and Language Therapy
- Community Nursing
- Social Workers
- Brokerage
- Behaviour support
- Intensive Support Team

Independent Hospitals (Bedfordshire, Luton and Milton Keynes)

Inpatient beds in independent hospitals are commissioned by both Bedfordshire and Luton CCGs on a spot purchase basis in exceptional circumstances only as a service of last resort They are commissioned for the shortest time possible when either the needs of the patient concerned are too complex to be supported by local (inpatient) services or when local inpatient services have no bed capacity. There are currently four patients from Bedfordshire and Luton accessing independent hospitals/inpatient services (figure excludes specialised commissioning patients.). These placements are in Central or Eastern England.

Similarly, Milton Keynes only commission beds in independent hospitals when intensive community support is insufficient to meet the individual needs of a patients, and an inpatient episode is required for assessment and/or treatment There are currently nine patients from Milton Keynes accessing independent hospitals (excluding specialised commissioning patients) These placements are also in Central or Eastern England, although placements are also occasionally made in London depending on individual clinical need.

Within the geographical footprint there are four independent inpatient services of significance. These are accessed by patients from all areas of the country and the partnership uses only a very small proportion of their bed capacity. The units concerned are:

- **Woodlea Clinic,** a forensic low secure inpatient service in Bedfordshire currently operated by South Essex Partnership University NHS Foundation
- **Milton Park Therapeutic Campus,** a 53-bed secure hospital for individuals with autism, a learning disability and/ or mental health needs. This is on the Bedfordshire/ Cambridgeshire border and is run by Brookdale Care.
- **Marlborough House,** a male only medium secure 28-bed unit situated on the Milton Keynes General Hospital site in Milton Keynes. Within this unit, Watling Ward is an acute admissions ward that has 20 beds, with an Intensive Care Unit including a de-escalation lounge. Chaffron Ward accommodates up to eight men who are progressing well in their recovery but still require medium secure services. Referrals are accepted from adult or forensic services, prison or high secure hospitals. Marlborough house is run by Oxford Health NHS Foundation Trust.
- **Chadwick Lodge**, a 52-bed medium and low secure unit within Milton Keynes, providing specialist treatment programmes for male and female patients who have been detained under the Mental Health Act (1983) and have a history of offending behaviour. The unit comprises 44 beds for men in four single gender wards (30 medium secure and 14 low secure) and eight beds for women in one single gender ward (medium secure). Chadwick Lodge offers care to those patients who present with a dual diagnosis of mental illness/personality disorder and mild learning disability and is run by the Priory Group.

The wider care pathway for adults with a learning disability (Bedfordshire and Luton)

Adults with a learning disability are able to access a range of specialist services as part of a pathway of health care including speech and language therapy, occupational therapy, psychology, outpatient medical care, art and drama therapy in accordance with their assessed clinical need as outlined earlier. The provision and function of community nursing is delegated to the Local Authorities through a S75 arrangement and care and support is provided through the care coordinator role. All these services work in close partnership with the Coppice and Intensive Support Team to provide an integrated model of health care. There is also a dedicated health facilitation team which focuses on supporting the wider population of people with a learning disability who access mainstream health services, health promotion and the completion of person centred health action plans and health checks.

The wider care pathway for adults with a learning disability (Milton Keynes)

Adults with a learning disability are able to access a range of 'specialist' health services as part of the wider health and social care CTALD team including speech and language therapy, bereavement counselling, physiotherapy, psychology and art therapy. There is no LD and/or autism specific inpatient provision within Milton Keynes, this was decommissioned in 2013 and in its place the Community Support Intervention Team (CSiT) was developed which supports people with LD and LD with autism with a focus on preventing hospital admission. The Health Action Team within the CTALD focuses on supporting the wider population of people with a learning disability to access mainstream health services, health promotion and the completion of health action plans and health passports. Milton Keynes also has a range of day opportunities and short breaks which are currently subject to review.

Forensic Support (Bedfordshire, Luton and Milton Keynes)

There is currently limited forensic/dedicated support for people with a learning disability and/or autism in the BLMK area with no embedded, dedicated learning disability forensic service or specialism.

Local diagnostic service for autism (Bedfordshire and Luton)

Since July 2013 adults aged 18 and over registered with a Bedfordshire and Luton GP have had access to an "in county" diagnostic service for autistic spectrum conditions This is available to people of any level of functioning including with a Learning Disability. The service is multi-disciplinary, person centred and flexible, offering a range of assessment tools/processes to take into account the individual's cognitive ability, individual circumstances and requirements. Short-term therapeutic intervention is offered to people for whom an autism diagnosis is confirmed. The service also considers referrals/enquiries on behalf of people with an established diagnosis with a view to offering signposting advice.

The diagnostic service builds networks with other local services and can offer specialist advice to other services regarding ongoing support/treatment requirements and reasonable adjustments, to promote equitable access for people with autism. This may form part of post-diagnostic intervention with an individual service user or more generic advice. To date the service has received 600 referrals undertaken 290 diagnostic assessments and given 130 people a confirmed diagnosis.

Living in the Community (Bedfordshire, Luton and Milton Keynes)

In Bedfordshire and Luton, a significant number of individuals with behaviour that challenges and/or complex needs are already successfully supported to live in ordinary housing within the local community, or in small scale residential care homes, with outreach support from specialist services as required. Hospital admissions and inpatient episodes are

generally kept to a minimum for this cohort, however may sometimes occur in the event of an acute mental health episode or escalation of challenging behaviour. There may also occasionally be a complete breakdown in placement and resultant hospital admission. We closely monitor inpatient admissions from these settings to see how the quality of care can be improved and care and support plans adapted to minimise the risk of admission.

In Milton Keynes 91% of people with learning disabilities are living within the boundaries of Milton Keynes with 33% of people known to services living with family.

Since 2001 there has been a strategic commitment to Supported Living as the first option for consideration when service users require accommodation away from the family home. Service users are tenants in their own homes and receive support through an external provider or the internal Community Support Team (CST). There were 239 people living in accommodation with a tenancy in 2015. This represents 43.4% of people with learning disabilities known to services aged 18-64 living in Milton Keynes.

The number of people living in residential or nursing care funded by Milton Keynes is significantly lower than its comparator authorities with 97 people (17%) accommodated in this type of provision. Almost half of them (40) are living out of area.

Case study: Personalised support for an individual with complex needs living in their own tenancy in the community.

Please note all personal information including the name of the patient has been changed in order to maintain confidentiality.

Phil is a person who we support He has a learning disability, autism and Pica. At times this affects him in such a way that he is at considerable risk, both at home and in the community. The Pica behaviours for Phil involved a focus on used cigarette ends, pieces of glass and small objects. If Phil saw any of these items he would have an uncontrollable urge to ingest these; the resulting effect being that Phil needed high levels of support and ongoing issues in relation to risk to his health, which often led to pain and discomfort and consequently behaviours which challenged those supporting him.

A referral was completed to the learning disability nurse and the in-house behavioural analyst. This led to a functional behavioural assessment and a behavioural support plan being developed. The team were supported to understand the behavioural support plan by working alongside the behavioural analyst throughout its implementation. This included training in behavioural support strategies to ensure staff possessed the necessary tools to actively redirect Phil at the necessary times in a safe and controlled way.

Alongside this, health investigations were carried out to eliminate any specific health issues that contributed to the behaviours. Medication was prescribed to counteract the health issues. Phil's living environment was assessed and changed to ensure Phil was able to live on his own with more focused support design.

Assistive technology was explored to identify solutions to managing the risks of Phil's Pica when in the community. A handheld 'vacuum' device was identified as an effective way of eliminating small objects from Phil's sight. Phil now leads a full and active life in his own property and accesses his community safely

This has resulted in Phil being able to be less intensively supported and a greater focus upon him living more independently. Phil is now supported by a well-matched, consistent

staff team who know him really well. He is continuing to thrive and his level of challenging behaviour has reduced considerably since we have been supporting him. Phil now lives a very happy and fulfilled life in the community and has avoided hospital admission.

Out of area (residential) placements (Bedfordshire, Luton and Milton Keynes)

There are presently 149 people with a learning disability and/or autism who may present behaviour that challenges who are placed out of area (please see table 2.08). Many have been placed out of area due to a lack of local options either as young people or in early adulthood. It is generally more difficult to monitor the quality of out of area placements and the input from local specialist NHS services can by highly variable. Occasionally there may be a complete placement breakdown for individuals in out of area placements, who may either be admitted to a hospital in the local area, or in some cases return to the Coppice (Bedfordshire and Luton) A significant objective of this plan is to address this particular issue and enable more people to either stay in area or return if they wish to do so, through commissioning appropriate services.

How we serve children and young people

Current state: Children

Details of the current inpatient population as of 4th April 2016 are detailed in the tables below for both within the TCP footprint (table 2.13) and out of area (table 2.14). Locations have been anonymised in order to maintain confidentiality.

Table 2.13 TCP inpatient population in beds in footprint

Unit (NHS)	Unit (Non NHS)	CCG or NHSE?	Type of bed	No of beds	No of beds commissioned / contracted by TCP	No of beds currently in use by TCP

Note: There are no children currently in this cohort within the TCP, therefore this table is empty.

Table 2.14 TCP inpatient population in beds outside footprint (out of area)

Unit (NHS)	Unit (non NHS)	CCG or NHSE?	Type of bed	No of beds currently in use by TCP
	Non NHS Unit A	NHSE	Low secure	1
	Non NHS Unit B	NHSE	Medium secure	1

Child and Adolescent Mental Health (CAMH) services Bedfordshire and Luton

The Bedfordshire and Luton CAMH service comprises:

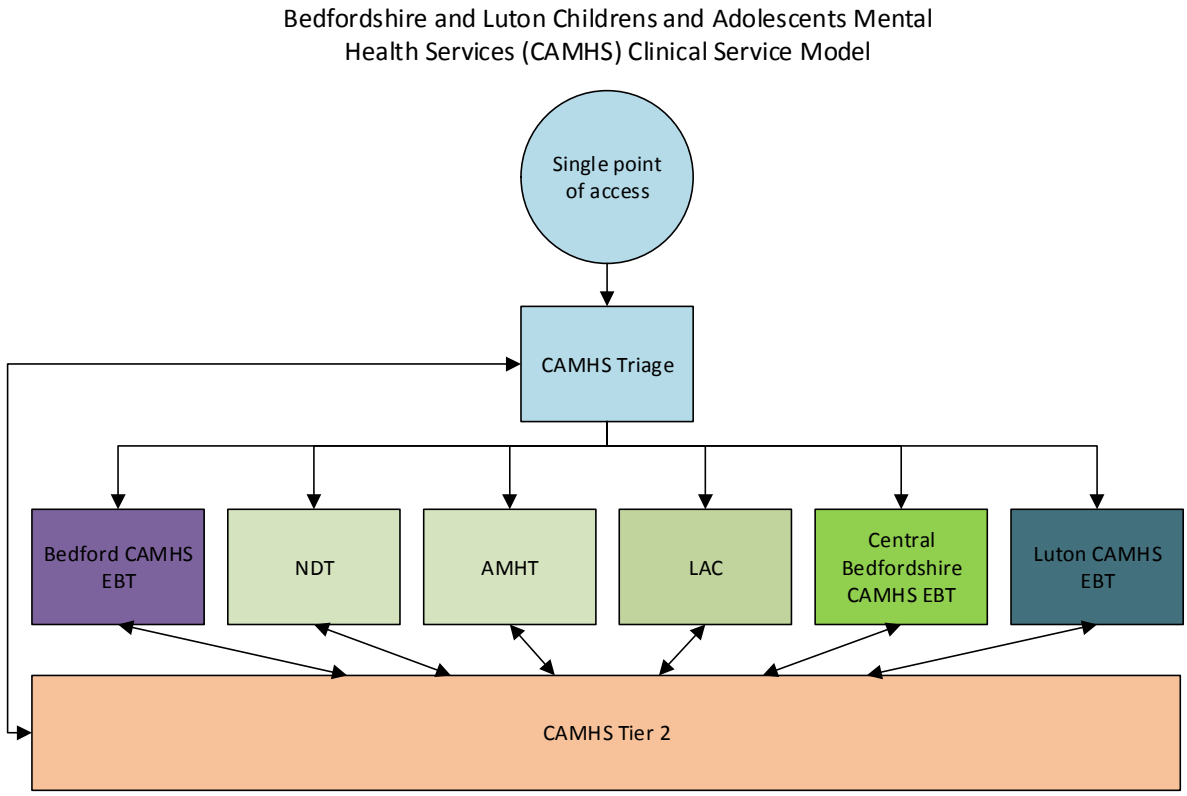
- CAMH Learning Disability
- CAMH TIER 4 provision is commissioned by NHS England.
- CAMH TIER 3 SEPT Paediatric, Occupational Therapy, Physiotherapy, Paediatric Nurses, Speech and Language Therapy and ELFT CAMHS service.
- CAMH TIER 2 Early Intervention

- CAMH TIER 1 is provided by universal providers, e.g. schools, GPs.
- CAMH Home treatment,
- CAMH Looked After Children and Young Offenders

Core elements required from the Bedfordshire and Luton CAMH service Model are highlighted below:

- an integrated service
- a single point of access
- a focus on early intervention
- improving input from children and young people
- Community-based delivery
- Moving from a medical to a social model.
- Key outcome measures
- A single assessment process
- Reduced waiting times and no internal
- Quick response to Mental Health crisis
- Focus on Early intervention.
- Vulnerable groups such and Looked after Children, those with a learning disability and Young offenders require dedicated resource to ensure that their specific needs are prioritised.

Chart 2.01 The Bedfordshire and Luton CAMHS Clinical Service Model



EBT = Emotional and Behavioural Team
NDT = Neurodevelopmental Team
AMHT = Adolescent Mental Health Team
LAC = Looked After Children

CAHMS Services (Milton Keynes)

CAHMS Services are structured in the following way in Milton Keynes:

- **Tier 1** is provided by universal providers, e.g. schools, GPs.
- **Tier 2** provision is commissioned from CNWL by Milton Keynes Council (MKC) as a key component of 'Early Help' commissioned services.
- **Tier 3** provision is delivered by CNWL and commissioned by Milton Keynes Clinical Commissioning Group (MKCCG).
- **Tier 3+** (Liaison and Intensive Support Team [LIST]) is a pilot provision is delivered by CNWL and commissioned by Milton Keynes Clinical Commissioning Group (MKCCG). The pilot runs to March 2016.
- **Tier 4** provision is commissioned by NHS England. On occasions of high demand and uncertainty of need, young people are admitted into the wards of Milton Keynes University Hospital Foundation Trust (MKUHFT) or the local adult Mental Health Unit – the Campbell Centre. The nearest unit for young people is The Sett in Northampton.

The geographical location of Milton Keynes presents specific challenges in relation to patient flows and the interface with NHS England Specialised Commissioning teams and the Tier 4 in-patient unit placements commissioned by them. This is primarily due to the academic and clinical networks of Milton Keynes predominantly facing into Thames Valley/Wessex area.

Mental Health and Wellbeing Local Transformation Plans (LTP's) – Bedfordshire and Luton

New provider guidance was issued in May 2015 to implement the requirements for 'Future in Mind'.

NHS England (NHSE) have identified five years of recurrent funding from 2015/16 up until 2020 for each CCG to implement changes to children's mental health services in recognition of the need to increase early interventions which will reduce the need for crisis services in the future and achieve parity of esteem for Children and Young People. From 2020 this funding will be base-lined into CCG budgets.

In order to release funding from NHSE to each CCG a robust assurance process has been undertaken through development of local transformation plans which includes key outcomes and KPIs against which we will be monitored to ensure the funding is spent according to the priorities identified in Future in Mind. Our local transformation plan has been completed jointly between LCCG and BCCG to ensure efficiencies in costs across specialist services such as eating disorders and perinatal pathways are achieved.

The LTP identifies the outcomes and key performance indicators' (KPI's) signed off through BCCG Executive team and both Health and Wellbeing Boards against the four priority areas:

- Eating disorders community service
- Perinatal mental health
- Early Intervention / crisis prevention
- Addressing the needs of vulnerable groups and embedding CYP- IAPT (improved access to psychological therapy) principles.

The plans provide NHSE the assurance process to enable them to release funding to the CCG. A monthly steering group titled 'Bedfordshire and Luton Future in Minds Steering group' has been set up with key stakeholders invited. This steering group will monitor the

progress of the LTP and report back through the appropriate governance structures identified into each of the organisations: Bedford Borough, Central Bedfordshire and Bedfordshire Clinical Commissioning Group.

In addition, BCCG have been successful at bidding for a further non recurrent fund of £50,000 to become part of a Schools/ CAMHS training pilot which commenced in November 2015 to support this programme. Part of the requirement for receiving this additional funding was to match fund an additional £50,000 from the NHSE allocated transformation funds. This will support KPI's identified to improve early identification and early intervention to improve outcomes for Children's mental health and wellbeing.

Community Support (Bedfordshire, Luton and Milton Keynes)

The majority of children with a learning disability and/or autism are supported to live at home in family settings. There are a number of well-regarded special day schools and children and young people are able to access a range of support options including direct payments, homecare and respite. CAMHS teams have a strong focus on behavioural support and multi-disciplinary behavioural support plans are used effectively to support the majority of children and young people to live at home, however a small cohort of individuals cannot currently be supported in this way because of their intensity of need.

There is currently a shortage of local resource to support this cohort who are at risk of moving into residential schools/ 52-week placements out of area. The BLMK area currently has a total of 35 young people under the area in such placements. There are very few admissions to CAMHS inpatient units and this is now a service of last resort. Milton Keynes currently have no children and young people in inpatient units, and there are no children or young people covered in the remit of this plan from Bedfordshire or Luton in CAMHS inpatient units.

What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

There is not a significant estate in the BLMK area. The only relevant NHS estate for Bedfordshire and Luton is the Coppice, in Bromham, Bedfordshire. This is a seven-bedded unit accessed by people with a learning disability across Bedfordshire and Luton during episodes of crisis.

Locally the NHS does not directly provide accommodation or housing to individuals covered in this plan. The situation across the various local authority areas is detailed below:

Within Bedford borough partnership working is critical to meeting the housing needs of people with learning disability. There is a key role for Adult Services and the following links are also an important element to consider:

- Children's Services work with young people with a learning disability. An effective system must be in place for transition plans and year nine reviews to inform future accommodation planning and commissioning

- Bedford Borough Council does not hold a housing stock. Working with partners – particularly Housing Associations – is central to meeting housing needs.

- The Supporting People programme delivers housing related support to enable people with learning disability to live as independently as possible.

- The private rented sector is growing in size and importance within the overall

housing market. The Council's learning disability team members and Supporting People can work together on assured tenancies as a model for housing and support.

- This should include working with a range of bespoke solutions, e.g. solution housing supported by Turning Point; to make facilitate access to house ownership where that is a possibility.

Central Bedfordshire Council is committed to providing appropriate accommodation to people with a learning disability as part of its overall housing strategy.

Luton Borough Council works in partnership with a number of registered housing providers that provide either individual tenancies or small scale supported living schemes to some of the individuals covered in this plan. The council is currently reviewing its housing strategy for vulnerable adults; and is also looking to expand its own housing stock for people with a learning disability and/ or autism, particularly as there is a shortage of appropriate housing. A bid for TCP capital funding to support this is in the process of being submitted as a part of this programme.

Luton Borough Council is also building a new purpose built day centre and respite centre for adults with a learning disability. The services will be used by people with complex needs and challenging behaviour.

Milton Keynes Clinical Commissioning Group is coterminous with Milton Keynes Council, a unitary authority.

Housing in Milton Keynes is in high demand:

- There is limited housing stock directly owned by the Council.
- The majority of tenancies are a mix of the private and social housing sectors.
- Land in Milton Keynes, that is not privately owned, is controlled by the Milton Keynes Development Partnership and not the local authority

It is recognised that a cross-needs housing strategy needs to be developed in Milton Keynes for vulnerable adults considering Adult Social Care and Health and a housing steering group is to be established to manage this particular work stream. This will make best use of the available resources and provide a steer for housing partners, potential investors and developers. A combined approach is required to meet the needs of these groups in Milton Keynes and raise the profile of this work corporately within organisations at a time of extreme housing pressures across the population.

Milton Keynes has two NHS managed buildings where respite services are currently provided by the Joint Service. There is a 38-bed Mental Health inpatient unit which is rarely utilised for people with a Learning Disability and/or Autism. There is also a six bedded community unit that was decommissioned in 2013 as an LD inpatient facility, and re-provisioned for Mental Health services.

In addition to the above, the Council also delivers services for people covered by this plan from buildings it owns:

- Four day centres for adults
- A building for short breaks for adults
- A building for residential short breaks for children and young people
- A residential home for Looked after Children

The use of Residential Care has reduced locally, and is provided in housing association and privately owned buildings. The trend locally has been to de-register Residential Settings for a number of years. People have been supported to secure tenancies with social, or private, landlords and supported in their home by supported living providers. This trend is reflected in the Council's performance for Adult Social Care Outcome Framework (ASCOF) 1G indicator the proportion of adults with learning disabilities who live in their own home or with their family ("settled accommodation") with the 2015/16 Q3 performance of 80.1% compared to the England average (2014/15) of 73.3%. This will be the preferred option to support people covered by this plan wherever possible.

A combined approach, and housing strategy, across social care is required to meet the needs of the people of Milton Keynes going forward.

Moving forward the provision of additional accommodation and housing will be an essential element of the transformation plan across the partnership area.

Further detail is provided in section 4 of this plan under the heading "How will your local estate/housing base need to change". Work is in progress to develop the estates part of this plan and the overall programme which will address the demand/supply for accommodation; funding considerations and possibilities; and affordability issues/solutions. This includes the establishment of a housing steering group to scope accommodation and housing provision across the partnership and the development of an approved housing strategy for the partnership.

What is the case for change? How can the current model of care be improved?

What is working well in the BLMK area?

The three CCGs and four local authorities have already taken significant steps to reduce inpatient admissions and promote individualised support to people with a learning disability and/or autism. There is already a clear focus on supporting people in the community rather than in hospital. However, there is still room for improvement and the model of care can be developed further, to reduce delayed transfers of care, provide enhanced behavioural support, develop forensic support and ensure that the individuals who are currently living in hospital or out of area have the option to live in the community / closer to home, with a personalised package of care.

In Milton Keynes and in Luton there are well-established joint commissioning arrangements and budget pooling, which lead to joined up approach to commission of care/services is this area.

Where are the gaps in provision?

The most significant gaps in provision that would enable more people to live as independently as possible in the local area have been identified as follows and how they will be addressed is detailed later in the plan:

- Lack of readily available suitable accommodation. This is one of the main barriers that prevents individuals from returning back to area or from leaving hospital in a timely manner and has been a significant factor in recent delayed transfers of care.

- Sufficient high quality community support providers to meet the range of needs covered by this plan. There are a number of providers in the area that work well to support individuals that display behaviours that can (severely) challenge in either small scale residential care or supported living units, however we need more of this

type of care provision to meet a wide range of needs.

- Limited forensic services and support. There is currently limited forensic support for people with a learning disability / and or autism in the BLMK area, for individuals who have either offended or who are at risk of offending, with no embedded/ dedicated Learning Disability Forensic Service or specialism. Following the changes made to the Criminal Justice Teams the role of Social Supervisor for those patients with a learning disability being managed in the community under the Care Programme Approach were not considered within the integrated Community Learning Disability Teams (CLDT). This has left a significant gap in current care management function that is delegated to the Local Authorities within the CLDT's.

- Limited provision and lack of clarity around care pathways for individuals who have autism but not a learning disability. There have been improvements for this cohort however we are still developing care pathways for individuals who have an autistic spectrum condition but not a learning disability to ensure that they receive the best ongoing clinical and community support

- Some areas of the partnership have significantly higher than average numbers of children and young people with severe/ profound learning disabilities, however there is no local specialist residential school to cater for their needs. There are a several highly regarded specialist day schools and good access to respite within the partnership area however these are often not sufficient to support young people with the most complex needs. Consequently, these individuals are often leaving the area, often as teenagers to access specialist residential schools. Once out of area it is more difficult to support these individuals to return to area when they reach adulthood. We would like to work with children commissioners to look at innovative solutions to support more young people stay in area and a strong focus on transition services.

It is the intention of the TCP to plug these gaps through commissioning appropriate services (See Section 4 Implementation Planning)

- The CAMHS Transformation Plan has identified a need to develop a multi-agency-approach to planning and monitoring progress for children/young people in Tier 4 placements including supporting their return to community services. Practice should be that local providers continue to case manage to ensure continuity of care and to facilitate and expedite care being provided closer to home

- There is a lack of clarity around the care pathway for children and young people with complex and challenging behaviour, including children with Learning Disabilities.

What are the biggest challenges for the current service model in BLMK partnership area over the next three years?

- The Transforming Care programme reflects the growing agenda initiated by Winterbourne View, which involved small numbers of patients with high and complex needs. Transforming Care has expanded to be about how we provide services for a much broader population with learning disability/autism, mental health and challenging behaviours. This will require much more discussion and the issue of financial resource presents a significant challenge given the unprecedented growth the councils and CCGs are experiencing.

- The TCP will need to carefully consider commissioning challenges to provide

appropriate services that provide excellent value for money.

- The need to further enhance local community services and behavioural support, develop forensic services and fund additional community packages thus enabling more people to live safely within the community with limited financial resources available

- The partnership area has only a small NHS estate and therefore limited opportunities to remodel existing (building based) services and free up capital to develop new services and/ or increase capacity.

- Population increases, particularly in numbers of children and young people with complex needs will put pressure on community capacity, schools, inpatient units and other resources.

- The ageing population of those with a learning disability and/or autism requires will also require more proactive support, integrated around co-morbidities which are more common in later life. This care needs to focus on keeping people healthy and well in the community, and maintain their independence

- Given the challenges of an increasing population, with complex needs. we will need to work hard to ensure that we do not increase the number of spot purchased beds in independent hospitals

- We will need to identify appropriate land and resource to develop new purpose building accommodation and/ or access the existing housing stock more effectively and flexibly to support more people to live locally.

- We need to enhance whole system awareness and working and enhance integration between children and adults' services

- We need to build up a skilled and flexible workforce to work with individuals whose behaviour may challenge, across the partnership area

- Local Authorities are facing further austerity measures and will have to make further substantial savings in the next three years

To address these challenges, we will build on our strengths and implement the following:

- A system wide approach across specialised and CCG commissioning, education health, and social care and other services e.g. housing, criminal justice services for those in Bedfordshire, Milton Keynes and Luton with a learning disability and/or autism and behaviours that may challenge.

- A collaborative approach to commissioning relevant services across the partnership area

- Enhanced care and support services designed to minimise inpatient care and out of area placements when it is the best place for the person concerned e.g. intensive support, behavioural support, crisis intervention and respite.

- Significant market development and provider liaison is required to achieve the

changes required by building the skills and capacity in the market, and to avoid destabilisation

What would improved provision look like?

Improvement priorities for the BLMK partnership include the following key areas:

- Further developing comprehensive behavioural and intensive support services across the partnership area, which integrate fully with crisis intervention services

- Provision of specialist forensic intervention and support for those who have either offended or who are at risk of offending to ensure that behaviours and risks are effectively managed in the community. This is likely to be a community based forensic service which provides support, assessment and intervention at all stages of the individual's contact with criminal Justice Services for a variety of offending behaviours. During years 2 & 3 of the programme we will scope the requirements for this service and develop an options appraisal and business case.

- Developing a range of accommodation and support options available to support the varying needs of people with a learning disability and/or autism who may display challenging behaviour (including young people in transition) This would include faster access, options for shared ownership and a dedicated provision for people who are at risk of being admitted to hospital or placed out of area, or those who have already been placed out of area and wish to return.

- Ensuring full and effective utilisation of all local resources for people with a learning disability and/or autism who may display challenging behaviour across the partnership area, that aim to reduce the need for inpatient care. This includes the existing services such as the intensive support team, the Coppice Crisis Intervention Service and respite/ short stay provision.

- Ensuring that the ongoing transformation of local day services and day opportunities provide a clear emphasis on supporting the needs of individuals with a learning disability and/or autism who may display challenging so that more individuals with complex needs can access this provision locally.

- Establishing a range of "preferred providers" across the partnership area creating a pool of community based providers that have a proven track record of delivering high quality, cost effective "specialist" care to individuals with a learning / disability or autism with complex needs and behaviour that may challenge services. This would help provide economies of scale across the TCP and avoid duplication of effort.

- Developing a well-defined care pathway and a range of support options for individuals who have autism but do not have a learning disability.

- Developing a wider understanding of the factors that can lead to behaviours that challenge, and models of care that promote active support and positive behavioural support across the health and social care workforce to help prevent the incidences of challenging behaviour and to enhance independence and community involvement across learning disability services in the partnership area.

- Aligned to this is working alongside children's services and CAMHS to gain a better understanding and awareness of the factors that lead to children and young people

with complex and /or intense needs moving into 52-week placements out of area before they reach adulthood. From this we will need to learn, explore best practice and develop more innovative solutions for supporting children and young people with this level of need to live within area.

- An integrated care pathway for children and young people with complex and challenging behaviour, including children with Learning Disabilities which includes a diagnostic service for Autistic Spectrum Condition (ASC), Attention Deficit Hyperactivity Disorder (ADHD) and conduct disorders which meet the needs of 0 to18 year old Children &Young People (C&YP).

- In consultation with children, young people and their families, the pathway for a young person with a learning disability will be developed and strengthened including existing services that promote mental health and wellbeing for C&YP with specific needs including long term physical conditions, and children with Learning Disabilities so that children with specialist needs have access to psychological support.

Please complete the 2015/16 (current state) section of the 'Finance and Activity' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

A finance template has been completed by the three CCG areas and is now shown as a combined template for the whole TCP area. This can be found as a separate attachment and includes notes and caveats as appropriate and where possible.

3.Develop your vision for the future

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

Projected end state: Adults

Table 3.1 TCP inpatient population in beds in footprint

Unit (NHS)	Unit (Non NHS)	CCG or NHSE?	Type of bed	No of beds	No of beds to be commissioned / contracted by TCP	No of beds required by TCP**
NHS Unit		CCG	Crisis	10	10	10
NHS Unit		NHSE	Secure	UK*	0	4

*UK = Unknown

**The aspiration for the partnership is for all partners to move to the model where inpatient beds are used for crisis only enabling people to remain within the community as far as possible. However care will be planned around the person and the best course of action may be to make a longer term of arrangement. Due to the low numbers involved it is anticipated that this would be out of area

Table 3.2 TCP inpatient population in beds outside footprint (out of area)

Unit (NHS)	Unit (non NHS)	CCG or NHSE?	Type of bed	No of beds required by TCP
	Non-NHS units	CCG	Locked Rehab	1
	Non-NHS units	NHSE	Secure	7

Note that the level of need both within and outside the footprint is dependent upon the right package of support for the individual and this may not be available within footprint.

Projected end state: Children

Table 3.3 TCP inpatient population in beds in footprint

Unit (NHS)	Unit (Non NHS)	CCG or NHSE?	Type of bed	No of beds	No of beds to be commissioned / contracted by TCP	No of beds required by TCP

Note – at this stage it is anticipated that there will be no in area provision.

Table 3.4 TCP inpatient population in beds outside footprint (out of area)

Unit (NHS)	Unit (non NHS)	CCG or NHSE?	Type of bed	No of beds required by TCP
	Non NHS Unit/NHS*	NHSE	Secure	4

Note that the level of need both within and outside the footprint is dependent upon the right package of support for the individual and this may not be available within footprint.

What are our aspirations for LD services and outcomes?

Quote from service user following repatriation after a 2-year period in hospital out of area

"I have a lot more freedom here, as now I have left hospital I'm doing a lot of things myself, and I don't need a lot of help from anybody really"

"In the past I needed a lot of support, I'm pretty independent now"

The vision of this partnership is that we will work with service users, their families and carers and other stakeholders to deliver a plan that

- reduces the numbers of in-patient admissions required for people with a learning disability and/or autism
- manages effective discharge and transition for people in hospital
- builds resilient community services to support people to live as independently as possible in the most appropriate community setting.

At this stage the BLMK transforming care partnership "vision statement" matches that of the national service model:

"*Children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition have the right to the same opportunities as anyone else to live satisfying and valued lives and, to be treated with the same dignity and respect. They should have a home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life"*

Source: Supporting People with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition: Service Model for Commissioners of health and social care services, October 2015.

The localised vision for the partnership was discussed further at a workshop supported by NDTi on 23rd March and discussed further in the TCP Programme board taking place in the afternoon of the same day. The localised vision will be developed further during the early stages of the programme (Q1 2016/17) with a focus on the individuals, their families and carers and their normal life and aspirations. This will take into consideration evidence based best practice and look at opportunities for innovation in prevention, workforce and market development.

Purpose and aims of the BLMK transforming care partnership

The purpose of the BLMK transforming care partnership plan is to bring about greater collaboration and strategic planning across adults and children's services and commissioning agencies to deliver an improved model of care for people with learning disabilities and/or autism with challenging behaviour across the partnership area. This will promote prevention and early intervention and further reduce admissions to hospital and inpatient units and delayed transfers of care. A significant part of our plan will also be about enabling more people to have a long term home in the local area, rather living in out of area placements.

The partnership expects that care and support will:

- Be closer to home (within partnership area)
- Informed by best practice
- Be personalised and responsive to individual needs over time
- Be based on individuals' needs and wishes (and those of their families)
- Be of high quality
- Provide value for money

The expected outcomes for people with a learning disability and or autism as a result of the transformation are:

- More people with learning disability and/or autism will be supported to live locally in the community/in their own homes, this includes people who are currently living out of area in residential placements and young people who are transitioning into adulthood.

- The frequency of people displaying behaviours that challenge will be reduced, as will the severity of behavioural episodes

- People with a learning disability and/or autism who display challenging behaviours will be supported and enabled to live safely in their homes wherever possible

- In the long term fewer people from the partnership area will be admitted to non-secure and secure hospitals, with fewer beds in independent hospital spot purchased for the Bedfordshire, Luton and Milton Keynes population

- Delayed discharges will be minimised

- Any necessary inpatient stays will be as close as possible to the individual's home and support networks, and for the shortest period necessary

- People with a learning disability and/or autism who display challenging behaviours will enjoy an improved quality of care and an improved quality of life

- More people with a learning disability and or autism will have a personal health budget or integrated personal budgets and more joined up planning over the course of their lifetime

How will improvement against each of these domains be measured?

The following national indicators are likely be used to measure improvements:
Table 3.01 National Indicators and source of data/evaluation tool

Indicator	Source of data/ evaluation tool
Reduced reliance on inpatient beds	Assuring Transformation Data Set
Quality of Life	Health Equality Framework
Quality of Care	To be confirmed, NHS England is supporting the development of a basket of indicators around personal budgets, direct payments, personal health budgets and other evaluation methods. This will be considered as a part of the programme. See Appendix A.

Alongside the quantifiable measures outlined in Appendix A, we will also measure our success against the expected outcomes identified above and against individuals' perceptions and outcomes in relation to the care and support they receive. The Building the Right Support service model "Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition" October 2015 defines 9 principles seen from the point of view of a person with a learning disability and/or autism:

- I have a good and meaningful everyday life
- My care and support is person-centred, planned, proactive and coordinated
- I have choice and control over how my health and care needs are met.
- My family and paid support and care staff get the help they need to support me to live in the community
- I have a choice about where I live and who I live with
- I get good care and support from mainstream health services
- I can access specialist health and social care support in the community
- If I need it, I can get support to stay out of trouble
- If I am admitted for assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high-quality and I don't stay there longer than I need to

We will aim to build a local set of statements working with people to develop them. As an example, these could include working with people to develop "I statements" such as:

- I am safe
- I am supported to keep in touch with my family and friends
- I have regular care reviews to assess if I should be moving on
- I am involved in decisions about my care
- I am supported to make choices in my daily life
- I am supported to live safely and take an active part within the local community
- I get good quality general healthcare
- I get the additional support I need in the most appropriate setting
- I get the right treatment and medication to keep me well
- I am protected from avoidable harm, but also have my appropriate freedom to take risks
- I am treated with compassion, dignity and respect
- I have a choice about living near to my family and friends
- I am cared for by people who are well trained and supported

(These have been adapted from "Transforming Care for people with learning disabilities in Arden, Herefordshire and Worcestershire" and will be reviewed and updated by local Service Users and Carers to meet local requirements)

Describe any principles you are adopting in how you offer care and support to people with a learning disability and/or autism who display behaviour that challenges.

Policy, Legislation and locally agreed underpinning principles

The BLMK partnership will follow the main principles of the key Department of Health policy documents for people with a learning disability and autistic spectrum conditions. These include the long established strategy "Valuing People: A New Strategy for Learning Disability for the 21st Century" which fully promotes the rights, independence, choice and inclusion of people who have a learning disability, "Think Autism" and "Fulfilling and

Rewarding Lives: The Strategy for Adults with Autism in England." These national strategies promote the principle that adults with autism have the same rights as everyone else, and that they should be able to access services and participate in society on an equal basis

The partnership will also work to the key principles set out in primary legislation including The Mental Capacity Act (2005), the Care Act (2015) and Children and Family Act (2015), collectively these will support us to meet out aspirations, objectives and expected outcomes by embedding the following underpinning principles:

- Service users and their families will be at the heart of decisions about their care, they will be provided with more choice and control over their care, this includes promoting a culture of positive risk taking and coproduction.

- We will assume a person has the mental capacity to make decisions about their care, unless it is established that they lack capacity for that specific decision – and all practicable steps will be taken to support the individual make their own decisions

- We will establish the extent of a person's mental capacity as soon as there is any doubt as to whether the person has the mental capacity to make decisions

- Services will be commissioned which promote local solutions, prevention, early intervention and wellbeing to support people of all ages, including children, who are at risk of developing challenging behaviours and minimise inappropriate admissions to hospital, and the Criminal Justice System

- We will encourage the use of mainstream services as the starting point for care and support, available and accessible for those with a learning disability and/or autism

- Where mainstream services are insufficient to meet a person's needs we will provide access to specialist multi-disciplinary community based housing and support expertise

- We will work in partnership with care and housing providers, as well as others stakeholders to deliver the transformation agenda and ensure people's homes are in the community

- Commissioners and providers of care and support across the partnership area will collaborate and share knowledge, experience and best practice to achieve the best outcomes for service users, this includes collaborating regionally across the wider Eastern Region and with NHS England specialised commissioners where appropriate

- People involved in implementing the plan will use a problem solving 'can do' approach

- We will develop cost effective services which promote individuals' independence

- We will provide support in the least restrictive setting possible that is therapeutic and safe for all. Where restrictive interventions are required they should be for the shortest time possible

- We will proactively use intelligence from a range of sources to identify and respond to commissioning gaps and to facilitate and shape the local health, social care and housing market

- We will protect those with a learning disability and/or autism from abuse and neglect wherever possible, and address safeguarding concerns as soon as they arise

- We will ensure that people with a learning disability and/ or autism and their carers have access to advocacy support to voice their views at all stages of their journey.

Please complete the Year 1, Year 2 and Year 3 sections of the 'Finance and Activity' tab and the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

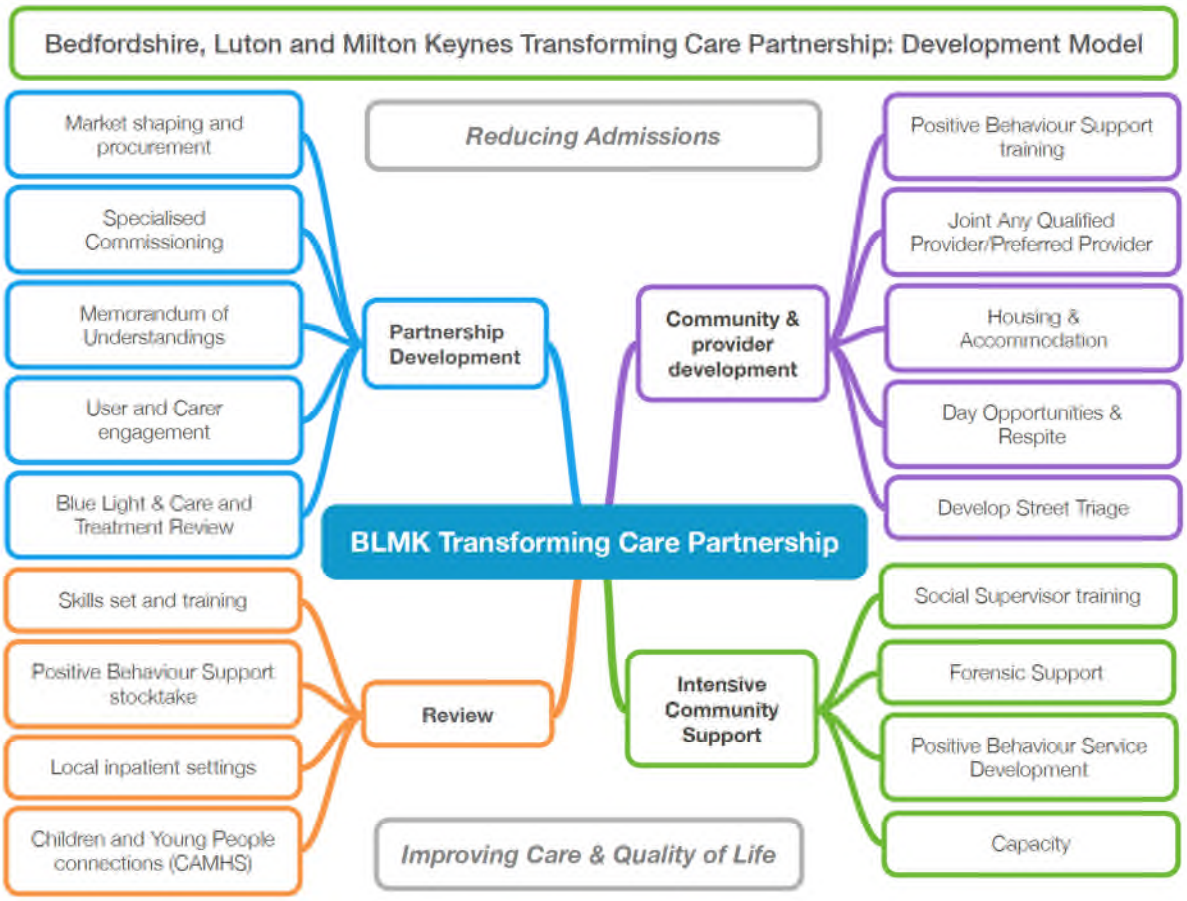
A draft finance template has been completed by the three CCG areas; the combined template can be found as a separate attachment.

4.Implementation planning

Proposed service changes (incl. pathway redesign and resettlement plans for long stay patients)

Overview of your new model of care

Chart 4.01 Bedfordshire, Luton and Milton Keynes Transforming Care Partnership: Development Model



Our current plan has three key phases to deliver this model and can be summarised as follows:

Phase 1 – 2016/17

- Establish the foundations of a tri-CCG approach to transforming care; this will include establishing a formal agreement across the three health commissioners. The purpose of the agreement is to formalise a memorandum of understanding on how the areas will work together in a way that enhances our services and improves the offer available.

- Development of a stakeholder engagement and communications strategy and plan also to incorporate:
  - Further engagement with the two Autism Partnership Boards and three Learning Disability Partnership Boards and four Carers Partnership Boards to ensure that

we are all working together on this agenda, and that we have appropriate representation at both reference group and Transforming Care Board levels

- A review of the way we are involving people from all five cohorts in the design and development of the local service model to ensure we have ways of including all of them in ways that are meaningful to them.

- Working with Children's and Transitions Services to establish how they wish to lead on this aspect of work, and how we will work together towards the all age approach that is required

- A joint approach will include sharing systems for working and commissioning providers, such as a joint Preferred Providers List (PPL) / Any Qualified Provider (AQP). We will jointly scope our market position and the viability of an enhanced supported living scheme across the footprint for those aged 16-25 years. This scoping will include Continuing Health Care (CHC), out of area placements and challenging behaviour.

- Further work on identifying the number of current and future patients likely to require forensic support. The formulation of a TCP footprint approach to this group also provides wider opportunities to understand and enhance day opportunities and respite for at risk groups.

- Development of a cross-needs housing strategy for vulnerable adults considering Adult Social Care and Health and including those with a learning disability and/or autism and challenging behaviours

- During this phase we will implement a process to share information, intelligence and quality data on the various providers of support and hospital admission.

- Robustly work on our data to ensure its validity and aid accurate and effective planning for Phase 2 and 3 to inform any regional commissioning outside of this partnership.

- We will look to extend the scope of the PPL/AQP to include social care across the TCP footprint.

The activities from Phase 1 will inform both Phases 2 and 3 which are likely to expand. The plan needs to be have sufficient flexibility to respond to newly identified and changing needs

Phase 2 – 2017/18

- We will understand, plan and cost a community based forensic solution focused on reducing the offending and reoffending rate of people with a learning disability/autism.

- We will scope out the unmet needs of individuals who have autism but not a significant learning disability to map out gaps in service provision and how the care pathway can be improved for this cohort.

- We will scope out the factors leading to 52-week out of area placements for children and young people under 18, and start to map out how the care pathway and models of support can be improved for this cohort.

- We will model the TCP footprint inpatient requirement assuming a reduction in out of area placements of 75%.
    - building up our community services- more providers providing better quality support accommodation
    - up skilling of our community workforce – preventing admission/reducing potential for people to escalate to a crisis situation
    - more robust service specification and monitoring of providers
    - increased provision of respite services
    - Improved transition plans for people returning to area

Phase 3 – 2018/19

- We will aim to build the capacity and capability of the market for community services, potentially commissioning a TCP forensic service working together across the footprint if appropriate.

- We will jointly provide an inpatient learning disability /autism solution across the TCP footprint, with a reduction in the average length of stay. Delivering a service model across the footprint that draws on a shared understanding of positive behavioural support, an emphasis on support being provided where the patient is, and available 24 hours a day seven days a week.

- We will start to explore an "all age integrated" approach for care, support and financial planning for the cohorts covered in this plan

Delivering this transformation requires significant planning and implementation effort, and a programme to achieve this will be in place for at least the next three years.

What new services will you commission?

The BLMK partnership will commission:

- Additional (individualised) care packages for those who are either currently in hospital, out of area residential placements (school) or living at home with families. This may involve collaborative procurement for priority commissioning areas (see above)

- Social Supervisory training for care managers within the Adult Learning Disability Teams in the Local Authorities to enable and skill the work force to manage those individuals who are under CPA and require a Social Supervisor.

- Training around Positive Behavioural Support (including cascade training) to up skill and develop a framework for the learning disability providers and family carers. This will be intelligence led and developed in partnership with in both the health and social care arena to enable providers to offer a higher quality and safe support to people living in the community.

- A review of transition services for young adults to include modelling a small intensive support unit shared across the partnership, with a view to procurement

- Specialist forensic intervention and support for those who have either offended or who are at risk of offending to ensure that behaviours and risks are effectively

managed in the community.

- Engage and scope innovative approaches to support more young people to stay at home or in area rather than move to residential school out of area and away from their friends and family network. This will be done in partnership with key stakeholders to enable the exercise to be system wide.

What services will change or commission less of?

The key expectations of the BLMK TCP Partnership are to:

- Reduce the usage of spot purchased beds in independent hospitals in the long term. This will be achieved by making more effective use of NHS learning disability crisis intervention services and mainstream mental health beds in area.

- Commission high quality and sustainable community based care and support packages; rolling out a programme for positive behavioural support; and where necessary intensive support, for those at risk of admission; as key measures to prevent the escalation of challenging behaviour.

- Commission fewer residential care placements out of area (including 52-week placements for children and young people). The partnership plans to develop appropriate (supported living) services in area. These will focus on young people in transition and individuals moving back into area from out of area placements, as well as providing long term support for those currently living with family members or carers as required. This will include:

    - the identification of additional providers of respite services to support children and families and reduce the risk of a crisis situation developing
    - scoping the potential for providing additional, specific therapeutic support for children outside what is currently provided by NHS or social care provision

- The provision of high quality and personalised support in area will positively promote continuity of care, independence and increased stability for the individuals concerned, with reduced the likelihood of placement breakdown.

- Individually and collectively, partner organisations will work with stakeholders, including people with Learning Disability and/or Autism, to identify additional services that do not add significant value to their lives to consider using resources more effectively in other areas.

- Over time commissioning will be towards those services that work and hence those that have no evidence base for better outcomes can be de-commissioned

More detailed proposals as to how the partnership can work towards significantly reducing the number of 52-week out of area placements for children and young people will emerge after initial scoping in Phase 2 of the partnership plan once we have a clearer picture of the key factors and challenges influencing current practice.

It should be reinforced that CCG's within the partnership area have already taken significant steps to reduce reliance on inpatient care and it is therefore not considered appropriate to further reduce residual NHS acute crisis inpatient beds.

What existing services will change or operate in a different way?
The phase plan detailed above in the section "Overview of your new model of care" details how service transformation will be achieved.

Below we have identified some of the key changes that existing services will need to make within the lifetime of this plan. Individually and collectively, partner organisations will need to work with stakeholders, including people with a learning disability and/or autism, to identify what other changes existing services might to make to add the most value and make better use of available resource. All services will be encouraged to self-audit as a part of the clinical model work-stream.

Specialist Learning Disability Services
Commissioners will need to work with specialist services to ensure that all services delivered meet requirements of this plan, in particular this will require a review of capacity for forensic support and intervention for those whose have either offended or who are risk of offending. Commissioners will also need to work with specialist services to ensure that there will be adequate specialist medical and psychological support for individuals returning to area from long stay hospital placements.

NHS Acute Crisis Service and Intensive Support Teams
The partnership will explore the possibility of the Coppice acute crisis intervention unit taking limited referrals from Milton Keynes, as well as Bedfordshire and Luton This will involve a full options appraisal/ feasibility study. This action will support the objective to reduce usage of spot purchased beds in independent hospitals as Milton Keynes has no acute crisis inpatient service at present and currently uses independent hospitals for this type of provision.

A gap analysis will be taken forward by ELFT to review the Coppice and IST. We will build on the AIMS LD accreditation review for these services that is due to take place in Quarter 1 2016/17 to identify any gaps in service provision and any further changes required to make improvements. The ambition is to have a responsive modern crisis intervention service that can be utilised across the partnership.

The partnership would also ideally like to increase the capacity of the intensive support teams, this would enable a greater presence in and closer joint working with community teams in each of the local authority areas, and increased focus on crisis avoidance and potential further reduction in inpatient usage. We have submitted a bid to fund additional nurse support for the intensive support teams

Care Management
Care coordinators across the partnership will continue to operate a person centred approach ensuring where possible that the MDT provides a timely and responsive approach that avoids crisis and prevents hospital admissions. Care coordinators are well placed to promote the use of personal health budgets and direct payments to maximise choice and control for customers and their family carers and to ensure advocacy support is accessible when needed. The partnership will ensure that care coordinators have the right skills to respond appropriately to customer needs as they step down from secure and acute inpatient settings.

Independent hospitals
Within the transformation agenda it is essential that independent hospitals consider future

demand and the likelihood of a reduction in overall bed base. We will work with independent hospitals and inpatient units to encourage them to review existing service models so that they align with new models of care and are clearly focussed on a care pathway that supports focused interventions, timely and well supported discharges and develop expertise and innovation in community settings rather than hospital.

Community Living

Care and support providers will need to continue to ensure that they have well trained and supported staff so that they can build confident, consistent and competent staff teams to support the individuals in each of the 5 cohorts. They will also need to ensure that staff have effective skills in positive behavioural support and active support, to build on individuals' strengths and independence and deescalate behaviour that may challenge. Providers will also to ensure that they are able to recruit an increasing number of appropriate staff to support people to live in the community, adopt a proportionate and positive approach to risk taking, develop crisis prevention plans and deliver responsive services that demonstrate clear outcomes and offer excellent value for money. It will also be essential for care and support providers to work in partnership with commissioners and housing providers to develop sustainable housing solutions.

During our review and scoping of day opportunities and respite services which are currently being reconfigured, we will ensure that the needs of our transforming care cohorts are fully incorporated into the service transformation plans

Wider pathway

Commissioners, the health facilitation teams and Intensive Support Teams will need to step up their approach to ensure that the wider health and social care workforce and mainstream services (including mental health inpatient units) are up-skilled in making reasonable adjustments for people with a learning disability and /or autism. The ongoing development of the wider workforce will help ensure improved access to mainstream services where appropriate, continuity of practice and enable flexibility and person centred approaches, all of which support promote equality and the implementation of this plan.

CAMHS

Commissioners will need to work with CAMHS services to identify strategies in supporting more children and young people with complex/and or intense to live at home rather than in 52-week residential placements out of area or in hospital. This will build on good practice already in place around home based intervention and behavioural support, best practice and innovation.

Describe how areas will encourage the uptake of more personalised support packages

Personalised Support in Hospital and Inpatient Settings

Patients who access the Coppice acute crisis intervention service will continue to receive integrated and person centred support from IST throughout their stay to provide seamless and focused support and continuity of care.

Patients admitted to inpatient settings will have timely Care and Treatment Reviews on or shortly after admission in accordance with national and local protocols to ensure that hospital is the most appropriate setting and to make sure that patient receives both high quality and focused inpatient care, with clearly defined expected outcomes and person centred discharge planning

Person centred care and support plans will be developed with the patient and or their family during their stay and will likewise aim to ensure that care is person centred and has clear objectives which will support them to build their independence when they return to the community. Additional tools such as communication passports will also be developed as required.

We will also continue to ensure that individuals in inpatient settings have access to good quality advocacy

Quality and contract monitoring arrangements will monitor and evaluate the extent to which individuals are receiving personalised support in inpatient settings.

Personalised Support in the Community

The intensive support teams will continue to provide person centred support aimed at admission avoidance and integrated care model.

Through the provision of information, market shaping, market development and focused procurement we will aim to improve the range and choice of providers across partnership area to cater for the range of needs of those covered by this plan. We will ensure that service users get good quality information about the services available and will develop a market position statement for the partnership area with the aim of building up a strong network of providers and a common preferred provider list that details local providers that have a good track record of providing person centred care to people with behaviour that challenges and complex needs.

To complement this approach, we will continue to move towards an outcome based approach to commissioning and through our various quality assurance mechanisms focus on key outcomes such as quality of care and support, quality of life and increased independence and community participation.

Accommodation – we will aim to increase the range of accommodation options available to the individuals covered in this plan, exploring innovative and joined up solutions. We will explore shared ownership, etc.

The partnership area will continue to promote the use of personal budgets, personal Health Budgets and Integrated Personal Commissioning for people with a learning disability. An example of the local offer is attached (in this case for Milton Keynes) as appendix B.

One of the CCG areas (Luton) has become an Integrated Personal Commissioning (IPC) demonstrator site. IPC is a new initiative being piloted by NHS England to join up health and social care for those with high level, complex needs. It fits well with the transforming care agenda as it shifts power to the individuals who access health and social care, allowing them to shape services around their needs instead of fitting around standard service provisions. The goals of the programme are to create a better quality of life for those with complex needs and their carers, prevention of crises that lead to unplanned hospital and institutional care, better integration and high quality of care. IPC will involve producing one care plan which covers all the health and social care needs of the individual and an optional integrated personal budget, where appropriate, to enable those needs to be met with the services of the individual's choosing. The programme runs for three years – individuals with a learning disability and/or autism will be in a phase within the next two years. We will identify individuals who fall within the remit of this plan who would be interested in taking up IPC as part of the pilot.

We will also continue to offer personal budgets and personal health budgets across the partnership and enable and support higher uptake, working with advocacy organisations to

shared information and encourage uptake. Luton is an early adopter of personal health budgets and this experience will be shared with the partners to support successful delivery.

We will continue to support individuals to complete and update their person centred plans, health action plans and health checks to ensure the development and delivery of personalised support packages

The partnership will work with the wider learning disability workforce to raise awareness of approaches such as positive behavioural support and active support to help to develop a proactive and positive approach to working with individuals whose behaviour may become challenging.

The partnership will continue to provide advocacy support for individuals in the community to ensure that voice of the most vulnerable is heard and we will fully engage with people with a learning disability and/ or autism through the relevant partnership boards, focus groups and co-production projects to ensure they are partners in the review of existing services and the design of new services.

Advocacy service in Bedfordshire

An example of the work currently being done to improve the advocacy service within the partnership comes from Bedfordshire where BCCG, CBC and BBC are committed to providing accessible and safe services within its budget envelope and has, in partnership, redesigned the Advocacy Service model to ensure it reaches the vulnerable people it is intended for, whilst meeting its statutory obligations.

Partners have been working with the current provider, POhWER, on the service redesign for 2016/17.

The redesigned advocacy service is summarised as follows:

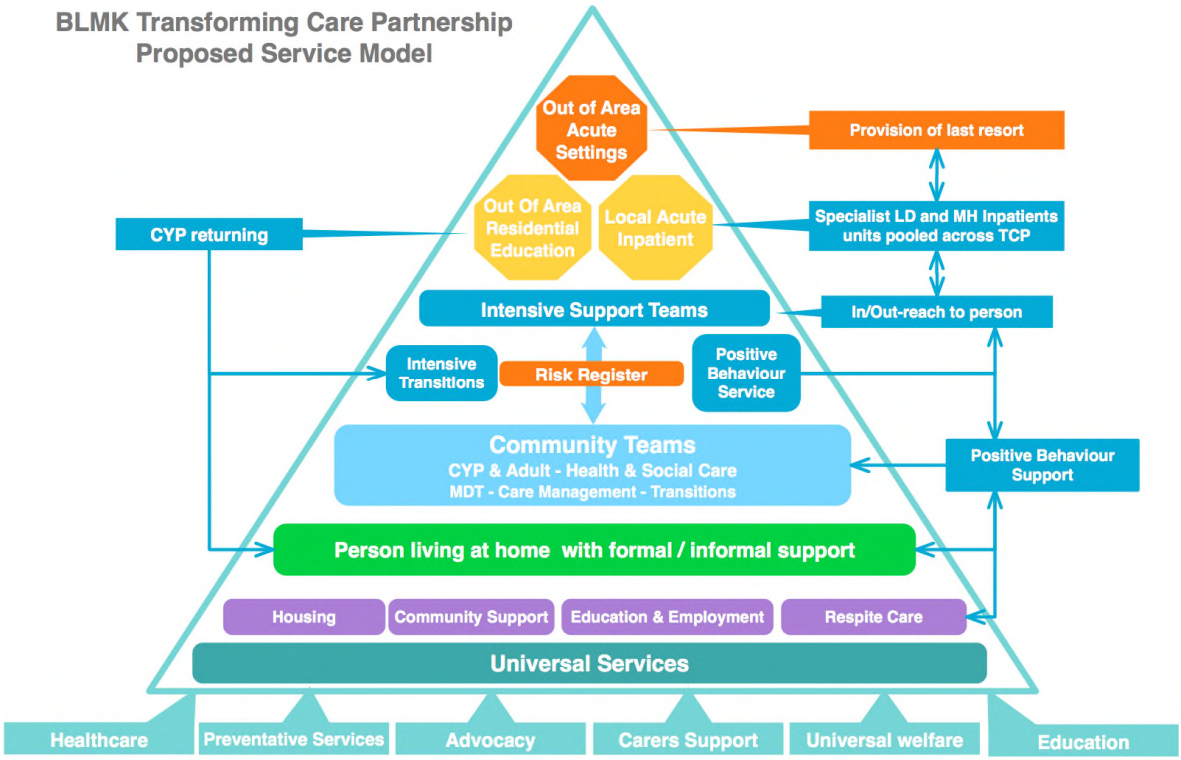
- Meets all necessary statutory requirements.
- Provides the best standards of care and support for people using our services within available financial resources.
- Ensures best value for money.
- Introduction of eligibility criteria, to ensure advocacy services are in place for vulnerable people.
- Local Authorities will work with support organisations where possible to signpost people to the most appropriate service.
- BCCG has committed additional funding to support the Care Treatment Reviews, in turn helping to keep people out of hospital as part of the Transforming Care Workstream.

It is intended that the advocacy contract will be re-tendered for 2017/18, with work beginning on the procurement of the new contract in the first quarter of 2016/17. The purpose of this is to continue to ensure best value for money whilst ensuring the service meets all statutory requirements and provides the best standards of care and support for people using the service.

What will care pathways look like?

The proposed service model is in development and will be further developed as a part of this programme; however, the current proposed model (as of 11th April 2016) is depicted in Chart 4.02 below.

Chart 4.02 Bedfordshire, Luton and Milton Keynes Transforming Care Partnership Proposed Service Model



As described previously the current configuration and alignment of services across the partnership varies both from area to area, and between children's to adult's services. Hence the proposed service model in the diagram above is not specific to one area but rather details the structure of services and interventions that can be flexed around the individual.

The proposed service model will mean the reconfiguration and development of existing community resources. The diagram above shows how the principles of Positive Behaviour Support (PBS) will move with individuals through the system and wider services.

The investment in PBS training across the partnership will help the recovery of complex individuals by enabling a more consistent approach across services. This learning will also cascade to develop services to best meet the needs of people and stop an escalation of these needs.

The aims of the model are to:

- Support people in settled accommodation as close to their informal networks as possible.
- Ensure the support they receive is positive and proactive.
- Ensure the support accessed is embedded in their community.
- Up skill the wider workforce to support lower level risk groups effectively and avoid future escalation of need.
- Further develop specialist interventions that can be applied flexibly across the system as required.

A more joined up approach both within systems, and across the wider partnership, will

enable a better understanding of those who may be at risk of admission and the adjustments and support needed for existing services to deliver individual approaches to maintain peoples wellbeing.

The aim of the model is to move away from a purely pathway approach to care and support, where people enter and leave a system, to a flexible model that can wrap around individuals and those who care for them, at times of need.

How this model will look in practice will likely continue to vary from area to area. As the partnership embeds, and strands of the plan are implemented, the consolidation of these practices will produce more joined up ways of working and drive the transformation of care across the partnership.

How will people be fully supported to make the transition from children's services to adult services?

Across the partnership young people are currently referred into adult social care around the age of 16 years and this practice will continue. There are dedicated transitions workers in the community learning disability teams who work with the majority of young people transitioning through from children's services to ensure a smooth, well planned transition.

Young people (and their parents / carers) are introduced to the idea of preparing for the adulthood from the age of 14. This is a statutory obligation for young people with Statements of Special Education Needs.) Locally there are still issues in relation to young people getting the most appropriate support when they become adults and leave (educational/ residential) placements as there are not always appropriate services available locally. This is a priority need for the partnership to address. There are also still some problems for some young people who do not have a significant learning disability because it is not always clear which team is best placed to work with them. We will continue to develop a clear and effective pathway for these groups and develop appropriate local services so that young people have opportunities to return to area and receive the high quality support. We need to make sure that we are investing in the right services and building capacity to meet the needs of the growing number of young people moving into adulthood as it is projected that numbers will grow very significantly from 2020 in some parts of the partnership area.

We also need to embrace partnership working with young people, their families and carers involving them fully to make sure that we are building the most appropriate person centred services for the future. We will also review existing resources accessed by young people to make sure that they are person centred and enable people to gain independence and meet their individual goals.

How will you commission services differently?

Across the partnership there will be an increased focus on outcomes when commissioning services, notably around the quality of care and support, and the quality of life enjoyed by those with a learning disability and/or autism, and their family and carers.

The partnership will develop a joint market position statement and strategy and engage in collaborative commissioning to establish a common preferred provider list (PPL/AQP) and undertake shared procurement exercises where this is beneficial. This way of working will help form a "critical mass" of people in need of specific services which will encourage providers to establish themselves within the locality and create some degree of "economy of scale" This will help overcome some of the problems previously experienced in

commissioning services.

The TCP and commissioners will need to work with the independent and third sector to ensure there is a vibrant and high quality market to support the needs of people with complex needs. As different models of care emerge local commissioners will need to explore opportunities to commission services in different ways to fit people's needs with a range of providers.

Greater understanding of the children's and autism population will mean commissioning arrangements may need to change. Market development activities will be required where providers do not currently have the capability required.

The increase in complexity of needs and also the increased use of personal budgets and personal health budgets means that a small niche of providers is likely to be required to address some of the accommodation requirements. Therefore, commissioning mechanisms, as well as market development activities, are likely to need and encourage a much smaller type of provider.

Luton and Milton Keynes have pooled budgets in place across their CCG's and Councils. These arrangements will continue.

Bedfordshire do not have a pooled budget arrangement for learning disabilities, however there is a S117 Protocol in use between Bedfordshire CCG, Central Bedfordshire and Bedford Borough Council.

The purpose of this protocol is to:

- Establish a locally-agreed shared understanding between the responsible authorities in Bedfordshire, of their obligations under Section 117;
- Provide guidance to practitioners responsible for the delivery of Section 117 Aftercare in Bedfordshire, and;
- Ensure the consistency and quality of aftercare services provided under Section 117 across Bedfordshire.

Funding for Section 117 aftercare is a joint responsibility of Bedford Borough Council or Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group. Funding responsibility is determined by the primary mental health need of the patient and the nature of the service provided. There are three possible options for funding arrangements and these include shared funding, Bedfordshire Clinical Commissioning Group funding where the individual is assessed to have a Primary Health Need (PHN) and Local Authority funded care.

If a patient is assessed to have both social care and health care needs under Section 117 then funding is shared between Bedford Borough Council or Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group on a 50:50 basis, e.g. a joint package of funding whereby Bedford Borough Council or Central Bedfordshire Council pays for accommodation and personal care support services and Bedfordshire Clinical Commissioning Group pays for additional therapeutic services or other healthcare support/interventions.

In June 2014 the Joint Improvement Programme audited Bedfordshire as a site in relation to their Transforming Care programme of work. A report was produced detailing the outcome of the audit and a number of recommendations were identified. The report states that BCCG and BBC / CBC are working together '*excellently'* and have developed *'high level of trust and confidence in each other'* but the formal financial planning and joint funding approaches

are *'relatively underdeveloped'.* The report went on to further describe:

> *'Progress had generally been made because a few people got together, decided to do something, and persuaded other people to let them get on with it. Generating a sense of shared ownership – rather than a written document – was often the starting point. Whilst it is good to encourage this sense of 'entrepreneurship', it means there is always a risk that work will stop if some key people leave or the organisations decide to withdraw support. Also, it means that different people may have different understandings of what the work is about and what it is trying to achieve'.*

A recommendation was to develop a local joint commissioning protocol in place of pooled budget arrangements to enhance the current joint working and commissioning arrangements. The key principles for this joint commissioning protocol are:

- document the key working principles
- document the processes already in place to commission joint packages of care for people with learning disability with complex needs between BCCG and BBC
- define the locally agreed shared understanding between the responsible authorities
- ensure continuity of care in the absence of key individuals and to thereby minimise risks to patients
- formalise the escalation routes in the event of disagreements

Case study: How innovative commissioning enabled three Bedfordshire patients to step down into supported living in the community

In December 2014 Bedfordshire CCG was served notice by an independent hospital that required three patients to be moved from the provision within a number of weeks. There was no provision identified locally for this cohort of patients and they all presented with behaviour described as challenging.

The CCG waivered a procurement process enabling the commissioner to approach three providers requesting that they submit plans as to how they would provide care and support to these three individuals based on their assessed level need.

The multi-disciplinary team (MDT) within the hospital setting made recommendations and the level of staff support was 3:1 in the community for these patients.

One of the three providers presented a plan whereby they would purchase an identified property within the patients Local Authority area and convert the property into seven one-bedroom apartments. The apartments would have their own front door however the scheme would have shared living space both inside the property and outside the property to enable integration for those who wanted to socialise. This would also enable floating staff support so that there would be flexibility within the service to manage unplanned situations should they arise.

The three patients had to be discharged from the hospital due to closure and an interim provision was set up as the scheme was not ready. This required the provider, commissioner and care coordinator to work with a registered social landlord where an old bungalow was converted into living areas for the three patients whilst the scheme was being purchased and built. One of the patients had not left the hospital building for over a year

and a full CPA, MCA and BI was carried out. The outcome was that the patient was sedated and conveyed via secure ambulance to the interim premise with a medical team on board. The patient would challenge if attempts were made for him to leave the site. All patients were discharged successfully into the interim placement which was a supported living scheme whilst the actual scheme was built.

The patients and their families were heavily involved in the design of the apartments and they were purpose built for the individuals with the support of occupational therapists (OT's) to enable reasonable adjustments to be made that were bespoke to the individual.

The patients moved into their new home in March 2016 and the patient who previously required a secure ambulance and sedatives, was conveyed to his new home in his hire vehicle with no PRN medication administered.

The scheme is fully operational now and individuals who are placed out of area in specialist residential / educational placements and who were placed out of area as there was no provision locally that could meet their needs are now being assessed for a placement within this new scheme.

How will your local estate/housing base need to change?

Changes to the local NHS estate

As explained in Section 2 there is limited NHS estate relevant to this plan in the BLMK footprint and therefore there are no real opportunities for recycling of capital receipts.

The limited local specialist learning disability inpatient unit provision will be reviewed across the partnership. It is anticipated that there will be a small increase in local NHS acute crisis provision. We expect that that by moving to this model we shall see:

- Focussed intervention at times of crisis
- Inpatient care closer to home
- A long term reduction in the net number of inpatients placements across the partnership (including placements in independent hospitals)
- A reduced length of stay (for current acute model average length of stay is seven weeks and we would expect this to align across the partnership)
- Improved quality assurance and AIMS LD accredited service provision.
- Increased local ownership across the partnership.
- Improved discharge and transition planning for a partnership provision.

Changes to the wider housing base

As identified in earlier sections of this plan suitable and readily available housing and accommodation are currently in short supply for the five cohorts of individuals within the remit of this plan and will be required to prevent delayed discharges and enable more people with live in the community within the BLMK area

We plan to work in partnership with the housing departments of four unitary authorities within the partnership to review the existing housing strategies for vulnerable people (including those in the five identified cohorts). We will feed into this review the anticipated demand generated by the transforming care agenda over the next five years. It is likely that registered housing providers and private landlords/ developers will have a significant role to play in meeting future housing need and we will ensure that anticipated demand is also reflected in the market position statement developed across the partnership area.

There are significant challenges in sourcing sustainable and affordable housing solutions,

particularly in view of rising housing prices, rent levels, uncertainty about future housing benefit and grant funding. For new developments. At a local level a good deal of work has already been initiated to engage with both council housing departments and registered housing providers to raise awareness of housing need related to transforming care and to start to find solutions in meeting it. We will need to take a range of approaches if we are going to be successful in meeting the significant new housing need generated by this plan, these are likely to include:

- Working with housing departments and registered housing providers to include the needs of the five cohorts in any potential Homes and Communities Agency (HCA) development bids
- Woking with Local Authority housing departments to purchase specific properties or renovate existing buildings as part of an invest to save programme
- Working with registered housing providers who may be able source suitable accommodation in the private rental market or be in a position to purchase suitable properties.
- Exploring potential options for individuals to have shared or full property ownership
- Working in partnership with care and support providers who may have existing relationships with housing providers.
- Where appropriate supporting individuals to assess general needs housing through choice based letting
- Applying for capital investment available as part of this transformation programme.

In relation to children transitioning to adulthood, during the phase 1 stage of our programme we intend to scope the need for children and young people approaching adulthood with a view to forecast for the next five years (2020/2021) We will ascertain the need for both accommodation and support across the TCP footprint; and work in partnership with both housing and care providers to meet it. We anticipate applying for capital funding to help meet building costs as part of this plan. The expected outcome will contribute towards enhancing community capacity that will support more people to remain independent and avoid hospital admission.

Alongside service redesign (e.g. investing in prevention/early intervention/community services), transformation in some areas will involve 'resettling' people who have been in hospital for many years. What will this look like and how will it be managed?

It is not anticipated that resettlement will be a significant issue for the BLMK partnership; however, we are awaiting confirmation of the final settlement from NHS England Specialised Commissioning.

The BLMK partnership has relatively few hospital placements that have in place for over 5 years, it also has low numbers of placements that have lasted 2-5 years

Table 4.01 Numbers of hospital placements lasting 2 years or more (CCG and NHS England Specialised Commissioning) as of 11th April 2016.

Area	Number of people who have been in hospital 2-5 years	Number of people who have been in hospital 5 years	Total
CCG	4	8	12
NHS Specialised Commissioning	4	5	9
Total	8	13	21

Individuals leaving hospital after a period of 5 years from the 1st April will be entitled to a financial "dowry", the exact details of which will be determined at a local level. The BLMK partnership will explore the possibility of taking a common approach to this. The partnership is also aware that there is a small complex cohort of individuals who are likely to have been in hospital for a significant length of time currently funded by specialised commissioning that are not yet allocated to a CCG. Risks around potential increase in patient numbers linked to this cohort are recorded as part of the risk register (section 5 – Delivery).

The BLMK partnership fully recognises that individuals who will be resettled after being in hospital even after several years are likely to have very specific and/ or complex needs. Resettlement will need to be well planned, person-centred, and care and accommodation may be of a much bespoke nature. Additional support may be required for the transitional period whilst the individual settles into the community and it will be essential that both patients (and their families) to have access to high quality advocacy throughout the resettlement process.

Overall, based on previous resettlement experience commissioners and practitioners will need to be mindful of the following challenges ensuring that relevant risks are carefully managed and mitigated both at an individual and local level, housing related issues will need to feed into any emerging housing strategies:

- Potential culture clashes and differences in ethos between the outgoing inpatient provider and incoming community provider which may lead to tensions, resistance and mistrust
- Accommodation- there may be issues around void underwriting as funders may not be willing to underwrite the risk that a placement in the community fails
- High rental charges for the types of properties required may not always be covered by housing benefit threatening the sustainability of a placement
- The types of property required may be in short supply/ not readily available.
- Budget holders may need to agree duplication/ double funding in the transition period.
- Patient willingness to move/ or otherwise
- Expectations and concerns of patient and family members.

Case Example

Please note all personal information including the name of the patient has been changed in order to maintain confidentiality.

John is a resident within the BLMK area, placed within hospital following a break down in his care and support. He was placed in an independent hospital in order to address his mental ill health. John was identified as someone who could eventually be supported in the community in a supported living environment. Following meetings with John and his care team a potential provider was identified to work with him. Accommodation was identified and the provider began the process of working with John in his current placement. This meant meeting with him and taking him out for the day, as part of the transition plan John was supported to travel back to his home area and view the accommodation and provide feedback in relation to the furniture and layout of his flat.

John was also provided with support from his local community team who continued to visit him and work with him and his transition team. After nearly three years in hospital John was supported to return back to his original area. At first he required a high degree of input and

support 24 hours a day, over the following months this reduced as he became settled and further engaged with community services and support from his family.

In the two years since John has returned to the community his reliance on services has dramatically reduced with the cost of his care reducing from £112,116 a year to an annual cost of £30,756.

How does this transformation plan fit with other plans and models to form a collective system response?

This joint transformation plan will link closely with the following existing strategies and plans and across the partnership area: -

- Local Transformation Plans for Children and Young People's Health and Wellbeing
- Local action plans under the Mental Health Crisis Concordat
- The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)
- Local Autism Strategies (Bedfordshire, Luton and Milton Keynes)
- The roll out of education, health and care plans
- CAMHS Mental Health and Wellbeing strategies for Bedford Borough and Central Bedfordshire

The joint Transforming Care plan supports the Joint Health and Wellbeing Strategies for all of the partners, e.g. the Milton Keynes Joint Health and Wellbeing strategy 2015-18, and in particular 'starting well: giving every child the best chance in life' and 'living well: working with communities to live longer and healthier lives'.

This joint transformation plan references and supports the:

- Local Children and Young Peoples Mental health and Wellbeing Pathway.
- The Local action plans under the Mental Health Crisis Concordat
- The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)

We will ensure that strategic links are made with the boards, implementation groups and work streams overseeing all of the above to ensure that plans fully join up, make the best use of resources and support integrated service delivery for people with a learning disability and / or autism. In phase one (2016/17) of our delivery we will develop and implement a consultation and engagement plan to ensure this happens.

Any additional information

5.Delivery

Plans need to include key milestone dates and a risk register

Phase 1 sees the development of the work packages as part of a programme management function that will reflect upon the following work streams as illustrated earlier in this document:

- **Workforce development & training** – the development of a workforce able to deal with the changing service and commissioner requirements. This is a major work stream which will commence in 2016-17 with a workforce review and skills mix analysis
- **Finance and activity** – which will need to develop financial and activity baselines to inform the business case and on-going reporting
- **Pathways & Clinical model** – we will establish a clinical reference group who will ensure the clinical model and pathway work is all clinically sound, safe and of high quality
- **Communication, Service user Engagement and co-production** – we will share information with our service users across the 3 years of the programme and consult with people who use services and work together with them from the start to the end of the programme.
- **Commissioning – market, provider and accommodation development** – this will focus on the development of integrated commissioning & personal (health) budgets; market management including housing; forecasting/modelling demand and measurement of success; the development of a procurement strategy for the partnership and ultimately the development of a joint preferred provider list.

Attached is the BLMK road map demonstrating

- Key work streams
- Key activities and steps
- Key milestones

Key activities to date include:

December 2015:

- Organisational / governance arrangements (mobilise 'partnerships') agreed and confirmed
- Senior Responsible Officer SRO and deputy from health and social care appointed
- Lead CCG (for host finance arrangements) agreed
- Involvement and engagement with NHS England specialised commissioners agreed
- Launch or 'go-live' date for partnership (where not already working together formally) agreed
- Outline scope of transformation plan and timescale for local delivery (includes publishing meeting dates for governing board) agreed

January to March 2016:

- First governing board meeting
- Work streams and leads identified, route map developed
- First and second cut transformation plans submitted 8th February and 14th March. Local assurance of plan coordinated through NHS England with stakeholders
- Plan finalised following regional and national moderation and feedback within March 2016

April 2016

- Final plan submission 11th April
- Begin to implement plans

Across the partnership, there are a number of areas where there is agreement to a single shared work-stream or plan for all partners. In some instances, the delivery of these common plans will be through local resources where in other areas it will be delivered through shared resources or a single service jointly commissioned by partners. There is also agreement across partners that there are areas where there will be separate plans that will be delivered locally. Across all plans, work-streams and deliverables, all partners will share good practice and successes to assure the best support and outcomes can be assured to all those suffering or at risk. The role of the Partnership board is to assure the delivery of all these plans regardless of whether they are locally or jointly commissioned and delivered.

Who is leading the delivery of each of these programmes, and what is the supporting team.

The key enablers particularly at this initial stage of the project are the Directors of Nursing (DON's) and Directors of Adult Social Services (DASS's).

Local resource across the partnership has not yet been identified for the long term plans; however the TCP have taken take responsibility for identifying key area leads to progress and take forward each identified work stream listed within the plan.

The Partnership has defined one overall programme of work. An interim programme manager is in place for the development of the partnerships Transforming Care plan. A programme manager will be appointed for the delivery of the overall programme for the partnership. It is recognised, however, that in a number of areas the work that will be delivered will be delivered by different projects or programmes across the partnership.

Table 5.01 sets out the identified individuals leading each of the work-streams inside the programme and key team members. The partnership is in the process of identifying and assigning leads to the Pathways and Clinical Model work stream and also the Workforce Development and Training work stream.

Table 5.01 Breakdown of work streams and work stream leads for the BLMK TCP Transforming Care Programme.

Work-stream	Work-stream lead	Team
Communication, Service user Engagement and co-production	Lisa Levy	David Pennington (Milton Keynes); Bridget Moffat (Luton); Kaysie Conroy (Bedfordshire)
Commissioning-market, provider and accommodation development	Bridget Moffat	Robin Goold (Milton Keynes); Michelle Bailey/Mary Bennis (Luton); Kaysie Conroy (Bedfordshire)
Finance and activity	Liz Cox	David Pennington (Milton Keynes); Bridget Moffat (Luton); Kaysie Conroy (Bedfordshire)
Pathways & Clinical Model	TBC	Fiona West (Childrens Milton Keynes), Amanda Griffiths (Milton Keynes), Service

		Manager TBC (Luton), Ops Manager TBC (Bedfordshire). Trish Brodie (Provider – ELFT)
Work Force Development and training	TBC	Robin Goold (Milton Keynes), Bridget Moffat (Luton), Kaysie Conroy (Bedfordshire)

There are area leads across the local authorities/CCGs. These are David Pennington (Milton Keynes); Bridget Moffat (Luton) and Kaysie Conroy (Bedfordshire). Additionally, within each organisation there is a single lead for each organisation who attends the Programme team meetings. Finally, within each organisation, there is a project team that oversees and delivers the work locally.

Additional key enablers include specifically the community teams' local practitioners, care managers, and social workers.

What are the key milestones – including milestones for when particular services will open/close?

Please refer to overview of the service model described earlier in the template, section 4 which describes the three proposed phases over the next three years and the attached route map.

The next key milestone is for the plan to be taken through the formal governance processes of the various partners for approval of the plan and associated templates by the end of July 2015.

What are the risks, assumptions, issues and dependencies?

The key risks, issues and dependencies for the BLMK programme are set out in table 5.02 below. The partnership is newly formed and covers four local authorities and three CCGs. The governance of the programme is therefore complex which the partnership recognises and acknowledges the risks that this raises. The most significant risks and constraints concern capacity, complexity and finance. The Programme Management Office will ensure adequate rigour is in place to manage these risks The programme risk register will be developed further as plans are progressed in more detail.

Table 5.02 Risk register for the BLMK TCP Transforming Care Programme as of 16th April 2016.

a result of….	There is a risk that….	With the result that…	RAG Rating	Mitigation and Controls in place	RAG Rating
A number of LD in-patients currently being unallocated to CCG areas	Specialised Commissioning will allocate an unknown number to BLMK	Costs will rise for either the in-patient budget or for the transition of patients back to the community		- Maintain close communications with NHS England in relation to the numbers and costs of patients - Challenge appropriately to ensure CCGs only takes responsibility for their own patients	
An shortage of housing stock in BLMK	insufficient, appropriate housing will be available for LD patients	patients will not be able to be transferred from in patient units back to the community		- Scope current provision - Work closely with local authority and private providers across the partnership to develop shared and innovative thinking in relation to accommodation	
Difficulties with recruitment and retention of suitably qualified staff	it will be difficult to appropriately staff the community services	patients will not be able to be transferred from in patient units back to the community or will not be able to be supported in the community and will need admission to hospital		- Undertake skills audit as part of workforce work stream - Consider training requirements as part of the plan	

The partnership financial position	the organisation is unable to support the required level of transition funding	the transition from hospital bed provision to enhanced community provision will be delayed		- Maintain close communication with NHS England in relation to transformation and capital funds available - Project team to work closely with CCG finance teams to ensure full understanding of plans and financial implications - Approved business case	
Multiple partners engaged in this process	difficulties agreeing and engaging	impact on the quality of life on those people who are to be supported to live in the local community		Plan is realistic and the setup of Memorandum of Understanding between partners will facilitate joint agreement and working.	

Dependencies

Successful delivery of this programme is dependent on a number of work streams and other plans. Robust programme management will support the partnership to manage these dependencies. The dependencies identified to date are listed below:

- Mental Health & Learning Disability Programme Boards
- Children & Young People Programme Boards
- Care Pathway & Primary Care Programme Boards
- Primary & secondary care health services
- Children & Young People services
- Older People Mental Health services
- Education
- Transformation plans e.g. CAHMS
- Health & Well Being strategies
- Private providers

Constraints

Project constraints that might restrict the delivery of this programme will continue to be identified and documented throughout the life of the programme. To date those identified, include:

- Transforming Care timescales and reporting requirements
- Financial constraints including the ongoing significant cuts to local authority budgets
- Capacity for delivery
- Recruitment and retention of a suitably skilled workforce

Assumptions
There are certain assumptions that have been made which will assist in the development of the risk management plans for this programme. To date these have been identified as:

- The newly formed partnership will continue to develop successfully, effective relationships can be formed and the Memorandum of Understanding (MoU) can be agreed.
- The provider market can be developed across the partnership
- An appropriately skilled workforce can be developed
- The new model will be affordable given the constraints detailed in the risk register and elsewhere in this plan and the finance and activity templates.

What risk mitigations do you have in place?

We have mitigated this by the CCG Senior Responsible Officer's working with partners and our boards to receive an agreement in principle to the plan subject to going through partners' governance and obtaining political sign off.

A robust risk management strategy is essential for successful delivery of the programme. The programme risk management is an iterative process, managed by the PMO ensuring that

- A risk register is maintained
- Risks are identified and analysed
- Identified risks have mitigation plans developed
- Risks are tracked and reported

The risk register detailed in the previous section shows current mitigations against the key risks.

The mitigations on relation to this plan can broadly be grouped as

- Governance – ensuring plans are signed off by appropriate bodies
- Communication – partnership working and an agreed communication plan are essential
- Sound financial planning and distribution of resources
- Workforce planning

Any additional information

Due to the short timescales for the joint draft plan and bid process, the details contained in this document and appendices have not been reviewed. A thorough assurance and governance process within each of the represented organisations is ongoing. Costs are indicative of the work required. Further assurance work will continue to test the financial assumptions and review the finances in more detail and taking into account NHSE financial guidance as this becomes available.

6.Finances

Please complete the activity and finance template to set this out (attached as

an annex).

These are detailed in the relevant section of the Finance and Activity spreadsheet. Work is ongoing for both transformation and capital bids and will continue with the support of the NHSE Transforming Care team. The following sections will be contained within the spreadsheet; however, they are difficult to read and a copy is provided here.

Item	Costing assumptions	Item Cost (£)
TCP Project management	Priority 1 - employment of a Project management support across the TC partnership to co-ordinate the joint work and engagement with all of our stakeholders. This role will include the formulation of work packages, scoping of our services, and co-ordination of the central project plan. These costs are based on the recruitment and on costs of a mid-range band 7 and a mid-range band 4 to provide admin support. This is 2 WTE over the 3-year period.	£217,524
Workforce development in Positive Behaviour Support	Priority 2 - Provision of a "train the trainers" programme that will develop the skills of the workforce to coach their teams and those that they support in the implementation of Positive Behaviour support programmes. This programme will also support practitioner in the formulation of challenging behaviour management plans. This programme is a three-day course for practitioners, with a cohort of 16, we will run the course four times across the partnership. During early stages of project consider format of training due to risk of trained trainers leaving - consider provision through external provider. Over the first two years of the project.	£16,940
Client engagement	Priority 3 - Develop experts by experience with support for transport, Care and Treatment Reviews, advocacy and easy read materials over three years	£11,000
Engagement events and facilitation	Priority 4 - For clients, carers, providers and commissioners - workshops over three years	£65,000
Increase capacity of IST	Priority 5 - Intensive support team - clinical nurse * 4 over three years	£768,000
Communications	Priority 6 - Consultations, communication updates, design and production of easy to read and access materials over three years	£20,000
Care Treatment Reviews (CTRs)	Priority 7 - Additional resource to undertake CTRs (especially NHSE clients) - 30 inpatients CTRs + 12 blue light over three years	£45,000
Social supervisor training	Priority 8 - Provision of training for our current care co-ordinators across the footprint in order that they can undertake the legal requirements of managing patients discharged from the Mental Health Act who are subject to MHA conditions. It is a requirement of the legislation to have a suitably qualified person to manage these individuals and report to the home office. The course is two days, and will be run four times across the partnership for cohorts of up to twenty-five individuals. This cost does not include the backfill costs for the individuals attending or further supervision for those undertaking the role. Focused during the first two years	£15,200
Evaluation	Priority 9 - Support expertise, e.g. university for evaluation of pilots and programme. Focused 17/18 and 18/19.	£20,000
Employment of architect	Priority 10 - For redevelopment of units providing specialist capacity/support - feasibility stages over the three years of project.	£60,000
	Total	**£1,238,664**

Please describe match funding here. Please provide as much detail as possible, breaking down contributions by source and financial year (2016/17, 2017/18 or 2018/19)

The TC partnership has invested in intensive support teams across the footprint. These services are tasked with reducing hospital admissions, and supporting people within the community.

For Milton Keynes the closure three years ago (2013) of our learning disability inpatient unit (Oakwood) identified monies to be transferred from inpatient services to the community (£162K) this currently supports 4 FTE (2 outreach nurses and 3 support workers) within our Community Support and Intervention Team (CSIT). This contribution to the transforming care programme is anticipated to continue for the next three years.

For Beds and Luton, the Intensive Support Team (IST) is commissioned at £1.1M, this supports the reduction in hospital stay and supporting more people in the community during episodes of crisis. this contribution to the transforming care programme is committed for the next seven years and makes up part of the contract with services.

Priority shown above relates to priority for funding purposes. Investment requested at this stage is c.£412k 2016/17, c.£422k 2017/18, c.£406k 2018/19. Total £1.3M.

Match funding comes from across the partners to the TCP and includes funding for adult intensive support team, additional staff capacity undertaking CTRs, in-house estates and communications support, in house programme leadership and project management, management and finance resource, GP sessional time and local authority advocacy support. Total far exceeding £1.3M per annum. In addition, there will be some savings from inpatient to in area community settings which can be reinvested. Further work will need to be done once client needs/packages have been appropriately costed.

Note that other requirements are anticipated as a result of the review and scoping work due to take place during the first phases of the project, e.g. increased forensic support offer. These will be costed as a part of these "scoping" pieces of work.

End of planning template

Annex A – Developing a basket of quality of care indicators

Over the summer, a review led by the Department of Health was undertaken of existing indicators that areas could use to monitor quality of care and progress in implementing the national service model. These indicators are not mandatory, but have been recommended by a panel of experts drawn from across health and social care. Discussion is ongoing as to how these indicators and others might be used at a national level to monitor quality of care.

This Annex gives the technical description of the indicators recommended for local use to monitor quality of care. The indicators cover hospital and community services. The data is not specific to people in the transforming care cohort.[2]

The table below refers in several places to people with a learning disability or autism in the Mental Health Services Data Set (MHSDS). This should be taken as an abbreviation for people recorded as having activity in the dataset who meet one or more of the following criteria:

1. They are identified by the Protected Characteristics Protocol - Disability as having a response score for PCP-D Question 1 (Do you have any physical or mental health conditions lasting, or expected to last, 12 months or more?) of 1 (Yes – limited a lot) or 2 (Yes – limited a little), and a response score of 1 or 2 (same interpretation) to items PCP-D Question 5 (Do you have difficulty with your memory or ability to concentrate, learn or understand which started before you reached the age of 18?) or PCP-D Question 13 (Autism Spectrum Conditions)
2. They are assigned an ICD10 diagnosis in the groups F70-F99, F84-849, F819
3. They are admitted to hospital with a HES main specialty of psychiatry of learning disabilities
4. They are seen on more than one occasion in outpatients by a consultant in the specialty psychiatry of learning disabilities (do not include autism diagnostic assessments unless they give rise to a relevant diagnosis)
5. They are looked after by a clinical team categorised as Learning Disability Service (C01), Autistic Spectrum Disorder Service (C02)

Indicator No.	Indicator	Source	Measurement[3]
1	Proportion of inpatient population with learning a disability or autism who have a person-centred care plan,	Mental Health Services Data Set (MHSDS)	Average census calculation applied to: • Denominator: inpatient person-days for patients identified as having a learning disability or autism. • Numerator: person days in denominator where the

[2] Please refer to the original source to understand the extent to which people with autism are categorised in the data collection

[3] Except where specified, all indicators are presumed to be for CCG areas, with patients allocated as for ordinary secondary care funding responsibility.

	updated in the last 12 months, and local care co-ordinator		following two characteristics are met: (1). Face to face contact event with a staff member flagged as the current Care Co-ordinator (MHD_CareCoordinator_Flag) in preceding 28 days; and 2. Care review (Event record with MHD_EventType 'Review') within the preceding 12 months.
2	Proportion of people receiving social care primarily because of a learning disability who receive direct payments (fully or in part) or a personal managed budget (Not possible to include people with autism but not learning disability in this indicator)	Short and Long Term Support statistics	This indicator can only be produced for upper tier local authority geography. Denominator: Sum of clients accessing long term support, community services only funded by full or part direct payments, managed personal budget or commissioned support only. Numerator: all those in the denominator excluding those on commissioned support only. Recommended threshold: This figure should be greater than 60%.
3	Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital	Hospital Episodes Statistics (HES) and Assuring Transformation datasets. Readmission following discharge with HES main specialty - Psychiatry of Learning Disabilities or	HES is the longest established and most reliable indicator of the fact of admission and readmission. • Denominator: discharges (not including transfers or deaths) from inpatient care where the person is identified as having a learning disability or autism • Numerator: admissions to psychiatric inpatient care within specified period The consultation took 90 days as the specified period for readmission. We would recommend that this period should be reviewed in light of emerging readmission patterns. Particular attention should be paid to whether a distinct group of rapid readmissions is apparent.

		diagnosis of a learning disability or autism.	NHS England is undertaking an exercise to reconcile HES and Assuring Transformation data sets, to understand any differences between the two. At present NHS England will use Assuring Transformation data as its main source of information, and will be monitoring 28-day and 12-month readmission.
4	Proportion of people with a learning disability receiving an annual health check. (People with autism but not learning disability are not included in this scheme)	Calculating Quality Reporting Service, the mechanism used for monitoring GP Enhanced Services including the learning disability annual health check.	Two figures should be presented here. • Denominator: In both cases the denominator is the number of people in the CCG area who are on their GP's learning disability register • Numerator 1. The first (which is the key variable) takes as numerator the number of those on their GPs learning disability register who have had an annual health check in the most recent year for which data are available • Numerator 2. The second indicator has as its numerator the number of people with a learning disability on their GPs learning disability health check register. This will identify the extent to which GPs in an area are participating in the scheme
5	Waiting times for new psychiatric referral for people with a learning disability or autism	MHSDS. New referrals are recorded in the Referrals table of the MHSDS.	• Denominator: Referrals to specialist mental health services of individuals identified in this or prior episodes of care as having a learning disability or autism • Numerator: Referrals where interval between referral request and first subsequent clinical contact is within 18 weeks
6	Proportion of looked after people with learning disability or autism for whom there is a	MHSDS. (This is identifiable in MHMDS returns	Method – average census. • Denominator: person-days for patients in current spell of care with a specialist mental health care provider who are

	crisis plan	from the fields CRISISCREATE and CRISISUPDATE)	identified as having a learning disability or autism or with a responsible clinician assignment of a person with specialty Psychiatry of Learning Disabilities • Numerator: person days in denominator where there is a current crisis plan

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Sustainability and Transformation Plan 2016-2020
Meeting Date:	27 July 2016
Responsible Officer(s)	Richard Carr, Chief Executive
Presented by:	Richard Carr, Chief Executive

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

1. **To note the requirement for a place-based health and care Sustainability and Transformation Plan.**
2. **To endorse the approach to developing the Sustainability and Transformation Plan for the Bedfordshire, Luton and Milton Keynes (BLMK) Footprint.**
3. **To endorse the five priorities for the BLMK Footprint.**

Purpose of Report	
1.	For the Health and Wellbeing Board to note the requirement for every health and care system to: “come together to create its own ambitious local blueprint for accelerating its implementation of the Forward View:” The NHS Shared Planning Guidance for 2016/17- 2020/21, published on the 22nd December 2015, requires local areas to produce a five year, place-based Sustainability and Transformation Plan (STP).
2.	STPs are an opportunity to develop a local route map to an improved, more sustainable health and care system. The Health and Social Care Act 2012 introduced significant new responsibilities for local government for Public Health and as system leader or place shaper in Health and Wellbeing Boards. STPs are a whole systems plan which requires system leadership to develop a shared vision to reduce inequalities in health, improve the quality of care and create a sustainable health and care system.
3.	The Plan must set out how the health and care system will achieve financial balance over the next 5 years and will form the basis of the application process to access transformational funding for 2017/18 onwards.

Background	
4.	The chancellor announced a national Sustainability and Transformation Fund of £2.1bn of which £1.8bn relates to the Sustainability funding to bring the NHS provider trust sector back into financial balance. This fund will grow from £2.1bn in 2016/17 to £2.9bn in 2017/18, rising to £3.4bn in 2020/21, with an increasing share of the growing fund being deployed on transformation.
5.	The transformation funding is to support delivery of the Five Year Forward View (FYFV. It will be used to fund initiatives such as the expansion of new care models, primary care access and infrastructure, technology roll out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health.
6.	These STPs are intended to be place-based, multi-year plans built around the needs of local populations and are seen as a means to build and strengthen local relationships, enabling a shared understanding of local issues and challenges, defining the ambition for 2020 and the concrete steps needed to get there.
7.	To do this, local health and care systems have been asked to work together in STP "footprints". There are 44 of these in England. Central Bedfordshire is part of the Bedfordshire, Luton and Milton Keynes Footprint.
8.	The STP will be an umbrella plan and will bring together local place-based plans to address the health and care triple aim as set out in the Five Year Forward View: • The health and wellbeing gap; • The care and quality gap; and • The finance and efficiency gap.
9.	Development of a STP also provides an opportunity for a whole system approach to addressing the wider determinants of health, such as housing, economic development and education. It will foster greater collaboration between the NHS and local government, with patients and the public kept at the centre.
Content of STPS	
10.	Sustainability and Transformation Plans cover all areas of CCG and NHS England Commissioned activity including specialised services. It must also cover better integration between health and social care services have a strong focus on prevention and reflect local Health and wellbeing strategies.
11.	A critical element of the STP is that the plan demonstrates system wide local sustainability which spans providers and commissioners. STPs will become the single application and approval process for being accepted onto programmes with transformational funding from 2017/18 onwards.

12.	The STP does not substitute for local leadership or responsibility of the health and social care agenda and the emerging priorities reflect those areas where significant benefits are expected through collective action by bodies operating across Bedfordshire, Luton & Milton Keynes.
Emerging STP Priorities for Bedfordshire, Luton and Milton Keynes	
13.	The BLMK draft plan sets out the priorities for delivering the triple aim. These are: 1. **Illness prevention and health improvement:** Preventing ill health and improving good health by giving people the knowledge and tools, individually and through local communities, to manage their own health effectively. 2. **Primary, community and social care:** Delivering high quality and resilient primary, community and social care services across Bedfordshire, Luton and Milton Keynes. 3. **Secondary care:** Delivering high quality and sustainable secondary (hospital) care services across Bedfordshire, Luton and Milton Keynes. 4. **Digitisation:** Working together to create a digital platform across BLMK, maximising the use of information and communication systems and technology. Enabling health and social care professionals to share care records so that all relevant information is available to inform clinical and care practice, whether in hospital, in the community or at home. 5. **Demand management and commissioning:** Working together to make sure the right services are available in the right place, at the right time for everyone using health and social care in Bedfordshire, Luton and Milton Keynes. .
Conclusion	
14.	The NHS Shared Planning Guidance for 2016/17- 2020/21, published on the 22nd December 2015 asks every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View (5YFV) by developing Sustainability and Transformation Plans (STPs).
15.	Bedfordshire, Luton and Milton Keynes is the local footprint for this area and a total of 16 STP partners have taken part in the development of the BLMK STP.
16.	The plans will show how local services will evolve, develop and become clinically and financially sustainable over the next five years (to 2020/21).

Reasons for the Action Proposed	
17.	The Health and Wellbeing Board has a key role in shaping the future of health and social care in their areas and need to ensure that they have meaningful input to the STPs. The emerging vision and priorities of the STP are consistent with the priorities of Joint Health and Wellbeing Strategy for Central Bedfordshire for improving health, wellbeing and reducing health inequalities.
18.	Health and care systems have been asked to come together to create their own ambitious local blueprint for implementing the Five Year Forward View, covering Oct 2016 to Mar 2021. NHS England will assess each STP. Plans of the highest standard will gain access to transformation funding from April 2017.
	Next steps
19.	Following submission on 30 June 2016, the draft plans from all 44 STPs across the country will be reviewed and considered by NHS England and NHS Improvement, amongst others. National leads will discuss the principles and priorities outlined in the draft plans with local STP leads.
20.	Work on the development of the five key priorities of the Plan will continue locally, With the involvement of local communities, staff and other stakeholders on the nine current work streams (health promotion and illness prevention; urgent and emergency care; primary, community and social care; workforce; shared care records, digitisation and assistive technology; new models of care; clinical support services; back office services and health and social care estate).

Issues	
Governance & Delivery	
21.	The BLMK STP programme has been overseen and indeed, driven by an STP Steering Group. This includes 16 key STP partners, all of whom act as equal partners in the STP programme. Representation on the STP Steering Group is at the CEOs and/or Director level. The Chief Executive of Central Bedfordshire Council is acting as a formal deputy to the nominated STP lead. The overarching design principle drawn upon to formulate the STP work programme has been that, as far as practical, the STP working groups draw on resources provided and/or insourced from STP partners. This helps to ensure that: • Ownership is achieved • Barriers in accessing data, intelligence, people and advice are reduced • Local expertise is harnessed • Third party costs are minimised

	The STP has established a communications collaborative, comprising communications leads (or delegated representatives) from all STP partners. This group, chaired by the designated communications lead for the STP, seeks to ensure all workstreams and the overarching STP has appropriate tactical and strategic communication and engagement plans in place.
Financial	
22.	One of the triple aims of the STPs is to secure achieve financial balance across the local health system and improve the efficiency of NHS services.
Public Sector Equality Duty (PSED)	
23.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between and in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
24.	Are there any risks issues relating Public Sector Equality Duty Yes/**No**
25.	If yes – outline the risks and how these would be mitigated

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

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Presented by Richard Carr, CEO Central Bedfordshire Council

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	Better Care Fund Plan 2016/17
Meeting Date:	27 July 2016
Responsible Officer(s)	Julie Ogley, Director of Social Care, Health & Housing Donna Derby, Director Commissioning - Bedfordshire Clinical Commissioning Group
Presented by:	Julie Ogley, Director of Social Care, Health & Housing Donna Derby, Director Commissioning - Bedfordshire Clinical Commissioning Group

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

1. **Endorse the Better Care Fund (BCF) plan for 2016/17 which was submitted on 5 May 2016, with approval from the Chair of the Board.**
2. **Note the core elements of the plan including themes, national conditions, metrics and the assurance process.**
3. **Note the outcome of the assurance process and for the Board to sign off the S75 Agreement for the 2016/17 Fund.**
4. **Note Quarter four return on the Better Care Fund Plan to NHS England.**

Purpose of Report	
1.	To update the Board on the development and submission of the Better Care Fund Plan for 2016/17
2.	For the Board to consider and approve the Section 75 Agreement for the 2016/17 pooled fund.
3.	For the Board to note the submission of the BCF Plan Quarter 4 performance return to NHS England and narrative on progress.

Background	
4.	NHS England published the 2016/17 Better Care Fund (BCF) Policy Framework in January 2016. The Policy Framework outlined the requirements that in developing BCF Plans for 2016/17, local partners will be required to develop and agree, through the relevant Health and Wellbeing Board : • A short, jointly agreed narrative plan including details of how they are addressing the national conditions • Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes • A scheme level spending plan demonstrating how the fund will be spent • Quarterly plan figures for the national metrics.
5.	The Better Care Fund is a single pooled budget to promote the integration of health and social care services in local areas. The full value of the Better Care Fund in Central Bedfordshire for 2016/17 is £20.534m.
6.	The Health and Wellbeing Board received the draft plan and agreed the key focus areas at its meeting on 6th April 2016. The Board agreed that the Chair should sign off the final plan prior to submission to NHS England on 5 May.
7.	Quarter Four performance return was submitted to NHS England on 27 May. The return also provides a year end feedback on the BCF Plan for 2015-16. Appendix One.
Better Care Fund Plan 2016/17	
8.	The Better Care Fund Plan 2016/17 is consistent with the priorities and outcomes of the Health and Wellbeing Board. It is focused on the progressive integration of health and social care services.
9.	The 2016/17 BCF Plan builds on the 2015/16 priorities. The narrative plan (appendix two) sets out: • The local vision for health and social care services showing how services will be transformed to implement the vision of the Five Year Forward View and moving towards fully integrated health and social care services by 2020, and the role the Better Care Fund plan in 2016-17 plays in that context; • The evidence base supporting the case for change; • A coordinated and integrated plan of action for delivering that change; • A clear articulation of how each national condition will be addressed; • An agreed approach to financial risk sharing and contingency.

10.	The total fund for Central Bedfordshire 2016/17 Better Care Fund equates to £20,534million. This is made up of a CCG gross contribution of £15,276m, Disabled Facilities Grant capital allocation of £1,315m; underspend from 2015/16 of £526,000 and an additional contribution from the local authority social care budget of £3,417m. Of the total CCG allocation, £4.341m is ring-fenced for NHS out of hospital commissioned services/risk share.
11.	To meet the immediate challenges, within our local health and care system, the BCF Plan for 2016/17 is focusing on three key schemes to help deliver improvements, cost efficiency, more streamlined pathways of care and to meet the national conditions. There is local recognition and agreement that a focus on these areas would deliver more significant benefits to the target population. The three themes are as follows:
	Theme One - Out of hospital care.
12.	This theme is focused on transformation of community health and care services. Our vision for a local model for community based services is likely to result in the need for substantial change in the way services are currently modelled and delivered. In 2016/17, the transformation of community services will reinforce the MDT model for proactive care (Caring Together) which is focused on those patients at risk of admission. It is anticipated that this approach will advance to a rapid response to avoid hospital admission. Jointly commissioning health and care services will improve patient experience, help to provide efficiencies, improve the quality of care and create opportunities to address local workforce challenges. The theme will facilitate integration of services, development of multidisciplinary teams across Central Bedfordshire localities and a common intermediate care pathway for joint assessments, care planning and provision.
	Theme two – Prevention
13.	The overall scope of the theme will address: patients being enabled to self manage; the use of assistive technology; disabled facilities grants and adaptations; paediatric admissions; falls prevention; accommodation and support to carers. This will ensure the most progressive, evidence-based prevention and early intervention programmes are available to our population. The 2016/17 BCF Plan continues the focus on mental wellbeing. A key initiative planned for 2016/17 is Maximising Independence through Supportive Technology (MIST). This will introduce systematic support for patients to self manage.

	Theme three – Protecting Social Services
14.	This theme will ensure the Council is able to respond to increasing demands and complexity of care needs, in a timely and appropriate manner. There is a real challenge in reducing delayed transfers of care, supporting Care Homes to deliver more complex care for people in their usual place of residence and delivering timely and integrated care packages, including domiciliary care. This scheme will focus on key areas which will help to reduce unplanned admissions, including rapid home care response – enabling people to remain at home longer.
	Key Delivery Areas
15.	The transformation of community services, based on GP clusters within localities will be a key trigger for our journey towards integration. Our case for change is predicated on the increasing levels of non-elective admissions which are evidenced in our quarterly submissions for BCF 2015/16. New ways of working will be required to deliver changes and ensure the sustainability of our health and care system in the face an ageing population with increasing complexity of needs.
16.	The GP Clusters with Multidisciplinary Teams (MDTs) will offer proactive care to high risk patients, reducing admissions as well facilitating reduced length of stay in hospital. These and a key focus on the following seven projects will underpin our approach in 2016/17: 1. Improving the Falls Service 2. Transforming Community Services - Multi-Disciplinary Team Working 3. Transforming Community Services - Maximising Independence through Supportive Technology (MIST) 4. Improving End of Life Care 5. Improving outcomes for stroke survivors 6. Enhanced Care in Care Homes 7. Delayed Transfers of Care (DTOCs)
17.	Details of the projects, objectives, and deliverables and how they align to the national conditions and metrics are set out respectively in Appendix three (a-g).

<table>
<tr><td></td><td>Pool Fund Allocation and Risk sharing</td></tr>
<tr><td>18.</td><td>The total BCF Pooled Fund is £20.533m and has been allocated across the three Themes as follows:
<table>
<tr><td>Theme</td><td>2016/17 Allocation

£m</td><td>2015/16 Allocation

£m</td></tr>
<tr><td>Out of Hospital Services</td><td>12.984</td><td>11.465</td></tr>
<tr><td>Prevention</td><td>4.962</td><td>4.687</td></tr>
<tr><td>Protecting Social Care</td><td>2.588</td><td>2.555</td></tr>
<tr><td>Total</td><td>20.534</td><td>18.707</td></tr>
</table></td></tr>
<tr><td>19.</td><td>New investment in 2016/17 has been allocated to support new Falls prevention activity £0.180m, Liaison Psychiatry £0.135m and Primary Care Mental Health Liaison of £0.144m. In addition a contingent sum of £0.389m has been set aside to mitigate the impact of failure to reduce non-elective admissions by 1%. Furthermore, an under-spend from the 2015/16 BCF Pool of £0.044m revenue and £0.482m capital has been carried forward into 2016/17 to support the programme.</td></tr>
<tr><td>20.</td><td>Both the Council and the Clinical Commissioning Group have a clear understanding of the challenges of reducing non-elective admissions and are in a better position to manage the trend currently being experienced. Consequently, and as required by the national guidance, the financial risk presented by the failure to reduce non-elective admissions by 1% will be positioned against the whole BCF pool of £20.5m and shared according to the proportion of spend from the BCF pool. A contingent sum of £0.388m has been allocated to mitigate the non achievement of the 1% target in the first instance although local agreement has been reached that the risk share will be shared on a 50/50 basis.</td></tr>
<tr><td>21.</td><td>The legal framework for the Fund derives from the amended NHS Act 2006, which requires that in each area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. All Section 75 agreements to be signed and in place by 30 June 2016.</td></tr>
</table>

	Assurance for 2016/17 Plans
22.	Unlike the 2015/16 BCF which was passed through a "Nationally Consistent Accreditation Review" process, the intention is for the 2016/17 BCF to be accredited on a regional basis by a panel consisting of NHS England and Local Government representatives.
23.	The assurance process will be undertaken within NHS England's Directors of Commissioning Operations' (DCO) teams, in alignment with the process for reviewing CCG operating plans. To support this, local government regional leads for the BCF (LGA lead CEOs and ADASS chairs) will be part of the moderation process at a regional level and will be consulted by DCO teams when making recommendations about plan approval
24.	As part of that regional moderation process an assessment will then be made of the risk to delivery of the plan due to local context and challenges, using information from NHS England, the Trust Development Authority, Monitor and local government.
25.	These judgements on 'plan development' and 'risks to delivery' will help inform the placing of plans by NHS England into three categories – 'Approved', 'Approved with support', 'Not approved'
26.	Early indications are that Central Bedfordshire's Better Care Fund Plan is likely to be approved with support. This allows the implementation of the BCF Plan with some ongoing support from regional teams to address specific issues relating to 'plan quality' and/or 'risks to delivery'.
27.	Work is now on-going with the Regional Better Care Advisor to identify the additional support required and to address the areas of concern.

Reasons for the Action Proposed	
28.	The BCF Plan is consistent with the priorities of Joint Health and Wellbeing Strategy for Central Bedfordshire for improving health, wellbeing and reducing health inequalities.
29.	The Better Care Fund Planning requires that the Plan is signed off by the Health and Wellbeing Board itself and by the constituent Council and Clinical Commissioning Group.

30.	The Health and Wellbeing Board (HWB) has a statutory duty to promote integration and is seen as a valuable forum for stakeholders to come together to review performance of the BCF and consider opportunities for transforming health and social care. The expectation is that HWBs will continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners[1].
31.	The BCF Plan for 2016/17 aligns and contributes to the delivery of the national health and care strategy as set out in Delivering the Five Year Forward View, published in December 2016 and the emerging Sustainability and Transformation Plan.
	Next steps
32.	• Work with the Regional BCF Advisor to secure full assurance for the BCF Plan • Mobilise the key projects for delivery • Complete sign off of Section 75 agreement

Issues	
Governance & Delivery	
33.	Progress on the Better Care Fund Plan will be reported to the Health and Wellbeing Board and delivery will be through agreed Joint Commissioning Board and governing boards for partners. The Health and Wellbeing board will provide overall assurance and sign off performance monitoring returns.
Financial	
34.	The Better Care Fund creates a pooled fund of £20.543m in 2016/17 to support the delivery of integrated care. This is made of up of contribution of £5.258m from Central Bedfordshire Council and £15,275 from Bedfordshire Clinical Commissioning Group. An amount of £4.977m has been assigned out of the CCG minimum allocation for the protection of social care services. The BCF pool also includes the Council's Disabled Facilities Grant of £3.417m.
Public Sector Equality Duty (PSED)	
35.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between and in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

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

36.	Are there any risks issues relating Public Sector Equality Duty	Yes/**No**
37.	If yes – outline the risks and how these would be mitigated	

Source Documents	**Location (including url where possible)**
BCF Plan 2015/16	http://www.centralbedfordshire.gov.uk/Images/The-Central-Bedfordshire-Better-Care-Plan-final_tcm6-62825.pdf#False

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Presented by Julie Ogley, Director of Social Care, Health & Housing
Donna Derby, Director of Commissioning - , Bedfordshire Clinical Commissioning Group

Appendices:

Appendix One – Quarter 4 Performance Return.
Appendix two - BCF 2016/17 Narrative Plan.
Appendix three (a-g) - Details of the projects, objectives, and deliverables.

Quarterly Reporting Template - Guidance

Notes for Completion

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

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

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 27th May 2016.

The BCF Q4 Data Collection

This Excel data collection template for Q4 2015-16 focuses on budget arrangements, the national conditions, non-elective admissions, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

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

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 9 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
5) Non-Elective Admissions - this tracks performance against NEL ambitions.

6) Supporting Metrics - this tracks performance against the two national metrics, locally set metric and locally defined patient experience metric in BCF plans.
7) Year End Feedback - a series of questions to gather feedback on impact of the BCF in 2015-16

8) New Integration metrics - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care
9) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Checklist

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

1) Cover Sheet

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

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 9 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the previous quarterly submissions and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously the 2 further questions are not applicable and are not required to be answered.

If your previous submission stated that the funds had not been pooled via a Section 75 agreement, can you now confirm that they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

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

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' or 'No - In Progress' that these have been met. Should 'No' or 'No - In Progress' be selected, please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed.

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

4) Income and Expenditure

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

Forecasted income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1 to Q4
Forecasted expenditure from the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual expenditure from the pooled fund in Q1 to Q4

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

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

5) Non-Elective Admissions

This section tracks performance against NEL ambitions. The latest figures for planned activity are provided. One figure is to be input and one narrative box is to be completed:

Input actual Q4 2015-16 Non-Elective Admissions performance (i.e. number of NEAs for that period) - Cell P8
Narrative on the full year NEA performance

6) Supporting Metrics

This tab tracks performance against the two national supporting metrics, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:
An update on indicative progress against the four metrics for Q4 2015-16
Commentary on progress against the metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

7) Year End Feedback

This tab provides an opportunity to provide give additional feedback on your progress in delivering the BCF in 2015-16 through a number of survey questions. The purpose of this survey is to provide an opportunity for local areas to consider the impact of the first year of the BCF and to feed this back to the national team review the overall impact across the country. There are a total of 12 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund
There are a total of 10 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Disagree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. Our BCF schemes were implemented as planned in 2015-16
2. The delivery of our BCF plan in 2015-16 had a positive impact the integration of health and social care in our locality
3. The delivery of our BCF plan in 2015-16 had a positive impact in avoiding Non-Elective Admissions
4. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Delayed Transfers of Care
5. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
6. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Permanent admissions of older people (aged 65 and over) to residential and nursing care homes
7. The overall delivery of our BCF plan in 2015-16 has improved joint working between health and social care in our locality
8. The implementation of a pooled budget through a Section 75 agreement in 2015-16 has improved joint working between health and social care in our locality
9. The implementation of risk sharing arrangements through the BCF in 2015-16 has improved joint working between health and social care in our locality
10. The expenditure from the fund in 2015-16 has been in line with our agreed plan

Part 2 - Successes and Challenges
There are a total of 2 questions in this section, for which up to three responses are possible. The questions are:
11. What have been your greatest successes in delivering your BCF plan for 2015-16?
12. What have been your greatest challenges in delivering your BCF plan for 2015-16?

These are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Leading and managing successful Better Care Fund implementation
2. Delivering excellent on the ground care centred around the individual
3. Developing underpinning, integrated datasets and information systems
4. Aligning systems and sharing benefits and risks
5. Measuring success
6. Developing organisations to enable effective collaborative health and social care working relationships
7. Other - please use the comment box to provide details

8) New Integration Metrics

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in the last BCF Quarterly Data Collection Template (Q2 / Q3 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

For the PHB metric, areas should include all age groups, as well as those PHBs that form part of a jointly-funded package of care which may be administered by the NHS or by a partner organisation on behalf of the NHS (e.g. local authority). Any jointly funded personal budgets that include NHS funding are automatically counted as a personal health budget. We have expanded this definition following feedback received during the Q3 reporting process, and to align with other existing PHB data collections.

9) Narrative

In this tab HWBs are asked to provide a brief narrative on year-end overall progress, reflecting on a first full year of the BCF, with reference to the information provided within this and previous quarterly returns.

Better Care Fund Template Q4 2015/16

Data collection Question Completion Checklist

1. Cover

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

2. Budget Arrangements

Funds pooled via a S.75 pooled budget, by Q4? If no, date provided?
Yes

3. National Conditions

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

4. I&E (2 parts)

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

5. Non-Elective Admissions

Actual Q4 15/16	Comments on the full year NEA performance
Yes	Yes

6. Supporting Metrics

		Please provide an update on indicative progress against the metric?	Commentary on progress
Admissions to residential Care		Yes	Yes
Reablement		Please provide an update on indicative progress against the metric? Yes	Commentary on progress Yes
Local performance metric		Please provide an update on indicative progress against the metric? Yes	Commentary on progress Yes
Patient experience metric	If no metric, please specify Yes	Please provide an update on indicative progress against the metric? Yes	Commentary on progress Yes

7. Year End Feedback

Statement:	Response:
1. Our BCF schemes were implemented as planned in 2015-16	Yes
2. The delivery of our BCF plan in 2015-16 had a positive impact on the integration of health and social care in our locality	Yes
3. The delivery of our BCF plan in 2015-16 had a positive impact in avoiding Non-Elective Admissions	Yes
4. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Delayed Transfers of Care	Yes
5. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Yes
6. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Yes
7. The overall delivery of our BCF plan in 2015-16 has improved joint working between health and social care in our locality	Yes
8. The implementation of a pooled budget through a Section 75 agreement in 2015-16 has improved joint working between health and social care in our locality	Yes
9. The implementation of risk sharing arrangements through the BCF in 2015-16 has improved joint working between health and social care in our locality	Yes
10. The expenditure from the fund in 2015-16 has been in line with our agreed plan	Yes

11. What have been your greatest successes in delivering your BCF plan for 2015-16?	Response and category
Success 1	Yes
Success 2	Yes
Success 3	Yes

12. What have been your greatest challenges in delivering your BCF plan for 2015-16?	Response and category
Challenge 1	Yes
Challenge 2	Yes
Challenge 3	Yes

8. New Integration Metrics

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Yes	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Yes	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	No	No	No	No	No	No

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Yes

Total number of PHBs in place at the end of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

9. Narrative

Brief Narrative	Yes

Cover

Q4 2015/16	
Health and Well Being Board	**Central Bedfordshire**
completed by:	Patricia Coker
E-Mail:	patricia.coker@centralbedfordshire.gov.uk
Contact Number:	0300 300 5521
Who has signed off the report on behalf of the Health and Well Being Board:	Julie Ogley, Director of Social Care, Health and Housing; Matthew

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

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	16
4. I&E	19
5. Non-Elective Admissions	2
6. Supporting Metrics	9
7. Year End Feedback	16
8. New Integration Metrics	61
9. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Central Bedfordshire

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

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Central Bedfordshire

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?

Condition	Q4 Submission Response	Q1 Submission Response	Q2 Submission Response	Q3 Submission Response	Please Select (Yes or No)	If the answer is 'No', please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?
1) Are the plans still jointly agreed?	Yes	Yes	Yes	Yes	Yes	
2) Are Social Care Services (not spending) being protected?	Yes	Yes	Yes	Yes	Yes	
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes	Yes	Yes	Yes	Yes	
4) In respect of data sharing - please confirm:						
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	Yes	Yes	Yes	Yes	
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Yes	Yes	Yes	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	Yes	Yes	Yes	Yes	
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes	Yes	Yes	Yes	Yes	
6) Is an agreement on the consequential impact of changes in the acute sector in place?	No - In Progress	No	No	No	Yes	

National conditions - Guidance

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

1) Plans to be jointly agreed

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

2) Protection for social care services (not spending)

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

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

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

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

The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right
Local areas should:

- confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.

NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

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

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

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

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

Footnotes:

Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously returned by the HWB.

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

Selected Health and Well Being Board: Central Bedfordshire

Income

Previously returned data:

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

Q4 2015/16 Amended Data:

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

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	No difference

Expenditure

Previously returned data:

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

Q4 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£0	£0	£0	£0	£0	£18,707,000
	Forecast	£4,665,865	£4,665,865	£4,665,865	£4,665,865	£18,663,460	
	Actual*	£4,534,000	£4,797,730	£4,665,865	£4,183,865	£18,181,460	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	The final position resulted in an underspend of revenue of £43,540 and capital of £482,000. Both will be carried forward into the 2016/17 BCF.

Commentary on progress against financial plan:	From the activity in all of the schemes the Pooled Fund of £18.707m came in with an underspend of £1.053m. As the non-elective admissions set out in the plan have not achieved the required 1.5% reduction, the Pooled Fund made a Pay for Performance payment of £0.527m. Deducting the Pay for Performance payments from the initial Pooled Fund under spend, this left an overall revenue surplus of £0.044m and capital surplus of £0.482m. Both elements will be rolled forward to support the BCF in 2016/17.

Footnotes:

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

Non-Elective Admissions

Selected Health and Well Being Board: Central Bedfordshire

	Baseline				Plan					Actual				
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
D. REVALIDATED: HWB version of plans to be used for future monitoring. Please insert into Cell P8	5,434	5,708	5,615	6,232	5,434	5,600	5,635	5,966	6,041	6,041	6,241	6,239	6,534	6,602

Please provide comments around your full year NEA performance	A major challenge within our BCF Plan is to reduce Non-Elective Admissions, which has increased in 2015/16 as reflected in the BCF quarterly performance reports. Additional projects mobilised as part of the 2015/16 BCF Plan around management of long term conditions, end of life care, Falls and Care Homes are beginning to have an impact on non-elective admission. This work will continue as part of the BCF 2016/17. The overarching ambition remains reduction of non-elective admissions in line with targets set for 2015/16.

Footnotes:

Source: For the Baselines and Plans which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs, as of 26th February 2016.

National and locally defined metrics

Selected Health and Well Being Board: Central Bedfordshire

Admissions to residential Care	% Change in rate of permanent admissions to residential care per 100,000
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	This measure is challenging due to the complex needs of our increasing and frail elderly population. Packages of care are scrutinised to ensure appropriateness of placements and there is improved joint working and coordination of hospital discharge with a focus on reducing reliance on institutional forms of care.

Reablement	Change in annual percentage of people still at home after 91 days following discharge, baseline to 2015/16
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Council reablement service achieved target. This is however an incomplete picture and agreement has now been reached to include community health services reablement outcomes.

Local performance metric as described in your approved BCF plan / Q1 / Q2 / Q3 return	Rate of emergency admissions for injuries due to falls in persons aged 65+ per 100,000 population
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	There was an increase in the number of falls reported in the 14/15 outturn. However we expect to see a reduction as a result of the additional projects focusing on falls reduction within Care Homes and investment in falls awareness training programmes.

Local defined patient experience metric as described in your approved BCF plan / Q1 /Q2 return	GP Patient Survey - In last 6 months, had enough support from local services or organisations to help manage long-term health condition(s)
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	The proportion of people who reported being satisfied with the support they received for managing their Long-term Conditions fell slightly from 65% in October 2014 to 63% in April 2015. However the proportion of people who said they have not needed support to manage their condition increased. We are also monitoring patient/service user experience through our Disabled Facilities Grant, with an outturn of 90%. An annual Adult

Footnotes:

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

Year End Feedback on the Better Care Fund in 2015-16

Selected Health and Well Being Board: Central Bedfordshire

Part 1: Delivery of the Better Care Fund		
Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes		
Statement:	Response:	Comments: Please detail any further supporting information for each response
1. Our BCF schemes were implemented as planned in 2015-16	Neither agree nor disagree	particularly in relation to reducing unplanned admissions to hospitals. Although there has been important progress in all scheme areas, there have been a number of factors that have impacted on the overall pace of delivery of the BCF Schemes. During part of 2015/16 BCCG's focus was on financial recovery, which included changes in leadership. This resulted in a new approach to the re-procurement of community health services impacting some of the schemes which
2. The delivery of our BCF plan in 2015-16 had a positive impact on the integration of health and social care in our locality	Agree	risk of admission and other people who would benefit from a more joined up response. A pilot across two GP Practices in two localities, Chiltern Vale and West Mid Beds is now underway. Facilitated imnproved co-ordinated for supported discharge from hospital with ongoing community care. A multi-agency partnershipfor Prevention and promoting independence partnership established.
3. The delivery of our BCF plan in 2015-16 had a positive impact in avoiding Non-Elective Admissions	Disagree	Delivery was challenging. A number of additional projects were mobilised to mitigate the challenge of reducing non elective admissions. Some of these have delivered some success.
4. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Delayed Transfers of Care	Agree	Supported early discharge planning and coordination through joint working has delivered improvements.
5. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Agree	The measure currently reports only on the Council's reablement service and does not include outcomes data in relation to rehabilitation/intermediate care provided through Community Health Services. Discussion to enable access to community rehabilitation data, has an taken place and an information sharing agreement signed to allow data to be collected and provide a complete picture of the effectiveness of intermediate and reablement services
6. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Agree	with frailty and dementia as the most common diagnosis for admissions. Packages of care are scrutinised through a panel process to ensure that all alternatives have been explored and that the focus remains on helping people to remain in their own homes. Residential and nursing placements made remain appropriate. Residential step up/step down with reablement, in Greenacres and Evergreen Care Homes, has been available through 2015/16. Reablement for falls has
7. The overall delivery of our BCF plan in 2015-16 has improved joint working between health and social care in our locality	Neither agree nor disagree	Partnership working with the community health service provider in 2015/16 has been a challenge, however, there has been continued delivery of projects within the BCF Plan.
8. The implementation of a pooled budget through a Section 75 agreement in 2015-16 has improved joint working between health and social care in our locality	Neither agree nor disagree	2015-16 BCF funding was underpinned by a Section 75 pooled budget arrangement jointly governed by the LA and CCG under an existing overarching arrangement. This will continue for 2016/17.
9. The implementation of risk sharing arrangements through the BCF in 2015-16 has improved joint working between health and social care in our locality	Neither agree nor disagree	It helped to clarify the challenges within the local health and care system, particularly in relation to reducing non-elective admssions and established a process for managing the trend. This included an analysis of the drivers for the increasing Non-Elective Admissions and predicting activity for 2015/2016.
10. The expenditure from the fund in 2015-16 has been in line with our agreed plan	Agree	From the activity in all of the schemes set out in for 2015/16, there was some underspend of £1.053m, in Pooled Fund of £18.707m. As the non-elective admissions set out in the plan did not achievethe required 1.5% reduction, an allowance of a Pay for Performance target payment of £0.527m was made. Leaving an overall revenue surplus of £0.044m and capital surplus of £0.482m. Both elements will be rolled forward to support the BCF in 2016/17.

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

11. What have been your greatest **successes** in delivering your BCF plan for 2015-16?	Response - Please detail your greatest **successes**	Response category:
Success 1	Central Bedfordshire Health and Care System have a shared vision for integration. There is a clear focus on a locality approach with development of locality integrated care hubs. There is wider engagement across the council and the recognition of this approach to secure improved outcomes for people through timely and appropriate access to better coordinated care and support in their localities.	6.Developing organisations to enable effective collaborative health and social care working relationships
Success 2	The refocusing of the BCF schemes helped the system to better understand the gaps and issues which are now helping to shape the transformation and reprocurement of commuity health services.	2.Delivering excellent on the ground care centred around the individual
Success 3	Improved joint working across the health and care system and an agreed approach to integration.	1.Leading and Managing successful better care implementation

12. What have been your greatest **challenges** in delivering your BCF plan for 2015-16?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	Partnership working with the community health service provider in 2015/16 has been a challenge, however, there has been continued delivery of projects within the BCF Plan.	2.Delivering excellent on the ground care centred around the individual
Challenge 2	Meeting the reduction in NEL Admissions target was a challenge. Schemes have demonstrated a reduction in NEL admissions, and project some of the demand but did not reduce the projected target.	4.Aligning systems and sharing benefits and risks
Challenge 3	During part of 2015/16 BCCG's focus was on financial recovery, which included changes in leadership. This resulted in a new approach to the re-procurement of community health services impacting some of the schemes which involved community health service transformation	1.Leading and Managing successful better care implementation

Footnotes:
Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Leading and managing successful Better Care Fund implementation
2. Delivering excellent on the ground care centred around the individual
3. Developing underpinning, integrated datasets and information systems
4. Aligning systems and sharing benefits and risks
5. Measuring success
6. Developing organisations to enable effective collaborative health and social care working relationships
7. Other - please use the comment box to provide details

New Integration Metrics

Selected Health and Well Being Board: Central Bedfordshire

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	No	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Shared via Open API	Shared via Open API
From Hospital	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Mental Health	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Specialised Palliative	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Shared via Open API

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable
Projected 'go-live' date (dd/mm/yy)						

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	No pilot underway

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	17
Rate per 100,000 population	6

Number of new PHBs put in place during the quarter	0
Number of existing PHBs stopped during the quarter	1
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	100%

Population (Mid 2016)	272,985

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	No - nowhere in the Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	No - nowhere in the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014).
http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html
Q4 15/16 population figure has been updated to the mid-year 2016 estimates as we have moved into the new calendar year.

Narrative

Selected Health and Well Being Board: Central Bedfordshire

Remaining Characters	27,226

Please provide a brief narrative on year-end overall progress, reflecting on the first full year of the BCF. Please also make reference to performance on any metrics that are not directly reported on within this template (i.e. DTOCs).

In 2015/16, we committed to 6 key schemes within the BCF Plan. Performance against these schemes has been regularly monitored, through the Better Care Fund Commissioning Board and reported the Health and Wellbeing board.From the activity in all of the schemes the Pooled Fund of £18.707m came in with an underspend of £1.053m. As the non-elective admissions set out in the plan have not achieved the required 1.5% reduction, the Pooled Fund made a Pay for Performance payment of £0.527m. Deducting the Pay for Performance payments from the initial Pooled Fund under spend, this left an overall revenue surplus of £0.044m and capital surplus of £0.482m. Both elements will be rolled forward to support the BCF in 2016/17. Progress against key schemes in the 2015/16 plan are summarised as follows:

Scheme One Transforming Primary Care:

A Lifestyle Hub pilot was established in February 2015. Clients are pre-dominantly aged 46-55 and are referred for advice/support related to obesity. The benefit of this service is that it considers the health of the whole person. A full review of this pilot, including cost effectiveness, was undertaken and referral criteria extended. This will inform the future roll out across Central Bedfordshire localities in 2016/17.

Accountable lead professional – All patients over 75 have a named GP. A standardised approach to risk stratification (manual & electronic) is being introduced as part of multidisciplinary working across Central Bedfordshire localities Long term conditions management in primary care - A more standardised means of collecting data in the four disease areas (asthma, diabetes, COPD, heart failure) using a LTC management template on SystmOne has been introduced.

Scheme Two Integrated Rapid Response:

A joint approach to the transformation of community health services has begun. Early discussion on integration of occupational therapy services is underway. A significant piece of work, reviewing the pathways for community beds has been completed. A key finding was that longer stay rehabilitation (slow stream) beds are an issue. We introduced a Multi-Disciplinary Team (MDT) working project to provide integrated response to those patients most at risk of admission and other people who would benefit from a more joined up response. The Caring Together pilot across two GP Practices in two localities, Chiltern Vale and West Mid Beds has been completed. Lessons from the pilot will be used to inform the ongoing review of Community Health Services and the roll out of MDT working across Central Bedfordshire. Dementia Health Needs Assessment completed. Dementia Friendly Communities programmes initiated. 280 CBC staff are dementia friends and nine Care Homes have gone through the CBC dementia quality mark process. A project on Paediatric Urgent Care aimed at reducing urgent care admissions amongst children and young people, and empowering parents to recognise and manage minor ailments, was completed. It also increased staff training to manage certain conditions in the community.

Scheme Three - Efficient Planned Care

Community services - A programme of work for a complete transformation of adult and children's' community services has now commenced. A Falls Project has commenced and is linked to facilitating a reduction in non-elective admissions. Fall prevention training is being delivered to Care Homes and

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Central Bedfordshire

NHS
Bedfordshire
Clinical Commissioning Group

Central Bedfordshire Better Care Fund Plan 2016/17

Narrative

Contents:

1. Introduction

This is the second Better Care Fund Plan for Central Bedfordshire. This Plan remains consistent with the priorities and outcomes of the Health and Wellbeing Board and is focused on the progressive integration of health and social care services through the Better Care Fund.

The 2016/17 Plan builds on the approved Better Care Fund plan for 2015-16.
It does not re-iterate all base-line information that formed part of the first plan. The Plan responds to the national requirements for Health and Care systems to produce a short, jointly agreed narrative plan including details of how the national conditions are being addressed.

In line with the 2015/16 BCF Plan, this narrative plan sets out:

- The local vision for health and social care services showing how services will be transformed to implement the vision of the Five Year Forward View and moving towards fully integrated health and social care services by 2020, and the role the Better Care Fund plan in 2016-17 plays in that context;
- The evidence base supporting the case for change;
- A coordinated and integrated plan of action for delivering that change;
- A clear articulation of how each national condition will be addressed;
- An agreed approach to financial risk sharing and contingency.

The Better Care Fund will create a pooled fund of £20.534m in 2016/17 to support the delivery of integrated care. This is made up of a contribution of £ 5.258m from Central Bedfordshire Council and £15,275m from Bedfordshire Clinical Commissioning Group.

This narrative plan does not restate information that is already satisfactorily provided in existing plans or previously set out in the 2015/16 BCF Plan. It however recognises the need for alignment of Plans across local health and care agencies and the national strategic drivers that influence them.

Cllr Maurice Jones
Chair
Central Bedfordshire Health and Wellbeing Board

2. The Vision for Integrated Care

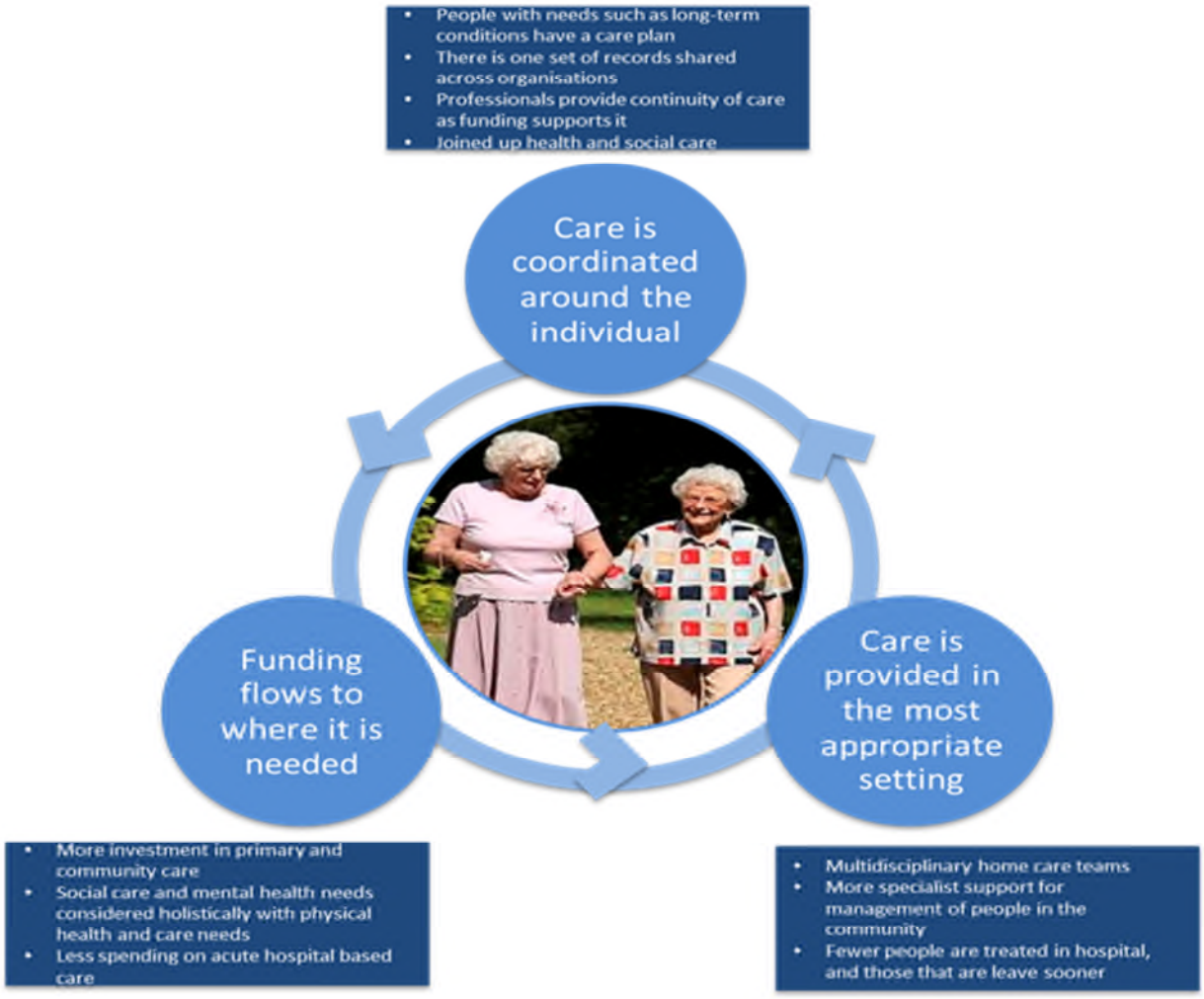
2.1 Vision for health and social care services

Our Better Care Plan is based on the overarching ambition to secure a fundamental shift in the ways in which care and support is provided to residents of Central Bedfordshire. It sets out a shared vision and ambition for transformational change across health and social care rooted in a locality based delivery model. Care should be coordinated around the full range of an individual's needs with prevention and support for maintaining and maximising independence remaining central.

We recognise the need to deliver these changes at some pace, underpinned by the following principles for integrated care with:

- Care coordinated around the individual;
- Decisions made with, and as close to, the individual as possible
- Care provided in the most appropriate setting; and
- Funding flowing to where it is needed.

These principles are reflected in the diagram below.



2.2 Key Priorities

Central Bedfordshire's agreed strategic approach is based on four key priorities for delivering integrated care at scale and pace.

In setting out the four priorities below, we recognise the importance of reducing reliance on hospital services. By developing greater range and capacity in community-focused care it will be possible to deliver improved health and care experiences as well as more effective use of resources by:

1. **Reshaping the model for prevention and early intervention** – through an integrated approach to primary, secondary, and tertiary prevention to stop or reduce deterioration in health.
2. **Supporting people with long term conditions through multi-disciplinary working** – focussing services around general practice in locality networks and helping people to manage their own conditions in the community.
3. **Expanding the range of services that support older people with frailty and disabilities** – integrating the range of housing, mobility, carers and other services that wrap around older people with specific conditions and issues and helping to manage new demand including through the Care Act.
4. **Restructuring integrated care pathways for those with urgent care needs** – ensuring that these are seamless, clear, and efficient to help deliver the clinical shift required to move care away from acute settings, where appropriate, as well as building future resilience for the responsibilities of the Council under the Care Act 2014..

These are the overarching priorities which are central to the outcomes the local health and care economy wishes to achieve for the local population. Three key themes which will help to secure these outcomes in 2016/17 are set out in Section 4 below.

2.3 BCF Patient and Service User experience and outcomes

Our Better Care Plan themes will ensure, over time that the discrete silos of current health and care provision are replaced with a model of care aimed primarily at supporting patients to be self-caring, independent and less reliant on acute or specialist intervention. There will be better, more timely and accessible information and community services. The focus of this would be to enable people to have healthier lifestyles and manage their long term conditions more effectively.

Unplanned emergency admissions would be avoided. Quality of life would be improved and people supported to live independently in their own homes for as long as possible. By 2019, our journey from fragmented working to an integrated and person-centred approach will be fully embedded. These changes in the way services are organised will mean our population will:

- Experience **seamless access to a timely, coordinated offer of health and care support**.
- Have **access to a wider range of support to prevent ill-health**, with increased emphasis on early interventions supported by voluntary, community and long-term condition groups, enabling them to stay healthier for longer;

- Be **supported to remain independent with integrated GP and community multidisciplinary teams** delivering care directly **within their own home** wherever it is possible to do so;
- Have access to a wider range of health and care services in the community that will **help to avoid unnecessary hospital admission** and, following any necessary admission, will enable discharge to home care as soon as it is safe to do so;
- Have **access to mental health services that are integrated with physical health and social care services**, through acute, primary, community and specialist teams and aligned to lifestyle Hubs.
- Have access to **rehabilitation and reablement** services that will avoid or minimise the need to enter into residential or nursing home care;
- Experience **reduced variations in care** with improved outcomes;
- Have **support for carers that is timely and person centred** with an integrated response underpinned with joint planning and assessment, as appropriate;
- Experience services that **are person-centred, highly responsive and flexible**, designed to deliver the outcomes important to the individual; and
- Benefit from **stream-lined and integrated working with joint information systems**.

Central Bedfordshire Council is implementing the "Making it Real" Markers for change and is working across the health and care economy to secure the outcomes and values set out in the National Voices document.

2.4 Locality Based Integrated Health and Social Care Services

The local shared vision is for health and social care rooted in a locality-based delivery model. In Central Bedfordshire there are four existing and well-defined population centres based around the towns of

- Dunstable and Houghton Regis,
- Leighton Buzzard and Linslade,
- Ampthill and Flitwick,
- Biggleswade and Sandy.

These population centres form the basis of well-established localities (Chiltern Vale, Leighton Buzzard, West Mid Beds and Ivel Valley) that are to be the focus of developments in health and social care. The Council's older peoples and disabilities services are coterminous with these localities.

We have already established integrated health and social care locality arrangements in the Chiltern Vale area and experience gained is supporting the expansion of this approach across the rest of Central Bedfordshire.

Our Caring Together programme (formerly Demonstrator project) involves two pilot schemes across GP Practices in Chiltern Vale and West Mid Beds. We have introduced Multi-Disciplinary Team (MDT) working to provide an integrated response to those patients most at risk of admission and other people who would benefit from a more joined up response. Lessons from the pilots are also informing a current transformation of community health services as well future procurement.

Locality arrangements are central to responding to local demographic pressures and the increasing complexity of existing pathways within health and social care. The strategic review of healthcare services in Bedfordshire and Milton Keynes indicated that locality based integrated care hubs are fundamental to achieving sustainability in our local health and care system.

The Health and Wellbeing Board, Council and the CCG wish to ensure that the population of Central Bedfordshire has access to good quality, safe, local primary, community, health and social care across the towns and rural areas. The framework for achieving this is through a number of primary care led Integrated Care Hubs that are based, in the first instance on our four Localities.

2.5 An Integrated Health and Care Hub in each locality

The proposed initial configuration of hubs is set out in Figure One. Strategically, we recognise that the number of hubs would increase in line with housing and population growth.
The hubs would provide a range of medical, nursing and social care interventions to support their local population, providing access to full range of health and care needs, including:

- A wider range of primary health services ;
- Accommodation for groups of practices who wish to co-locate under one roof;
- Improved access to GPs through extended hours, out of hours and walk-in services;
- A focus for management of more complex long term conditions including dementia care;
- Clinically-led locality multi-disciplinary teams (MDTs)
- Access to community and mental health care services;
- Social care services, including occupational therapy, reablement, and children's support;
- Access to all out of hospital care services and hospital specialists;
- A single platform supporting information sharing across multiple organisations and providing access to integrated data sets for patients.

These would operate seven days per week and would prevent people, especially the elderly frail, making unnecessary journeys to hospitals. Only those requiring expensive diagnostic equipment or hospitalisation would need to be transported out of their local areas, freeing up the ambulance services to focus on those with very acute needs. We would want to explore the use of technology to help deliver our "hospital without walls" concept.

In each locality, it is anticipated that some Practices will co-locate within new hub facilities whilst the remaining practices will stay in their existing premises in a hub and spoke type model. In Dunstable five town-centre practices are signed up to co-locate in a hub type facility whilst five other practices will use the hub services listed above.

We are developing new models of delivery including: access to diagnostics, salaried GPs, specialised GPs, specialist nurses, geriatricians, therapists, social care staff, information and advice. We are considering including the assessment of housing needs and prevention of homelessness within this approach to provide a holistic approach. This would better meet the requirements of the Better Care Fund Plan which sees housing support, such as Disabled Facilities Grants for adaptations, as an important component of integrated outcomes. This would sit alongside access to community equipment and low level minor works to properties, which enables people to leave hospital early or delay the need for institutional care. We are aware of the developments in other areas around elderly medical units without inpatient beds and would want to see access to this type of support.

These hub services will be underpinned with a shared record system and informatics platform. An integrated shared care record accessed through a flexible web based portal will provide timely

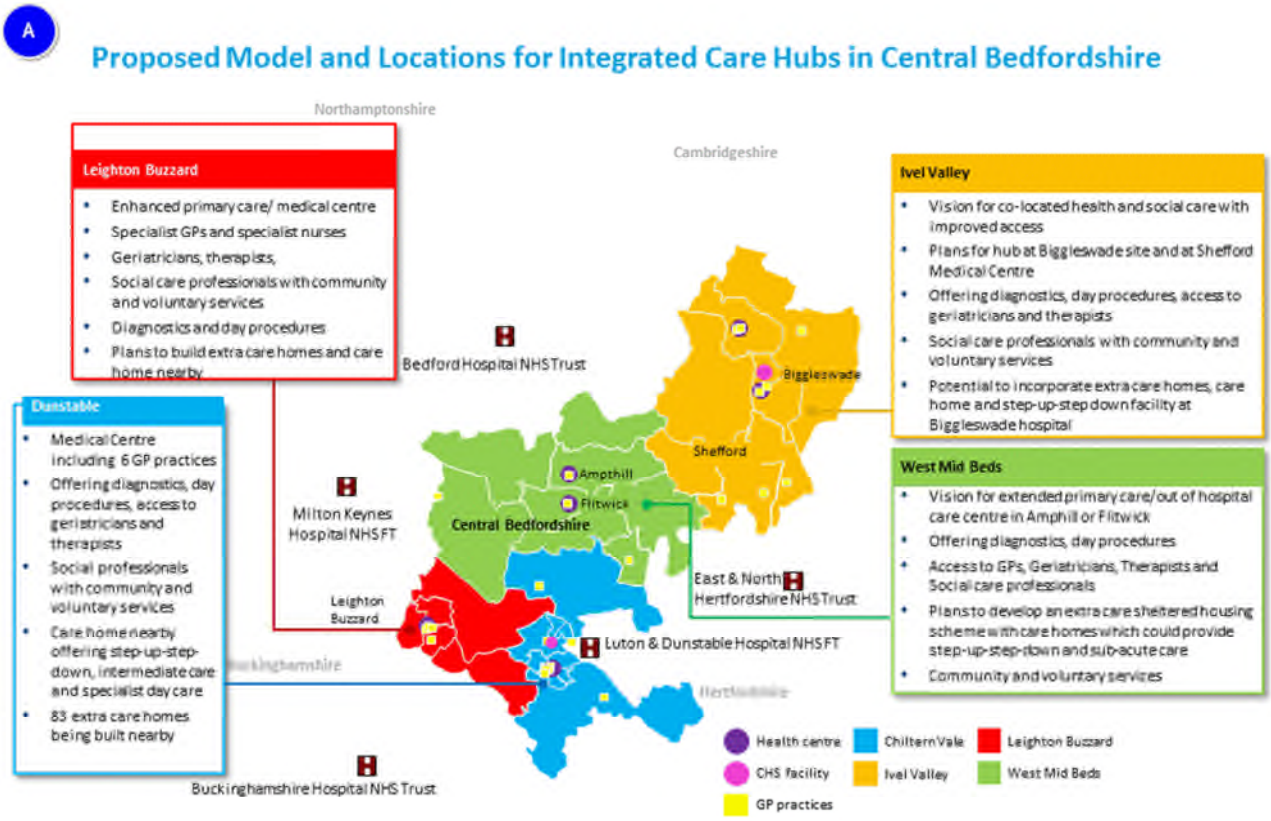
access to information and enhance joint working between health and social care teams. We will be developing our digital roadmap as required by the national conditions. Although this is very much in the early stages and will require resources and support to secure this effectively across our health and care system

We are exploring the models available as announced in the NHSE Five Year Forward View and more recently the GP Forward View, to underpin the integration of services needed to make the most effective use of these hub facilities.

The configuration of hubs and services proposed across all of Central Bedfordshire are set out below. Business cases are currently being developed for two of the hubs.

Figure One

A



2.6 Progress on developing Locality based Integrated Care Hubs

Chiltern Vale (Dunstable) Integrated Care Hub :

Following a successful bid to the 2015/16 Primary Care Infrastructure Fund, work is now on going to develop the Outline Business Case (OBC) for the Dunstable Integrated Care Hub; this work is being undertaken by Capita. Work is focused on the development of progressive care models and accommodation requirements. All stakeholders across acute, primary, community and social care are involved.

A further options appraisal is being commissioned for the development of a 'spoke' to the Dunstable Hub, in Houghton Regis to meet a significant increase in housing growth.

The practices will develop closer working relationships (organisational form to be developed) over the next year so as the planning for co-location evolves to maximise resources, deliver seven day services and collaborative approaches to shared facilities, including IT and back office functions.

Ivel Valley (Biggleswade) Integrated Care Hub:

A Project Initiation Document (PID)to the Primary Care Transformation Fund in 2016/17 has been produced and is ready for submission once the NHSE 'portal' is open. In the meantime, work has also started on developing a strategic business case for the future of Biggleswade Hospital as an integrated care hub. This work is directly linked to the One Public Estate Programme across Central Bedfordshire. The Council has supported the refurbishment of a new Ivel Medical Centre which will host both health and social care staff and facilitate joint working as a precursor to MDT development. This provides an important template for co-location and multidisciplinary working and is in line with the GP Forward View.

West Mid Beds (Ampthill and Flitwick) Integrated Care Hub: The CCG has started an Estates Review for West Mid Beds. A feasibility study and options appraisal around the future configuration of GP premises in the Mid Beds Area, in particular addressing planned housing growth and also to consider feasibility of co-locating a number of surgeries into integrated Health and Social Care Hubs is to be commissioned.

2.7 Alignment of BCF with NHS Five year Forward View

Our Central Bedfordshire BCF Plan is directly aligned and contributes to the delivery of national health and care strategy, as set out in Delivering the Five Year Forward View, published in December 2015. https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf which sets out a new shared vision for the future of the NHS based around new models of care and national 'must dos' for 2016/17. Our BCF Plan aligns closely to other programmes of work including the new models of care as set out in the NHS Five Year Forward View and delivery of seven-day services and reinforces the ambition that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care.

We have established a programme of transformational change that focuses an out of hospital strategy around the needs of people with long term conditions and delivers a journey for the integration of health and social care services. Our local health and care system leadership is focused on securing a whole system approach from 2017-20 and a move on from existing BCF programme management.

2.8 System Sustainability and Transformation Plan and the Bedfordshire and Milton Keynes Healthcare Review

The Sustainability and Transformation Plan [STP] covers the period between October 2016 and March 2021. STPs will become the local whole system blueprint for accelerating the implementation of the Forward View, to deliver the triple aim of better health, transformed quality of care delivery, and sustainable finances.

A transformation footprint for the STP has been defined locally covering Bedfordshire, Luton and Milton Keynes. Place-based planning on this scale recognises the work being undertaken within the healthcare review of services in Bedfordshire and Milton Keynes. The footprint recognises significant patient flows across Bedfordshire to both Bedford Hospital and the Luton and Dunstable Hospital and reflects the planning footprint for the development of our learning disability transforming care programme.

As NHS planning guidance suggests, the STP will be an umbrella plan, with differing levels of shared planning. Transformational change for care pathways such as urgent and emergency care will be mapped across this broad footprint. Area specific plans for Primary Care and out of hospital services will be described at local authority and CCG level and set out within our Better Care Fund Plan and emerging Integration Plan. This is particularly relevant for Central Bedfordshire's population in view of patient flows to hospitals outside of the local STP footprint.

3. The Case for Change

3.1 Evidence Base - Population and Health Indicators

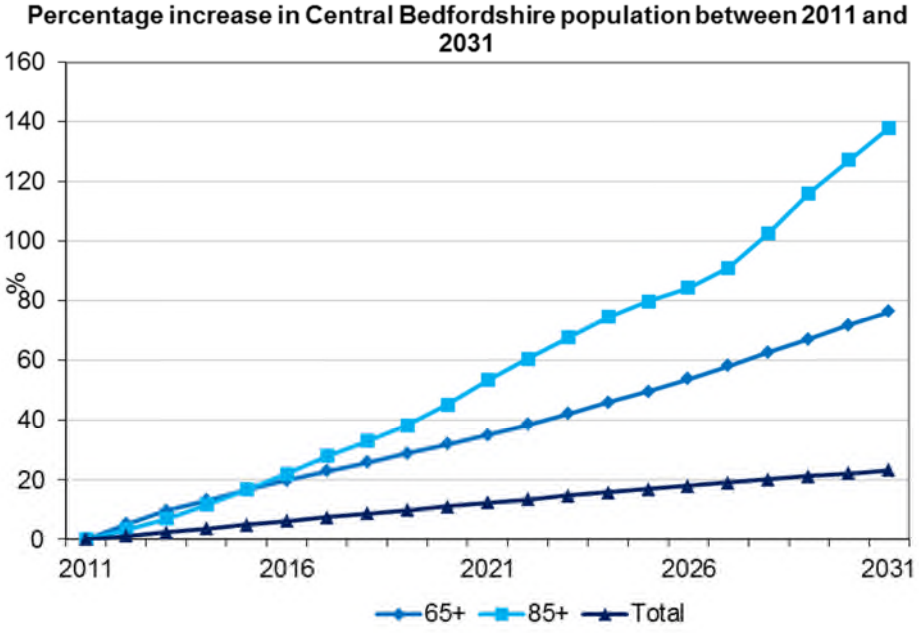
This section sets out the challenges facing our local NHS services, and the opportunities for transformation.

The Joint Strategic Needs Assessment (JSNA) provides a comprehensive picture bringing together about the health and wellbeing of the people living in Central Bedfordshire.
https://www.jsna.centralbedfordshire.gov.uk

A summary of the principal demographic and health characteristics are described below

- Growing population due to increasing life expectancy, a birth rate higher than deaths and inward migration
- In 2014 population of 269,000, with an increase of 6.3% by 2021. Older age groups will increase at a higher rate (65 + by 32.7%, 85 + 52.1%).
- Average life expectancy is 81.5 years for men and 83.8 years for women), better than the national average. Life expectancy is increasing at the rate of about 4.0 years for men and 2.1 years for women each decade.
- The main causes of death under 75 are cancer, heart disease and stroke.
- The largest towns in the area are Dunstable (33,805), Leighton Buzzard (32,753) and Houghton Regis (16,970).
- The population is 89.7% White British, with White: Other White (2.8%) and White: Irish (1.2%) being the largest minority groups.
- The number of people registered with Central Bedfordshire General Practices in early 2014 was 282,059

As the graph below shows, the overall population is expected to grow by over 23% between 2011 and 2031 compared to the number of older people aged 85 and over which will grow by 138% by 2031.



Central Bedfordshire is an area of significant opportunity with planned housing and employment growth and is a desirable place to live. Although Central Bedfordshire is a relatively affluent area with life expectancy that is greater than the national average, there are significant challenges resulting from an ageing population and pockets of urban and rural deprivation.

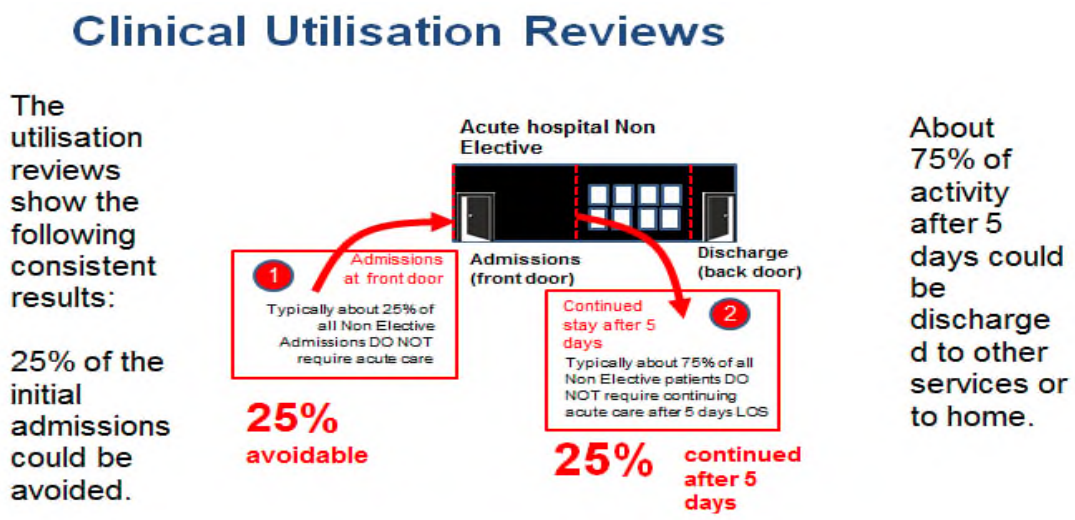
Demands on services for older people with disability and frailty will increase. Mental health problems, particularly depression and dementia, are more common and have a worse outcome in the 60% of older people who suffer from long standing illnesses. The prevalence of dementia across the UK is estimated at over 700,000 and predicted to reach 3,600 in Central Bedfordshire by 2020. Only one third of sufferers receive any form of formal diagnosis at any point in their care or during the progression of the condition. Evidence suggests that early diagnosis and treatment is vital and can improve the quality of life for people and increase their independence as the condition progresses.

3.2 Future Changes in Demand for Health and Social Care
Key factors that influence potential changes in demand for health and social care in people aged 65 and over living in Central Bedfordshire:

	2011	2015	2020	2025	2030
People living with dementia	2,634	3,031	3,677	4,516	5,440
		15%	40%	71%	107%
People living with a limiting long term conditions	17,288	20,098	23,061	26,620	30,528
		16%	33%	54%	77%
People unable to manage at least one personal care task	13,131	15,077	17,578	20,648	23,936
		15%	25%	57%	82%
People unable to manage at least one domestic care task	16,010	18,379	21,530	25,294	29,240
		15%	34%	58%	83%

3.3 Reducing Reliance on Hospital Services for less Complex Care

A major challenge within our BCF Plan is to reduce Non-Elective Admissions, which has increased in 2015/16 as reflected in the BCF quarterly performance reports. Developing services that reduce reliance on the hospital sector for those with urgent but less complex care needs that could be provided in out of hospital settings, is a key priority in our Plan. To quantify the scale of the change that could potentially be made a clinical utilisation review has been undertaken on non-elective admissions to identify the proportion of sub-acute care that could be provided in community settings. This will be shared with providers and will inform plans to change patterns of care supporting future sustainability. Figure 2 below provides an outline of the scale of change anticipated.



Using internationally recognised clinical protocols, the Utilisation Reviews shows that up to 25% of current non-elective admissions do not require acute care and that up to 75% of those staying longer than 5 days in hospital could be more appropriately cared for in sub-acute settings.

Ongoing modelling will determine the proportion of patients that can be cared for at home and the proportion that would require step-up or step-down care.

The scale of change is potentially very significant but caring for people in the most appropriate care setting is key to sustainability in the system. It is anticipated that an overall programme to take this change forward will form part of our system Sustainability and Transformation plan which will be produced in July 2016. The Better Care Fund plan will be key in taking forward the transition to more local care.

3.4 Service User Feedback

As part of the review of healthcare services, there are ongoing comprehensive engagement activities with local people, clinicians, organisations, communities and a range of sectors. There is active engagement with local people and key stakeholders in helping to shape and understand what high quality, sustainable services will need to look like to support care needs into the future. Care closer to home has featured as a significant priority within the engagement we have undertaken in relation to the transformation of community health services.

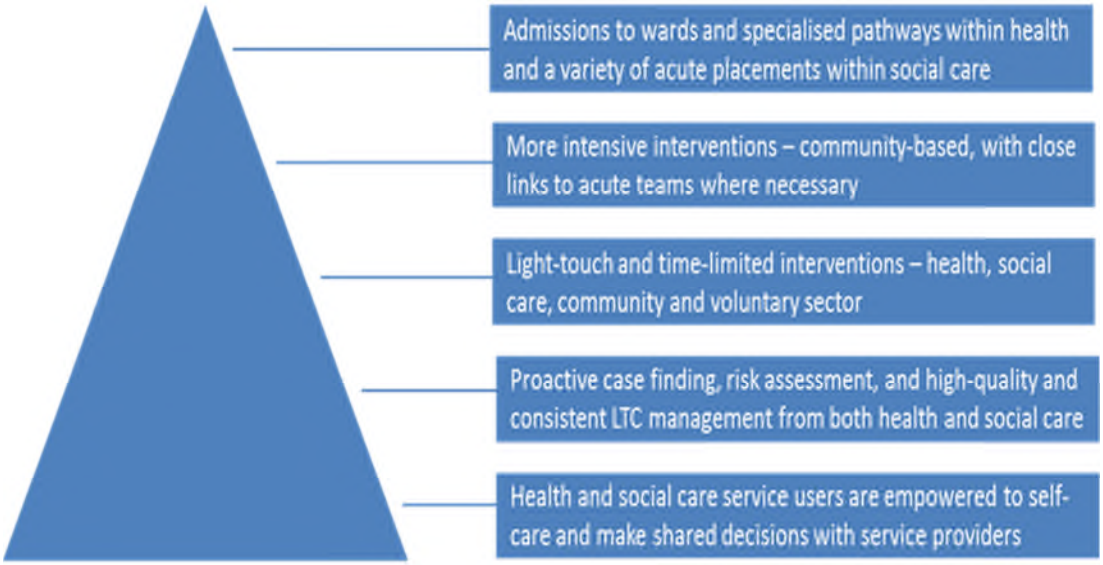
A strong theme in the conversations with patients and the public has been their wish to stay healthy and independent for longer and, to that end, to have more care provided closer to where they live, organised around their lives and available at times that suit them. In their discussions, clinicians describe how closer working between primary, community-based and hospital care can enable more care to be provided to patients without the need for hospital visits or inpatient stays. These feedback have influenced the focus for the BCF Plan, identifying what services could be delivered within the community and ensuring care closer to home becomes reality. Two further themes that emerged consistently were; more services offered out of hospital and GP practices, community services and social care providing one joined-up service, enhanced by greater networking across the NHS and the Council.
Further information on feedback from service users and our approaches on engagement are set at https://www.bedfordshireccg.nhs.uk/page/downloadFile.php?id=12381

Further information and evidence drawn from engagement on modelling community health services is attached.

AH_ BCF planning 16-17 - Engagement

3.5 Segmented Approach to Meeting Needs of Individuals

Our Care model is taking forward the following segmented approach (see below) to identifying and meeting the needs of individuals



Delivering this vision for integrated care means overcoming barriers between primary and secondary care, physical and mental health, and health and social care. Our Better Care plan brings resources together to address immediate pressures on services and establish a foundation for a much more integrated system of health and care delivered at pace. Our agreed model of care is underpinned by a new delivery framework for joint working across partners and client groups to deliver the full continuum of health and social care support. This includes prevention and early intervention, self-management, reablement and independence. For mental health this will focus on closing the gap between access to physical and mental health services
Key messages have been considered in shaping our whole systems response to the Case for Change, as part of the review of health care services in Bedfordshire and Milton Keynes, analysed alongside a range of pressures that currently challenge our local health and care services.

A full account of these challenges is described within the review midway report a Case for Change.
http://www.yourhealthinbedfordshire.co.uk/modules/downloads/download.php?file_name=37

3.6 Progress against BCF Plan 2015/16

In 2015/16, we committed to six key schemes within the BCF Plan. Performance against these schemes has been regularly monitored, through the Better Care Fund Commissioning Board and reported to the Health and Wellbeing board. Progress against key schemes in the 2015/16 plan are summarised as follows:

Scheme One Transforming Primary Care:

A Lifestyle Hub pilot was established in February 2015. Clients are pre-dominantly aged 46-55 and are referred for advice/support related to obesity. The benefit of this service is that it considers the health of the whole person. A full review of this pilot, including cost effectiveness, was undertaken and referral criteria extended. This will inform the future roll out across Central Bedfordshire localities in 2016/17.

Accountable lead professional – All patients over 75 have a named GP. A standardised approach to risk stratification (manual & electronic) is being introduced as part of multidisciplinary working across Central Bedfordshire localities

Long term conditions management in primary care - A more standardised means of collecting data in the four disease areas (asthma, diabetes, COPD, heart failure) using a LTC management template on SystmOne has been introduced.

Scheme Two Integrated Rapid Response:

A joint approach to the transformation of community health services has begun. Early discussion on integration of occupational therapy services is underway. A significant piece of work, reviewing the pathways for community beds has been completed. A key finding was that longer stay rehabilitation (slow stream) beds are an issue. We introduced a Multi-Disciplinary Team (MDT) working project to provide integrated response to those patients most at risk of admission and other people who would benefit from a more joined up response. The Caring Together pilot across two GP Practices in two localities, Chiltern Vale and West Mid Beds has been completed. Lessons from the pilot will be used to inform the ongoing review of Community Health Services and the roll out of MDT working across Central Bedfordshire. Dementia Health Needs Assessment completed. Dementia Friendly Communities programmes initiated. 280 CBC staff are dementia friends and nine Care Homes have gone through the CBC dementia quality mark process. A project on Paediatric Urgent Care aimed at reducing urgent care admissions amongst children and young people, and empowering parents to recognise and manage minor ailments, was completed. It also increased staff training to manage certain conditions in the community.

Scheme Three - Efficient Planned Care

Community services - A programme of work for a complete transformation of adult and children's' community services has now commenced. A Falls Project has commenced and is linked to facilitating a reduction in non-elective admissions. Fall prevention training is being delivered to Care Homes and Domiciliary Care providers. The Council's Urgent Homes and Falls Response Service is being piloted to provide support to Care Homes. A number of Care Homes have identified a Falls Champion. Five Step EOL training to Care Home staff, designed to not only improve EOL care but assist with best interest decision making on preferred place of death has been introduced. Training provided to Ambulance staff to support non-conveyance has by month eight resulted in 201 non-conveyances. The OT Service responds promptly to referrals for DFGs and has improved the average length of time from Occupational Therapy referral to DFG approval to eight weeks compared to a 2013/14 average of 10.9 weeks.

Scheme Four - Supported discharge

Discharge facilitation pilot in West Mid Beds – pilot completed. Learning from the pilot will be used improve patient pathways as part of the transformation programme for community services. A carers' lounge has been opened at the L&D to mirror that at Bedford Hospital. A multi-agency

partnership for prevention and promoting independence was established. Programmes for physical activity and exercise for frail older people are being commissioned.

Scheme Five - Care Act

Duties set out in Phase One of the Act have been embedded into local practice. Phase Two implementation has been deferred.

Scheme Six - Better Care Fund Implementation

A Better Care Fund Plan Commissioning Board was established, together with an Operational delivery group. A Provider Alliance was set up. Links with CCG Locality Boards established. Pooled budget established and S75 agreement signed. Performance and finance monitoring framework agreed and reviewed monthly, with quarterly reporting to NHS England. NHS number is now used predominantly as primary identifier across all agencies and systems.

3.7 What lessons were learned and what will change?

A review of the 2015/16 Schemes was undertaken by the Health and Wellbeing Board and based on the findings, made the decision to take a more focused approach to the 2016/17 Plan. **http://centralbeds.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=829**

It is clear that there are now real challenges within the health and social care system in Central Bedfordshire for delivering an ambitious BCF Plan, particularly in relation to reducing unplanned admissions to hospitals. Although there has been important progress in all scheme areas, there have been a number of factors that have impacted on the overall pace of delivery of the BCF Schemes. The Clinical Commissioning Group's financial recovery and changes in leadership has also had an impact on the delivery of the BCF Plan and schemes.

Uncertainties regarding the re-procurement of Community Health Services contract have also had an impact on delivery. Community health services provision is central to the BCF Plan. The majority of the schemes set out in the BCF Plan require new ways of working and in particular integrated services to facilitate seamless and timely care pathways for frail older people. These uncertainties in the system have undermined the delivery of the BCF Plan

The ongoing review of community services now means that a number of BCF Plan projects are subsumed into the scope of the review and being taken forward initially as part of the transformation of community health services in 2016/17.

In recognition of the financial challenges within our local health and care system, there is a clear focus across the system on achieving financial stability and sustainable health and care services, through transformation and integration. Our BCF Plan for 2016/17, as earlier stated is consistent with the ambitions of the CCG's Operational Plan 2016/17 and the Council's Five Year Plan. Our 2016/17 BCF Plan takes forward the following developments that will make a significant contribution towards delivering the vision set out in the Five Year Forward view and are reflected in our Schemes.

To meet the immediate challenges, within our local health and care system, our BCF Plan for 2016/17 is focusing on three key schemes to help deliver improvements, cost efficiency, more streamlined pathways of care and to meet the national conditions. There is local recognition and agreement that a focus on these areas would deliver more significant benefits to the target population.

Although there have been some successes, in 2015/16, the review of the schemes have shown that there are a number of key areas that would benefit from a greater focus and these have been scoped to ensure a more effective and achievable plan for 2016/17. The prevailing challenge is reducing non-elective admissions and the key projects have been mobilised to mitigate this. Additionally, the transformation of community services with introduction of multidisciplinary working and enhanced care into care homes should have an impact on this. A risk share agreement will be set out in the Section 75 Agreement. Performance will be monitored and reviewed by all key partners through the Systems Resilience Groups, the BCF Commissioning Board and the Health and Wellbeing Board.

4. BCF Plan 2016/17 Delivery

The transformation of community services, based on GP clusters within localities will be a key trigger for our journey towards integration. Our case for change is predicated on the increasing levels of non-elective admissions which are evidenced in our quarterly submissions for BCF 2015/16. New ways of working will be required to deliver changes and ensure the sustainability of our health and care system in the face an ageing population with increasing complexity of needs. The GP Clusters with MDTs will offer proactive care to high risk patients, reducing admissions as well facilitating reduced length of stay in hospital. These and a key focus on the following seven projects will underpin our approach in 2016/17:

1. Improving the Falls Service
2. Transforming Community Services - Multi-Disciplinary Team Working
3. Transforming Community Services - Maximising Independence through Supportive Technology (MIST)
4. Improving End of Life Care
5. Improving outcomes for stroke survivors
6. Enhanced Care in Care Homes
7. Delayed Transfers of Care (DTOCs)

Details of the projects, objectives, and deliverables and how they align to the national conditions and metrics are set out respectively in Appendix 1. The seven projects, which build on the 2015 /16 BCF Plan, fall into three themes as follows:

4.1 Theme One - Out of hospital care.

This scheme is focused on transformation of community health and care services. Our vision for a local model for community based services is likely to result in the need for substantial change in the way services are currently modelled and delivered. It is likely that investment in new ways of working and capacity will be needed. Jointly commissioning health and care services will improve patient experience, help to provide efficiencies, improve the quality of care and create opportunities to address local workforce challenges. The total BCF financial allocation against this scheme is £12.984m in 2016/17 compared to £12.019m in 2015/16.

In 2016/17, the transformation of community services will reinforce the MDT model for proactive care (Caring Together) which is focused on those patients at risk of admission. It is anticipated that this approach will advance to a rapid response to avoid hospital admission. This will be achieved through better cohesion and joint working across existing teams, such as the current rapid intervention teams, Urgent Homes and Falls Response Service and the Emergency Duty Teams.

The scheme will facilitate integration of services, development of multidisciplinary teams across Central Bedfordshire localities and a common intermediate care pathway for joint assessments, care planning and provision.

Principles for the design of community services are:

- To provide care closer to home
- Simplify services and remove unnecessary complexity, through integration and collaboration.
- Design services that are patient and family centred
- Develop teams and services to provide support to patients as an alternative to admission or hospital stay.
- Designed in line with evidence of best practice

The overall scope of this scheme will also include redesign of intermediate and rehabilitation services, improving access to community beds and delivery of seven day services. This will respond to the requirements of the national conditions for joint assessments, care planning and accountable professional.

4.2 Theme two – Prevention

There are important opportunities to influence, empower and reshape how people in Central Bedfordshire experience health and care services. The need for a system wide response to wider system issues around prevention and early intervention is recognised. There needs to be an integrated approach to primary, secondary, and tertiary prevention to stop or reduce deterioration in health. The total BCF financial allocation against this scheme is £4.962m in 2016/17 compared to £4.687m in 2015/16.

The overall scope of the scheme will address: patients being enabled to self manage; the use of assistive technology; disabled facilities grants and adaptations; paediatric admissions; falls prevention; accommodation and support to carers. This will ensure the most progressive, evidence-based prevention and early intervention programmes are available to our population. Local investment in prevention initiatives are set out in the template and builds on the key initiatives commenced as part of the 2015/16 BCF Plan.

A key initiative planned for 2016/17 is Maximising Independence through Supportive Technology (MIST). This will introduce systematic support for patients to self manage. The concept is a population based approach to prevention, targeted at particular segments of the population and is based around proactive health care coaching through telephone and outreach services. The self-management support service will help people to be independent through proactive interventions which enhance an individual's confidence and by coordinating health and social care as and when they need it. It will consist of four elements:

1. A proactive health care coaching (through telephone, outreach and assistive technologies such as telecare, telehealth etc.) service for patients identified by MDTs as being at risk of admission.
2. A reactive rapid response service for patients in care homes where care home staff can access expert support and information from dedicated Senior Nursing staff in a centralised hub to avert an emergency admission and gain access to community nursing or GP access/visits.

3. A single point of access for the new integrated community care and support service (currently in operation across SEPT provided by One Call)- linked to each of the nine operational integrated cluster care teams- providing support and referral management for staff and patients (including community and commissioned care home beds).
4. A service to provide direct care coordination for patients in the last year of their life (currently provided by PEPS) to support patients to die in their preferred place and provide patients, carers and professionals with a single point of contact for advice and support for palliative care.

The service will combine nurse-led telephonic management using electronic evidence based protocols which assess and case manages individuals on a multi domain holistic model. The target group will be high risk, high cost patients. A full business case is in development to support procurement for 2016/17.

The 2016/17 BCF Plan continues the focus on mental wellbeing. A number of self help guides have been introduced as part of the mental health and wellbeing campaign. The five ways to wellbeing encourages people to take actions which are proven to improve mental health. The guides contain useful hints and tips on self care and also signposts to professional help if required.

4.3 Theme three – Protecting Social Services

This scheme will ensure the Council is able to respond to increasing demands and complexity of care needs, in a timely and appropriate manner. There is a real challenge in reducing delayed transfers of care, supporting Care Homes to deliver more complex care for people in their usual place of residence and delivering timely and integrated care packages, including domiciliary care. This scheme will focus on key areas which will help to reduce unplanned admissions, including rapid home care response – enabling people to remain at home longer. The total BCF financial allocation against this scheme is £2.588m in 2016/17 compared to £2.001m in 2015/16.

Within this scheme, there will be a focus on implementing an integrated model of multi-disciplinary health and social care working that provides care in the patients' usual place of residence. Enabling care to be accessed through a network of support focused on meeting individual needs and supporting people's independence.

This scheme aims to transform care both in terms of new developments and for the key enablers that will underpin integration and joint working, for example workforce and data systems and shared records.

The Council has a programme for managing the accommodation needs of older people (MANOP). This programme is focused on delivering an expansion of independent living accommodation for Central Bedfordshire residents and in particularly securing alternatives to reliance on care homes. People with varying levels of care, can have access to extra care housing with support.

Pathways for coordinated discharge from hospital will ensure that people leave hospital with support to maximise their independence back in their own home. The discharge pathways will incorporate integrated rehabilitation and reablement with access to equipment and adaptations as required.

These schemes will complement the priorities areas set out in the Bedfordshire Plan for Patients 2016/17.

5. An agreed approach to Financial Risk Sharing and Contingency

The total BCF Pooled Fund is £20.533m and has been allocated across the three Themes as follows:

Theme	2016/17 Allocation £m	2015/16 Allocation £m
Out of Hospital Services	12.984	11.465
Prevention	4.962	4.687
Protecting Social Care	2.588	2.555
Total	**20.534**	**18.707**

New investment in 2016/17 has been allocated to support new Falls prevention activity £0.180m, Liaison Psychiatry £0.135m and Primary Care Mental Health Liaison of £0.144m. In addition a contingent sum of £0.389m has been set aside to mitigate the impact of failure to reduce non-elective admissions by 1%. Furthermore, an under-spend from the 2015/16 BCF Pool of £0.044m revenue and £0.482m capital has been carried forward into 2016/17 to support the programme.

As indicated above new investment has been made available to support the new Falls Prevention activity sitting within the seven transformation projects. The remainder, Multi-Disciplinary Team Working, Maximising Independence through supportive technology (MIST), End of Life Care, Improving outcomes for stroke survivors, Enhanced Care in Care Homes and Delayed Transfers of Care (DTOCs) will be supported by using existing resources across the Council, the Clinical Commissioning Group and Providers. Much of this work is focussed on driving improvement to service configuration and operations and will identify how to use existing investment in more effective and efficient ways to prevent unnecessary admissions to hospital and improve discharge arrangements from hospital.

Appendix two (a&b) shows how the BCF financial resources in the Pool in 2016/17 compares to the 2015/16 BCF and aligns with the three Central Bedfordshire Themes and national scheme types. Also see BCF 2016-17 Planning Template

5.1 Risk Share

Our Plan is focused on Integration and the improvements in quality of life for people with long term conditions and older people with frailty. For each of our schemes we will measure the impact on non elective activity. For the 2016/17 Plan we will continue to build on the work started in 2015/16, which we believe will stabilise current levels of admissions.

As a system we recognise that failure to meet the BCF targets will have an impact on the quality of life and experience of our population, when they need to make use of health and care services. This failure would lead to an increasing reliance on use of institutional care and non-elective admission. In addition, failure to increase use and effectiveness of Reablement and intermediate services could impact on the recovery and ability to regain important life skills following an episode of ill health.

Key performance and quality outcomes have been articulated with providers as part of the local CQUIN targets, and these will be further developed in 2016/17 to form part of contractual obligations. In addition to this, the Council has included the requirement for prevention and promotion of wellbeing, within council commissioned care services.

Both the Council and the Clinical Commissioning Group have a clear understanding of the challenges of reducing non-elective admissions and are in a better position to manage the trend currently being experienced. However, it is proposed that the financial risk presented by the failure to reduce non-elective admissions by 1% will be positioned against the whole BCF pool of £20.5m and shared according to the proportion of spend from the BCF pool. A contingent sum of £0.388m has been allocated to mitigate the non achievement of the 1% target in the first instance although local agreement has been reached that the risk share will be shared on a 50/50 basis.

The 1% risk share recognises the challenge of reducing non-elective admission which has continued to increase in 2015/16 against the BCF baseline. An analysis of the drivers for the increasing Non-Elective Admissions has been undertaken and is predicting activity at 2015/2016. (Attached)

BCF emergency admissions paper Fina

5.2 Risk log

Overall BCF Plan and project specific risks are described.

There is a risk that:	**Mitigating Actions**
Finance. Due to underperformance of the schemes or delays in realising benefits, there is a risk that the ring fenced sum for Out of Hospital Services has limited impact on reducing non-elective admissions in the current year.	1. All key providers signed up to their contribution to achieving a reduction in non-elective admissions. 2. All schemes will have business cases detailing evidence base, effectiveness, finance and activity. 3. Robust performance framework to ensure monitoring of performance and prompt action to mitigate under performance including discontinuing those not realising expected benefits. 4. A risk share agreement is in place
Due to the increased complexity and demand for services on adult social care and additional responsibilities resulting from the Care Act as well as the new national living wage requirements, there is a risk of financial pressure on care delivery.	1. Focus on early intervention and prevention to moderate progression to severe need. 2. Robust monitoring of performance and continuous revision of care packages 3. Development of more integrated approaches within the care market 4. Acceleration of integrated and joint working across all agencies. 5. Greater involvement of the Voluntary sector

There is a risk that:	Mitigating Actions
Reputational Risk Reputational risk to all partner organisations in the event of failure to meet statutory duties occurs.	1. Appropriate governance and system leadership structures in place with provision of regular, timely and accurate information to support monitoring of services ongoing. 2. The BCF Plan development has involved all our key providers, including Private, Voluntary and Independent (PVI) sector who have signed up to the plan.
Project Specific Risks	
Improving the falls service:	
• Luton CCG is the lead commissioner for the L&D hospital. As a result of the Fracture Liaison Service not being supported by LCCG there is a risk that development of an FLS at L&D isn't viable which may result in a FLS service not being developed in south Bedfordshire. • As a result of interventions being targeted at specific patient cohorts and the limitations of standard datasets to identify these, there is a risk that impact of the project may not be accurately measured due to coding and data recording issues.	• Work with LCCG to develop the financial model and understand benefits. Work with L&D to explore the practicalities of commissioning a CCG specific service. • Discussion with provider to address coding and recording issues, recognising the impact may not be visible in wider population level data and ensure that there are metrics to measure the impact of discrete interventions at a cohort level.
Multi-Disciplinary Team Working	
• As a result of the current CHS workforce there is a risk that there is not sufficient workforce capacity to deliver a new model of care	• Current workforce capacity obtained from SEPT • New models of care are proposing the use of multidisciplinary health and social care teams to provide more holistic care. The model will also include self-management as a key element, telecare to reduce reliance on professionals and the voluntary sector to increase capacity. • Work is underway by CBC to map and model the workforce between health & social care, as part of Beds and Herts Workforce Development Programme. • More effective care will be provided by personalised care planning of individual client needs. • Continuing discussions and investment with SEPT who will implement an aggressive recruitment campaign and consider additional skill mixing of staff to ensure maximum coverage

There is a risk that:	Mitigating Actions
Maximising Independence through supportive technology (MIST)	
• As a result of the sign off and funding for the project not yet being confirmed, there is a risk that the investment required for MDT working may not be available to support the additional workforce needed by SEPT to implement changes • As a result of a lack of dedicated project management resources for transformation there is a risk that transformation projects will not be managed effectively resulting in lost opportunities both in financial and patient benefits • As a result of the current CHS workforce there is a risk that there is not sufficient workforce capacity to deliver a new model of care • As a result of the national challenges of recruiting nursing staff, there is a risk that the recruitment element of the project plan will be affected and that mobilisation will be delayed.	• Process and timescales is being monitored and support by the Community Health Services Steering Group and risk is escalated by SRO. • New models of care are proposing the use of multidisciplinary health and social care teams to provide more holistic care. The model will also include self-management as a key element, telecare to reduce reliance on professionals and the voluntary sector to increase capacity. • MIST is closely aligned to MDT working which is part of the in-year transformation programme. • Requirement for additional project support has been escalated. A recruitment process is underway • Current workforce capacity obtained from SEPT • Work is underway by CBC to map and model the workforce between health & social care, as part of Beds and Herts Workforce Development Programme. • Continuing discussions and investment with SEPT who will implement an aggressive recruitment campaign and consider additional skill mixing of staff to ensure maximum coverage
Improving the End of Life Service	
• As a result of data submission not being in providers' contracts there is a risk that data may not be provided or not be provided on time. This may result in not being able to evidence the benefits of training. • As a result of trained staff not being able to put into practice the full content of the training there is a risk of inconsistent outcomes which may result in benefits not being realised.	• Providers are keen to continue this training as it provides benefits to staff therefore they are committed to evidencing the benefits of the training. • The training has now been running for one year, continued learning from reflective practice continues to inform course content.

There is a risk that:	Mitigating Actions
Improving Outcomes for Stroke Survivors	
• National gaps in recruitment of some therapy areas i.e. speech and language therapy mean that we might not be able to recruit the necessary staff • Limited availability of integrated pathways will delay securing the desired outcomes.	• Work with Health Education East on workforce development • Multidisciplinary neuro-rehab team established and developing integrated care pathways for stroke care.
Delayed Transfer of Care	
• As a result in an agreement not yet being reached by stakeholders across the system, there is a risk that there will be a delay in the sign off of the DTOC Policy which may result in a delay on progress • As a result of an agreement not being reached by stakeholders across the system for recognised priority areas of work, there is a risk that there will not be sufficient focus on areas that need to be addressed, which may result in the continuation of ongoing issues.	• A DTOC sub group has been established, as a sub group of the System Resilience Group. Much work has been undertaken as part of this with system partners, in order to ratify the localised DTOC policy. It is anticipated that this will be done by 30/9/16. • The DTOC and 7 day services SRG sub group meet monthly to progress work on priority areas, to prioritise the work to improve the self-assessment position as per ECIP recommendations.
Enhanced Care in Care Homes	
• Ability of care homes to recruit and retain appropriately qualified staff	• On-going work with Beds & Herts Workforce development partnership on transformation programme, focusing on recruitment and retention, training, support for existing staff and news ways of working. Including generic worker and Super Carer roles. • Ongoing work to making Caring profession a career of choice

6. The National Conditions

6.1 Plans to be Jointly Agreed

As previously indicated, the 2016/17 BCF Plan builds on the 2015/16 Plan. It reflects the more focused approach adopted by the Health and Wellbeing Board and takes account of local system-wide issues which have had an impact on overall success of the 2015/16 plan. The Health and Wellbeing Board has overall responsibility for both operational and financial delivery of the Better Care Fund, totalling £20.534m and will maintain oversight of the outcomes. **http://centralbeds.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=829** In addition the CCG and the Council through existing, robust governance mechanisms will ensure there is appropriate oversight and decision making.

The Central Bedfordshire BCF Plan has been jointly agreed. All key partners are represented on the Health and Wellbeing Board and both the CCG and the Council are agreed on the BCF Plan 2016/17 and are represented on the Joint BCF Commissioning Board which will monitor progress and report to the Health and Wellbeing Board. From 2015-16 BCF funding has been underpinned by a Section 75 pooled budget arrangement jointly governed by the LA and CCG under an existing overarching arrangement. This will continue for 2016/17. The Health and Wellbeing Board will approve the Scheme of delegation for the Pooled Budget and Section 75 agreements.

There is ongoing engagement through Healthwatch, as a member of the Health and Wellbeing Board, and systematically through service development initiatives, such as community services review and the strategic review of health and care services in Bedfordshire and Milton Keynes. Our Better Care Plan is strongly aligned to the Bedfordshire CCG Operational Plan for Patients, 2016/17 and the current Five Year Strategic Plan of the Clinical Commissioning Group which reference locality based approaches for health and care services. The Council's Five Year Plan has a strategic vision for integration and shifting the balance of care from institutional to personal solutions and the development of integrated care hubs. There is a programme for Meeting the Accommodation Needs of Older People which is part of the Council Five Year Plan.

Assessment of workforce requirement to support the BCF Plan

The general consensus in terms of future workforce is that there will need to be a shift away from specialism to more generic and transferable skills together with a shift of skills into the community. In terms of future care models, there is a focus on integrated workforce across health and social care, particularly for non-professional staff. There is now a much clearer picture of the size and shape of this workforce, and again this can be explored to a level of granularity to explore the implications of developing integrated roles.

Central Bedfordshire Council is leading a group of local commissioners and providers in a Bedfordshire and Hertfordshire Workforce Partnership project, which is mapping and modelling the Workforce. The project, which concluded in March 2016, gathered health and social care workforce information across Bedfordshire and Luton, to quantify current staffing levels, current staffing needs and future staffing needs, in order that joint solutions across adult health and social care can be modelled to support a process of addressing identified gap in future workforce capacity. The findings from the project was shared with National Better Care Support Team, who commented that the work "helped to bring things to life a little more for them with a practical example of the challenges involved in

understanding the current health and social care workforce and then using that to model the future workforce size, shape and skills against population needs and different models of care" and have subsequently used the data as evidence to support discussions at the integrated workforce working group, where membership included colleagues from the Department of Health who are working on policy papers on workforce integration.

In addition to this, work is ongoing to develop new multi-skilled generic worker roles. A 'super Carer' role has been developed in conjunction with University of Bedfordshire. Upskilling of staff will commence in May 2016.

The CCG and the Council have also mapped the workforce model for the transformation of Community Health Services. The work which was undertaken by a Health Economics Consortium sets out a model for rebalancing approach to shift greater emphasis on community based and out of hospital services. A clinical model associated with Multidisciplinary teams has been developed. MDTs are based on a cluster of approximately 40,000 people for keeping care close to home.

A Cross Sector workforce partnership group will be re-established and will take forward the framework for local workforce development in conjunction with Health Education England and importantly wider STP footprint.

6.2 Maintenance of Social Care Services

The Council recognises the need to continue to develop effective solutions for the provision of social care support to adults and older people assessed as having moderate, critical, or substantial needs. This is particularly relevant given the increasing complexity of need and an ageing population, with people 65 and over representing 19% of all people by 2021, compared to 12% in 2011.

An amount of £4.977m has been assigned out of the CCG minimum allocation for the protection of adult social care services. This level of spend is an increase on 2015/16 allocation. A total allocation of £10.223m has been made to support adult social care services which include a further sum of £5.258m from the Council. This allocation will mitigate the demographic pressures from the increasing ageing population and greater complexity of need in the frail and elderly; and for people with learning disabilities
This level of protection covers the costs of a range of services, including step up/step down provision, equipment, telecare, integrated hospital social work teams and care packages where residential care admissions are directly from hospital or respite.

Compared to the national minimum criteria which is set at Substantial, Central Bedfordshire Council's eligibility criteria is set at moderate and offers timely care and support to more people and is consistent with our local health and care economy's joint approaches to prevention and early intervention. This will ensure access to appropriate care and support before reaching crisis and thereby avoid unnecessary institutional care. Access to reablement services is consistent with the Care Act regulations which require intermediate care and reablement to be provided for up to six weeks with access to aids and adaptations to promote independence and help sustain people at home.

This will continue through reablement, additional funding for Disabled Facilities Grants (DFG) minor works, targeted provision of community equipment, community alarms, and

other telecare solutions, as well as investment in support to local communities to increase social capacity, such as, good neighbour/village care schemes. Progress will be measured through both Adult Social Care Outcomes Framework and other customer experience indicators which are reviewed by the BCF Commissioning Board.

Embedding the Care Act
A total sum of £599,000 is allocated for the Care Act and will enhance the ability to meet the additional duties and inherent cost pressures for adult social care. The Care Act 2014 requirements are now embedded into practice and remain an integral part of the delivery of our BCF Plan. Requirements of the Act include provision of universal assessments for all those in need of care and for carers. The provision of enhanced information and advice, signposting, and promotion of wellbeing and independence is central to our approach as well as a focus on identifying and supporting carers. Our approach to implementing the Care Act was set out in the 2015/16 Plan.

Provision of Carer-specific support
The value of the fund directly allocated to Carer Support is £532,000. Carers will also benefit from a wide range of investments through the fund activities.

The totality of our theme three is focused on services that will protect and enhance the quality of social care services for Central Bedfordshire population.

6.3 Seven day services

Appropriate seven day services are in place to facilitate effective hospital discharge. Services such as Reablement and the Urgent Homes and Falls Response Service have been expanded to seven days through investment from the Better Care Fund.

The Luton and Dunstable Hospital has defined a project to deliver the “seven day service offering” that supports both the Trust’s five year business development vision and the overarching aspiration for the future new hospital. Seven day services currently in place include imaging, therapies, social care, community services, pharmacy, and diagnostics and home care provision. This range of seven day services facilitates early assessment and discharges. The Trust is mid way through a three year project assessing appropriate lengths of stay for different patient groups. This includes developing short stay capacity with seven day consultant-led wards rounds to facilitate early discharge.

Bedford Hospital is 87% compliant against the standard that patients should be seen within 14 hours by a consultant (based on CQUIN data 2014/15). There is seven day access to the following diagnostic services - biochemistry, chemical pathology, CT, haematology, MRI, microbiology, radiology, endoscopy, ultrasound and X-rays. Consultant directed interventions is available on site 24/7, including access to critical care facilities, emergency general surgery and interventional endoscopy. Networked arrangements exist for the other services: cardiac pacing and percutaneous coronary intervention (Papworth), interventional radiology (Addenbrookes), renal replacement therapy (Lister), thrombolysis (Luton and Dunstable) and urgent radiotherapy (Addenbrookes). Network arrangements for interventional radiology services are currently being formalised with Addenbrookes. Twice daily ward rounds are being reviewed across all principal ward areas.

Central Bedfordshire Council operates a seven day service via the Hospital Social Work Team at the Luton & Dunstable Hospital. This service is also provided at by Bedford Council

at the Bedford Hospital for Central Bedfordshire residents. This Duty/First Point of Contact Team are responsible for the screening, assessment and support planning process. Cases are referred to reablement, and the identification of potential complex cases which will require timely intensive work. The team liaise with wards and community partners. The Duty/First Point of Contact Team is managed and led by the Advanced Practitioner as the Duty Manager. There is an agreed rota with practitioner providing cover over the weekend and on Bank Holidays. This ensures the continued high level of support with discharges and provision of appropriate packages of care

SEPT Community Health Services currently offer comprehensive seven day services through the community nursing; Clinical care at home nursing and therapy clinicians and access to on call Macmillan advice and support. New referrals are received via One Call and accepted according to the standard commissioned specification for each service.

ELFT Mental Health Services are now implementing the new stepped model of mental health care described in the CCG's mental health strategic objectives and as part of this ELFT have rapidly mobilised a service improvement plan, including priority projects for the CCG; Street Triage: Working in partnership with GP's, Acute Hospitals, Ambulance Trusts, Local Authorities and the Police to provide a service which can rapidly respond to people experiencing a mental health crisis delivering rapid treatment and intervention and ensuring any ongoing needs or support takes place in the most appropriate environment. Liaison Psychiatry: To fully integrate a liaison psychiatry service at Bedford Hospital and the Luton & Dunstable Hospital based on a Rapid Assessment Interface and Discharge (RAID) model to improve both patient and carer outcomes. Ensuring all patients attending A&E with mental health needs are seen with no exclusion criteria being applied. Providing a same day assessment (within one hour for urgent referrals) for all inpatients, irrespective of age.

Going forward the plan is to secure evidence of progress towards implementation of the four key seven day services standards through engagement with all the key care providers.

The SRG has undertaken a self assessment which confirmed that some services are available seven days a week, however some services, were more limited at weekend. The SRG work on delayed transfers of care and the BCF Project will aim to increase the levels of discharges from hospital and community services at the weekend to achieve the national targets (80% of weekday average and 35% respectively).The BCF Plan has key deliverables and milestones for 2016/17 – see Appendix 1.

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

Local Health Providers use the NHS number through using SystmOne. The Council has reinforced the collection of NHS numbers as part of the implementation of the Zero Based Review from April 2014. NHS numbers is routinely collected as part of the assessment framework and recorded within the adult social care system (SWIFT). We are committed to using the NHS Number as the primary identifier for correspondence. Currently 91% of social care records have NHS Number as primary identifier and are continuing to do number matching to achieve 100%. We will also be reviewing options for developing common and shared systems across health and social care to facilitate data sharing.

Work is ongoing to enable data sharing and risk stratification using pseudonmyised data sets based on the Mede-analytics pseudonymisation at source (P@S) tool, which enables high risk patients to be identified and to improve care pathways. This tool will facilitate

joining of datasets across primary, community and social care, particularly for MDT working. A Bedfordshire wide steering group has been established to drive this work forward and will develop the digital roadmap for data sharing.

The CCG and the Council are committed to pursuing interoperable Application Programming Interfaces (APIs). Local systems and standards are compliant with Health & Social Care Information Centre (HSCIC) Information Governance Statement of Compliance (IGSoC) and Interoperability Toolkit (ITK).

The vision set by the Better Care Fund will need to be supported by robust IM&T; in addition to all systems currently being compliant with IGSoC and ITK2.0, any systems implemented under the BCF going forward, will meet the same levels of compliance as the current. The proposed integrated Multi-Disciplinary Team (MDT) approach to patient care is dependent on integration of two systems, TPP SystmOne and Northgate Public Services SWIFT. Support will be required to progress this integration and will be taken forward as part of the Local Digital Roadmap.

Both the Council and the CCG have completed the Information Governance toolkit and are compliant. All staff undertake annual IG training along with confidentiality clauses written into their contracts. Both organisations have designated Caldicott Guardians. Information sharing agreements are in place and submitted as part of the Section 75 agreement.

MM_ Bedfordshire information sharing pl

Local people are advised on how their data is used. The Caring Together programme has produced a consent leaflet which advises people that their data will be shared for care purposes. Whoever consents the patient for Caring Together is responsible for ensuring the patient is aware of this.

The Council is participating in the Social Care digital maturity self assessment. This and the recent digital maturity self assessment carried out by providers will be used to inform the local digital roadmap. A key focus for this will be integrated record and care plans and the use of assistive technology for community based support and self management. The Roadmap will also align with the wider STP IM&T programme.

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

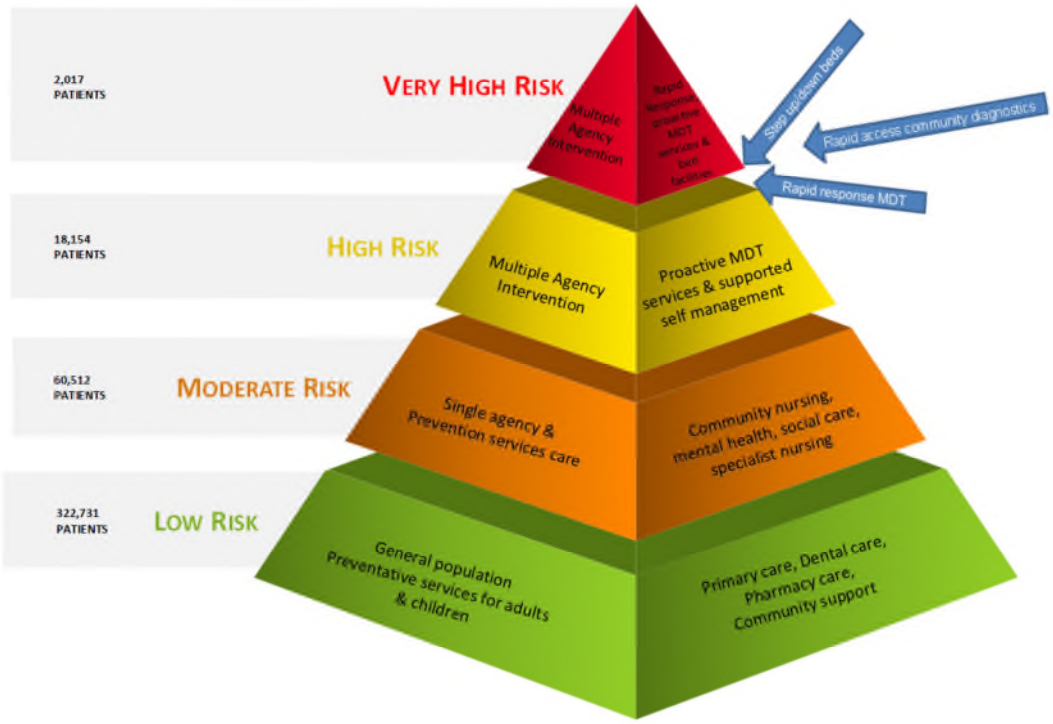
Integrated teams currently support people with learning disability and mental health in Central Bedfordshire. A model of multidisciplinary working and joint approach to assessments and care planning for older people is emerging. Our model for multi-disciplinary working in teams is based around primary care practices and clusters. (see figure 3) This is a key part of the transforming community health services programme and a key deliverable for the BCF Plan in 2016/17.

In 2015/16, we piloted the Caring Together proactive care project in the Chiltern Vale and West Mid Beds Localities. The project developed a risk stratification process based on the GP 2% of patients most at risk of emergency hospital admission. The work was led through an MDT with a Care Coordinator. The project is currently being evaluated and will feed into the planned approach for management of high risk patients based on a proactive case

management which will be rolled out across Central Bedfordshire as part of the transformation of community health services in 2016/17.

Three main tools have been made available to all GPs, a MedeAnalytics risk stratification tool, and two methodologies developed by local GPs. Agreement has also been reached across all providers for information sharing for risk stratification using pseudonmyised data sets based on the Mede-analytics pseudonymisation at source (P@S) tool. This enables high risk patients to be identified and to improve care pathways. This tool will facilitate joining of datasets across primary, community and social care, particularly for MDT working.

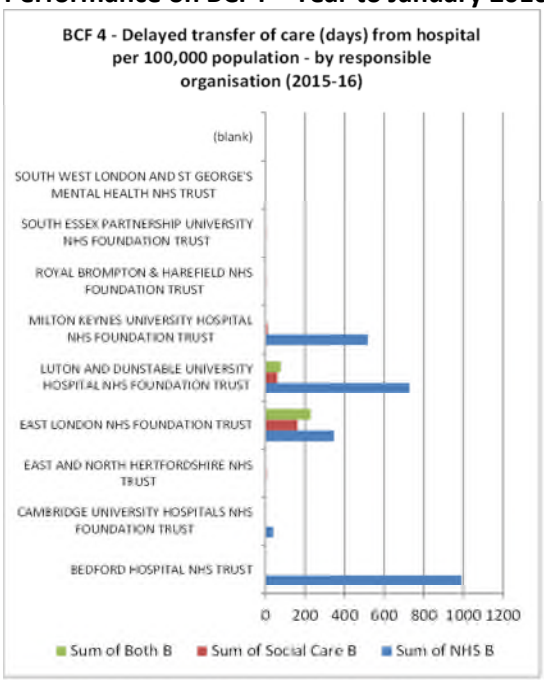
Figure Three

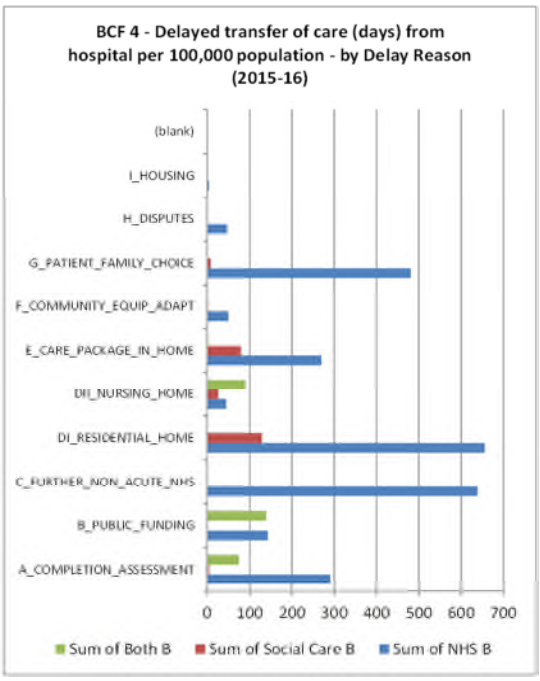


6.6 Agreement on local action plan to reduce delayed transfers of care (DTOC)

DTOC is regularly monitored through the SRG and the BCF Commissioning Board with regular reporting on performance to the HWB Board. Central Bedfordshire is represented at two local SRGs for Bedford Hospital and the Luton and Dunstable Hospital. There is now engagement with other hospitals outside the area that care for Central Bedfordshire residents. To date the overall performance against the 2015/16 BCF target is green although the last three months have shown a dip in performance however; we anticipate the outturn will still be green. We also expect to see some improvements from the projects that focus on DTOC and Enhanced Care in Care Homes during 2016/17.

Performance on BCF4 – Year to January 2016.





Source: DTOC NHS England

An Operational Group for DTOC has been established and a draft multi-system DTOC policy developed. The group will oversee a self-assessment of services in Bedfordshire against current services and ECIP eight high impact interventions as per the model below and the results of the self assessment will be used to develop a local plan for managing DTOCs. This will include setting a stretch target for DTOCs. The underpinning principles and aims for DTOC across the Bedfordshire system are as follows:

- Partners to work together to ensure that there are no delays across the whole system and that patients are moved safely through the discharge pathway, thereby improving efficiencies and patient experience
- Improving services for patients by avoiding situations where, patients are put at risk by remaining in the acute sector when they no longer need acute care.
- Partners to work together to improve current DTOC self-assessment against the eight ECIP recommended interventions, to prevent delays occurring in the first place.
- Retain and continue to build positive partnership working across all departments and organisations.
- Drive a better system of discharge planning encouraging the development of proactive planning for discharge to “pull” patients from acute beds
- From admission manage patients and their relatives/carers expectations and ensure that all patients receive a letter and booklet explaining discharge processes and possible discharge destination on admission.
- Trust clinicians are not expected and should not make recommendations or decisions about the discharge destination. This is a Multi- Disciplinary discharge pathway decision.
- Full assessment of need should not be undertaken while a patient is acutely ill or

still has potential for improvement

- Ensure there is consistency in the notification of Expected Discharge Date (EDD) to partner organisations as part of the assessment notification and proactively manage patients to ensure discharge on EDD is optimised and thereby improve patient flow
- Prioritise use of step down as well as step up beds.
- Continue to review against lessons learnt and best practice in order to ensure quality improvement.


Bedfordshire DTOC Policy Draft EHS 22 0


Winter SLI Model v3 LS.PPTX

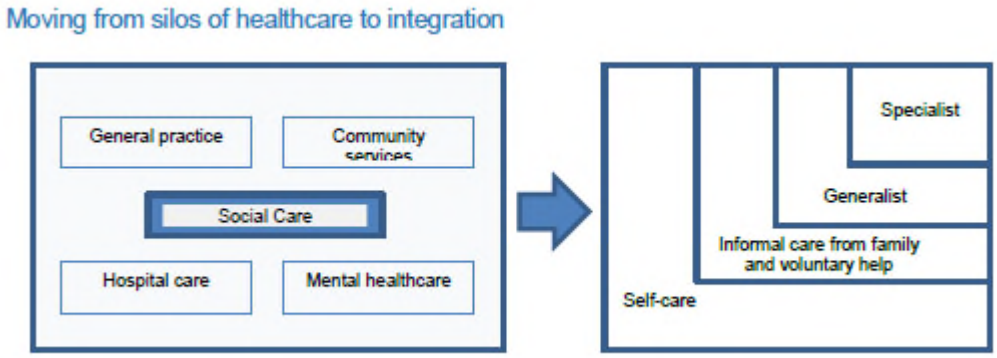
The Plan will be used to address DTOCs across the health and social care system, in relation to demand, capacity and quality. It will also help to plan future provision with the aim of developing seven day services across Bedfordshire to meet the needs of the population and to ensure that work is undertaken jointly across organisations to support. The key deliverables for the group are aligned to the BCF Project in Appendix 1.

In addition to the foregoing, as a Unitary Council, the disbursement of DFGs forms part of the overall approach to prevention and early intervention to promoting independence and ensuring people can remain at home and in their communities. DFGs will be used, in conjunction with the Council's housing assistance policy, to secure early discharge from hospitals and reduce non-elective admissions.

6.7 Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

The vision for Central Bedfordshire is for a whole system, person-centred and outcome focused community service which provides care closer to home, reduces reliance on hospital based care and ensures that people have access to good quality, safe, locally delivered health care services including primary care and health and social care across both towns and rural areas.

A programme of transformational change that focuses an out of hospital strategy around the needs of people with long term conditions and delivers a journey to integration of health and social care services has been established. In alignment with the CCG's Bedfordshire Plan for Patients which describes significant investment in Out of hospital care. The Better Care Plan provides the overarching vision and framework for integration and joint commissioning for adult services, described below.



Investment in NHS Commissioned out of hospital services will increase in 2016/17. Although the focus of this investment is in the transformation of community health services, all key projects mobilised by the 2016/17 BCF Plan will contribute to the overall ambition to reduce non-elective admissions, reduce delayed transfers of care and provide timely and proactive care for people with long term conditions and other vulnerable groups. By implementing transformational changes in 2016/17 such as realignment of community services to our proposed cluster modelling BCCG will be commencing an admission avoidance strategy (as detailed by HCD economics) and eventually aiming to effect up to 25% of all non-elective admissions (full implementation of the proposed model of care).

Transformation (realignment of services with a greater focus on prevention and proactive case management) with the use of clinical utilisation/management tools and additional investment from Social care (domiciliary care provision) as recommended by HCD economics, is hypothesized to impact on approximately 1.5% of all non-elective admissions. There were approximately 34,000 attendances in 2014/15 (based on SUS data, source MedeAnalytics) in Bedfordshire. Trends in admissions are set out in our BCF quarterly returns.

Additional projects mobilised as part of the 2015/16 BCF Plan around management of long term conditions, end of life care, Falls and Care Homes are beginning to have an impact on non-elective admission. This work will continue as part of the BCF 2016/17. The overarching ambition remains reduction of non-elective admissions in line with targets set for 2015/16.

Furthermore, in accordance with 2016/17 planning guidance, system resilience plans are now aligned across hospital, community/out of hospital provision, primary care and mental health services to ensure sufficient capacity is planned to cope with surges in demand for services.

6.8 Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

There is currently in place a Systems Leadership Group which has oversight of local strategic and operating plans to ensure alignment and cohesion. Key Providers have been engaged in the development of the BCF Plan 2016/17 and involved in delivery of the projects.

Two meetings to secure agreement on the consequential impact of changes took place on 24 March 2016 and 21 April 2016. The meetings, convened by the CCG and Central

Bedfordshire Council were attended by representatives from

- Luton and Dunstable Hospital
- Primary Care – representing GPs
- Bedford Hospital
- East London Foundation Trust – Mental Health Services Provider
- South Essex Partnership Trust – Community Health Services Provider
- East England Ambulance Services Trust
- Central Bedfordshire Social Care Services – Provider services lead.

A summary of the discussions is attached.

summary of provider impact meetings april

Key comments have been taken on board and as appropriate reflected in this revised version of the narrative plan. Key projects, such as MDT, MIST, DTOC and Enhanced Care in Care Homes seek to address some of the points raised.

In addition to these meetings, there has been further engagement with general practitioners through locality boards. Further engagement will be undertaken with Care Homes and the Community and Voluntary Sector Providers.

The Community Health Services Provider was slow to engage on the 2015/16 plan, which has had impact on key delivery areas. The CCG and Council have engaged with SEPT and a shared vision for transformation has been agreed.

The Transforming Community Health Services programme which is central to the success of the Out of Hospital scheme has been agreed with the current community health services provider. This has formed part of the contract negotiations for an in-year transformation. We will be embedding stepped changes with our community provider South Essex Partnership Trust (SEPT) in 2016/17, to implement improvements for multidisciplinary team working (MDT), complex care rehabilitation pathways and utilisation of community bedded units. A Community Health Services Transformation Programme Group has been established and a risk register specific to the transformation of community health services has been produced and is updated regularly by the Group, which includes the Provider (SEPT).

The approach and focus on integrated locality based delivery of health and care services align with other local plans and strategies. Implementation of schemes and new initiatives will be influenced through service user representative groups, e.g. Healthwatch Central Bedfordshire, and through our Making it Real Action Group. These groups currently agree with the strategic direction of both the CCG and Council and are working with local health and care agencies to provide a whole systems response to the challenges faced.

A Provider Alliance for integration has been established and there is a shared vision and

understanding on the future needs for health and care services. Discussions for a five-year Sustainability and Transformation plan for our local system involving all Providers is also helping to secure the agreements needed to deliver the ambitions of the Central Bedfordshire BCF Plan. The local Provider Alliance includes all key Acute, Community, Mental Health and Care Services Providers for Central Bedfordshire residents.

Shared System Leadership Group has been established to ensure alignment of plans and ambitions across the health and care system and is leading the development of the STP. The BCF Plan will form part of the future 2017 Integration Plan as well as influencing the emerging STP.

7. BCF Metrics and Performance Framework

Delivery against the BCF national metrics remains challenging. A description of the targets for 2016/17 and the rationale and key drivers are set out in appendix three.

7.1 Non Elective Admissions

A target of 1% reduction has been set. This represents a reduction of 261 admissions in the year 2016/17. Number of non-elective admissions has increased, as reflected in the quarterly submissions, due largely to the ageing population. We carried out review of non elective admissions (attached) and work has begun in areas with higher rates of emergency admissions with a focus around proactively managing people with long term conditions. A risk stratification model is also been used to support the work of multidisciplinary teams as part of the Caring Together Project.

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

Although on track for improved performance, we recognise that the 2015/16 target for this measure is not likely to be met. As such the 2016/17 target has been set based on the 2015/16 outturn. As at quarter 2 in 2015/16, there were 153 new placements into residential and nursing care against a target of 106 with frailty and dementia as the most common diagnosis for admissions. Overall outturn for 2015/16 will be undertaken as part of the Short and Long Term Support statutory submission.

Packages of care are being scrutinised through a panel process to ensure that all alternatives have been explored and that the focus remains on helping people to remain in their own homes. Work is on going to improve hospital discharge coordination and reduce reliance on residential care. Crisis prevention plans with carers are also being put in place. The Council's development of more independent living (extra care) accommodation will help to mitigate admissions into residential care.

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

This measure currently reports only on the Council's reablement service and does not include outcomes data in relation to rehabilitation/intermediate care provided through Community Health Services. Central Bedfordshire Council's figures show an improving trend and performance is currently above the national average. This has influenced the target set in the BCF template. An information sharing agreement with the community

health services provider has been reached which will allows for the follow of dataset with patient identifiable data to enable a more complete reporting on this measure. It is however not known what the impact of this will have on the target. We will monitor and discuss performance with the provider.

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

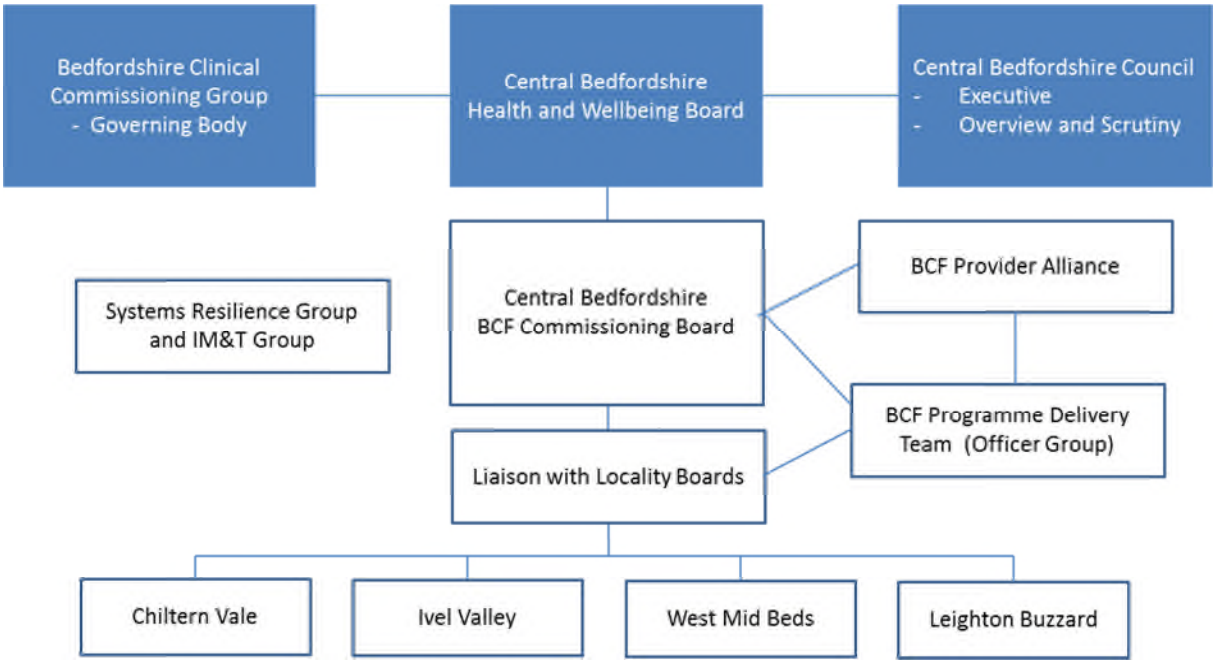
Overall for 2015/16 the actual performance is in line with the planned figures for 2015/16. Our review of the SITREP reports show that the main reasons for delay are attributed to patient and family choice and completion of assessment. Delays due to social care related reasons reduced. Central Bedfordshire has several hospitals which discharge patients into the area, none of which are within its boundaries. Support for early discharge planning and coordination through joint working with providers has been established. The 2016/17 target is based on a 2% reduction set by the Clinical Commissioning Group.
A specific project on delayed transfers of care is included in the BCF Plan and the Systems Resilience Group is producing a multi-agency DTOC Plan.

Our performance framework and dashboard, which also includes local measures, will be further developed based on the 2015/16 outturn and is attached for information (Appendix three). Performance will be monitored by the BCF Commissioning Board and the Health and Wellbeing Board. Monthly monitoring reports are also circulated to the Council's Corporate Management Team, Political Leadership and the CCG's Governing Body

8. Governance and Joint Approach

The BCF plan and overall integration programme for Central Bedfordshire is overseen by the **Health and Wellbeing Board**. The HWB membership includes the executive member for Health, Social Care and Housing and the Chief Officers of the CCG and Council.

The overarching accountability and governance structure remains with the Health and Wellbeing Board.



8.1 Management and oversight

Directly accountable to the Health and Wellbeing Board is the BCF Commissioning Board. This is a Chief Officer Group comprising

- BCCG Director of Strategy and Service Redesign
- General Practitioner Chairs of the Locality Groups for Ivel Valley, Chiltern Vale, West Mid Beds, and Leighton Buzzard;
- Director of Social Care Health and Housing
- Assistant Director of Public Health
- Finance Leads.

This Commissioning Board has overall responsibility for integrated care and BCF delivery and provides joint accountability and oversight of the strategic direction of the Better Care Fund Plan, pooled budgets and performance. Lead commissioner for the project areas have been identified and shown in the BCF Planning Template. A performance framework has been developed and aligns equally to the Council and BCCG performance monitoring processes. (Appendix 4)

A programme management approach is in place, see appendix five. A Delivery Programme Group comprising locality leads has been set up and works closely with the four locality Boards to support the delivery of the key projects and the BCF Commissioning Board. The Delivery Group reports progress on projects monthly to the BCF Commissioning Board. Our emphasis in devising these arrangements is to mainstream BCF governance to the greatest extent possible in order to achieve the maximum alignment of the programmes involved into existing change programmes.

8.2 Supporting Integration and Transformation

Successful integration requires strong foundations of stable organisations, clear governance and effective partnership working. Bedfordshire's local health and care governance is not as unified as it needs to be if we are to deliver a fundamental change in the way we commission and deliver our health, social care and public health services.

Work is ongoing with input from the Kings Fund to explore the potential for an Integrated Care Partnership, across emerging local health and care footprints which will take forward the strategic approach to securing wider integration and transformation across our health and social care economy. Central Bedfordshire Council, Bedfordshire CCG, and Bedford Borough Council with support from the Kings Fund, are working collaboratively to:

- develop a joint vision for integration
- secure senior leadership commitment to the vision including members and Health and Wellbeing Boards
- agree in principle to develop the foundations for integration, namely:
    - unified governance
    - joint commissioning and funding arrangements
    - shared information systems
- set out a clear road map for achieving integration across Bedfordshire by 2020.

As part of the focus on integration between health and social care, a joint CBC/CCG leadership group, which includes the local authority Chief Executive and Chief Officers of the CCG, has also been established. This leadership group will continue to have oversight on the vision and

programmes and performance which will influence the outcomes from the BCF. The BCF Commissioning Board provides a focal point for the wider integration and transformation agenda, supporting output from the Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan in the context of Central Bedfordshire. Consideration will be given to the governance structure to reflect the role of the STP in the emerging place-based approach.

Our ambition is that within the next five years, services will be coordinated and service users will say:

'My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes'

9. Additional Documents

- BCF Planning Template
- BCF Narrative Plan 2015/16 http://www.centralbedfordshire.gov.uk/Images/plan_tcm3-12383.pdf
- Appendices
    - *Appendix 1 – Boscards – Key Projects and Deliverables*
    - *Appendix 2 (a&b) - Financials against BCF National Conditions and Schemes*
    - *Appendix 3 – Performance Metrics*
    - *Appendix 4 – BCF Performance Dashboard*

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BOSCARD Matrix: Improving the End of Life Service **Theme: Out of Hospital Services**

Background	Each year many patients die in hospital who would have preferred to have died in their own homes. The 2016/17 year will be used to improve end of life care across health and social care through a number of initiatives including decreasing unnecessary EoL admissions into hospital. These will include additional training to EEAST paramedics Supported by the updated End of Life strategy, providers will work together to offer EOL training programmes to care home staff and paramedics which will include the introduction of a new Advance Care Plan (ACP) document for Bedfordshire.			
Objectives	The overall objective is to improve EOL care for our population • An increase in EOL patients offered an ACP conversation • An increase in the number of people dying in their preferred place of death • A decrease in the number of EOL patients having a hospital admission in their final weeks of life • An increase in the number of care home residents registered to PEPS			
Scope	Within Scope	• Any registered EoL patient • Paramedics and care home staff		
	Outside Scope	• Service users not at the end of their life. • Service users who need to be in an acute facility.		
Constraints	Cultural reluctance to talk about death			
Assumptions	• There is an assumption that an acute admission is avoidable for EOL patients, however for some this will be completely appropriate.			
Risks	• EoL training for EEAST staff is not currently contractual therefore there is no obligation for EEAST to release staff to attend the training. • As a result of trained staff not being able to put into practice the full content of the training, there is a risk of inconsistent outcomes which may result in benefits not being realised.	Mitigation	• Established relationships is ensuring a continuing participation and engagement in the EoL programme • Continued learning from reflective practice continues to inform course content..	
Deliverables	• EOL strategy reviewed and adopted by BCCG and the EOL Local Implementation Group - October 2016 • 12 Care homes trained and EOL champions established in each home – March 2017 • 80% of EEAST staff trained in EOL – March 2017 • Increased number of people registered with PEPS – Numbers registered – monthly monitoring • Reduction in conveyancing for ELO care by EEAST – Number of conveyances – monthly monitoring • Advance Care Plan document for Bedfordshire being issued across all providers – September 2016 • Develop and deliver training around communication for the new Advanced Care Plan – October 2016 • Use of ACP becomes standard – April 2017			
National Conditions	• 7 day working and unplanned admissions • Joint approach to assessments and care planning • Investment in NHS Out of Hospital Services and Social Care • Maintenance of Social Services	National Metrics • Unplanned admissions for End of life care • Number of people with advanced care plan		

BOSCARD Matrix: Transformation of Community Services – Transforming Stroke Care

Theme: Out of Hospital Services/Prevention

Background	Effective treatment of stroke can prevent long-term disability and save lives. Stroke services in Bedfordshire are fragmented with gaps in key elements of an integrated stroke pathway. Currently, placements are spot purchased, which is not cost effective and levels of quality provision and outcomes cannot be effectively monitored The aim is to address this inequalities in stroke care provision for patients who require longer length of rehabilitation or have more complex needs than the current SEPT community bed admission criteria allows. Stroke ESD would alleviate some of the need for spot purchased beds and maximize patients independence by providing intense rehabilitation in their place of residence and improve outcomes for stroke patients. ESD provides an early, intensive rehabilitation service for stroke patients and meets the national best practice stroke rehabilitation guidelines. With the introduction of this service patients will be able to leave hospital more quickly and return to their own homes so that they maximise independence as quickly as possible after their stroke			
Objectives	• Agree principles and implement a stroke early supported discharge service • Reduce length of stay in hospital for stroke patients • Improve outcomes for stoke patients including activities of daily living (ADL) • Increase access to rehab in community • To provide support to family members and carers			
Scope	Within Scope	Discharge home or care home with intensive rehab for those suitable for ESD		
	Outside Scope	Patients not suitable for ESD and require longer in patient rehabilitation Patients who require access to community bed prior to rehab at home		
Constraints	Capacity to deliver full vision of enhanced ESD for more complex patients (slow stream rehabilitation)			
Assumptions	• Acute and community providers will work to deliver this ambition • ESD will be delivered as part of the community transformation in 2016/17 year • Joint working across health and social care in the acute setting • Funding approved for complex patients			
Risks	• National gaps in recruitment of some therapy areas i.e. speech and language therapy mean that we might not be able to recruit the necessary staff • Limited availability of integrated pathways will delay securing the desired outcomes	Mitigation	• Work with Health Education East on workforce development • Multidisciplinary neuro-rehab team established and developing integrated care pathways for stroke care.	
Deliverables	• An agreed criteria for ESD suitable patients – September 2016 • Integrated discharge pathway that facilitates early discharges - September 2016 • Service specification – June 2016 • Recruitment of ESD Team - October 2016 • Access to 7 day rehabilitation for stroke patients - October 2016 • Rehabilitation pathway development - April – October 2016			
National Conditions	• Investment in Out of Hospital NHS Services • Protecting Social Care • Joint approach to assessments in care planning • Reduction in DTOCS • Seven day services	National Metrics • Effectiveness of Reablement 91 days following discharge • Reduction in DTOC • Reduced length of stay for stroke • Number accessing ESD and discharged with joint care plan		

BOSCARD Matrix: Transformation of Community Services (Multi Disciplinary Team Working)

Theme : Out of Hospital Services

Background	• The local vision is for a whole system, person-centred and outcome focused community service which provides care closer to home, reduces reliance on hospital based care and ensures that people have access to good quality, safe, locally delivered health care services including primary care and health and social care across both towns and rural areas. .This requires a realignment of community health services staff to work alongside GP Clusters, providing care within multidisciplinary framework. • The year 2016/17 is a transitional year for delivery of integrated and locality based out of hospital care. The realignment of MDTs to GP Clusters will be the first phase of a new model of community care which is, more efficient, effective and provides comprehensive services which will support the Health and Wellbeing Board vision of care closer to home and reduces the number of unnecessary hospital admissions		
Objectives	• Develop a detailed service specification and key performance indicators for the MDT service • Realign community adult services staff to work alongside the 9 GP clusters. The workforce will be deployed according to the demographics and geography of the clusters. • Establish effective multi-disciplinary working arrangements across Bedfordshire.		
Scope	Within Scope	Adult community services currently provided by SEPT including but not exclusive to: Community nursing, Community matrons, Rapid intervention, Rehab & enablement teams, Community Beds, Discharge team Social care assessment and care management is yet to be agreed (BBC)	
	Outside Scope	The primary care element is not within the scope of this project.	
Constraints	• Challenging implementation timeframe • Input and cooperation of all involved – BCCG/BBC and CBC		
Assumptions	• Project is dependant on the formation of GP clusters across primary care. • Transformation funding available to support community services alignment to the newly proposed model of care.		
Risks	• As a result of the current CHS workforce there is a risk that there is not sufficient workforce capacity to deliver a new model of care which may adversely affect patient care	Mitigation	• Invest in workforce capacity to deliver new agreed model of care • Work with Health Education East on Workforce Development Programme
Deliverables	• Aligning resources to clusters – September 2016 • Agreed integrated model of care for the service - June 2016 • cohort of people identified from risk stratification - June 2016 • Commencement of integrated care packages for patients in 16/17 • Increased number of patients with integrated care packages by 17/18 • Detailed service specification and service specification for the MDT service agreed – June 2016 • MDTs commence case management for people with LTCs – September 2016		
National Conditions	• Investment in Out of Hospital NHS Services • Protecting Social Care • Joint approach to assessments and care planning • 7 day working and reduced unplanned admission and effective discharges	National Metrics • Reduction in unplanned admissions • Reduction in admissions to care homes • Patients feeling supported with LTCs	

BOSCARD Matrix: Transformation of Community Services – Maximising Independence through supportive technology (MIST) **Theme: Prevention**

Background	• BCCG, CBC and BBC are in the process of jointly developing a new model of community care. 2016/17 is a transformation year and the MIST service will be the foundation stage of the new integrated community care support service across Bedfordshire targeted at prevention and proactive interventions. • The 2016/17 financial year will deliver the planning and commencement of procurement for the service to go live in April 2017 for a telephonic Centre staffed by clinical staff linked to outreach resources housed within MDTs • Model delivers proactive healthcare coaching and access to interventions through telephone and outreach services. • The model is based around the very high and high risk of admission to hospital patient population (22,500) and would seek to reduce unnecessary admissions into hospital by managing conditions closer to home.			
Objectives	To develop, agree and mobilise the plan to meet the following objectives in 2017/18 • Reduce fragmentation across services for patients • Improved patient experience/satisfaction and independence • Reduce hospital admissions and pressure on primary care • An increase in confidence of patients who become more independent through proactive interventions through coordinated health and social care • A single point of access 24/7 service for the patient cohort			
Scope	Within Scope	• Patients at the very high and high risk of admission to hospital in Bedfordshire • Awaiting agreement as to whether the BBC assistive technology service will be in scope • Awaiting agreement as to whether the BBC lifestyle hub will be in scope		
	Outside Scope	• Patients not in the very high and high risk of admission to hospital.		
Constraints	• Patients not in the very high and high risk of admission to hospital.			
Assumptions	• Investment for the project will be agreed. • Patients will engage with the programme • Information governance will not be a barrier to sharing information			
Risks	• Delay in sign off for the procurement process • Shortage of resources to deliver the objectives for the project • Recruiting a workforce with the right skills • Sign off and funding for the project is yet to be confirmed	Mitigation	• Process monitored and supported by CHS Steering Group • MIST closely aligned to MDTs • Priority within workforce development plan • Project will be part of transformation of CHS	
Deliverables	A developed model of care for the MIST – May 2016 To set up and deliver a successful procurement process for the MIST – Complete by Nov 2016 To have in place a mobilized plan to deliver the following in 2017/18 • Reduced unscheduled admissions to hospital – March 2017 • To have a 24/7 service in place – April 2017			
National Conditions	• Investment in Out of Hospital NHS Services • IT & better data sharing between NHS and Social Care • 7 day working – reducing unplanned admissions	National Metrics • Reduction in unplanned admissions for those receiving MIST support.		

BOSCARD Matrix: Delayed Transfers of Care (DTOC) **Theme: Protecting Social Care Services**

Background	• Delays in transfer of care remains a challenge and a national imperative. Extended lengths of stay in hospital has a significant impact on outcomes for individuals and their continuing levels of independence, particularly in relation to frail older people. To date the overall performance against the 2015/16 BCF target is green however, seasonal variation can affect this metric. • An operational SRG sub group has been established to self-assess Bedfordshire against current 7 day services and ECIST 8 high impact interventions to address DTOCs across the health and social care system, in relation to demand, capacity and quality. This will inform the plan for future provision with the aim of developing 7 day services across Bedfordshire to meet the needs of the population and to ensure that work is undertaken jointly across organisations.			
Objectives	To have whole system sign up to robust integrated systems and processes as follows to support effective and early discharge planning:- • Systems to Monitor Patient Flow • Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector • Home First/Discharge to Assess • Seven -Day Services • Trusted Assessors • Focus On choice • Enhancing Health in Care Homes			
Scope	Within Scope	Development of improved pathways across Bedfordshire with the two main acute providers, BHT, L&D, ELFT and SEPT		
	Outside Scope	Other acute providers outside of BHT and L&D		
Constraints	• Organisational governance boundaries • BAU Workload			
Assumptions	• Stakeholder support and engagement			
Risks	• Delay in agreement and sign off of the localised DTOC Policy • Delay in agreement and sign off to recognised priority areas of work	Mitigation	• Draft policy produced and system partners aligned to sign up to the policy. • DTOC and 7 day services SRG with clear focus on improving self assessment as per ECIP recommendations	
Deliverables	• Establish direct links with DTOC programmes in neighbouring systems and incorporate into local policy and plan – May 2016 • Joint Commitment and DTOC Policy signed off – September 2016 • Increased discharges from hospital at weekends to be 80% of those during the week – March 2017 • Increased discharges from community settings at weekends – March 2017 • Increased discharges from hospital settings before 1pm to be at 35% of whole daily discharge numbers – March 2017 • Agree localised stretch target of not less than 2% - May 2016 • Better integration of patient centred urgent care services through integrated and interoperable pathways of care regardless of organisational boundaries – September 2016			
National Conditions	• Local action to reduce DTOCs • 7 day services and effective discharges • Joint assessment and care planning • Protecting Social Care Services	National Metrics • Delayed Transfers of Care.		

BOSCARD Matrix: Improving the Falls Service **Theme: Prevention**

Background	• Falls and fall-related injuries represent a major system wide health and social care challenge. Approximately 30% of people aged 65 years and over living in the community are likely to fall at least once a year and this increases to 50% of people older than 80 years (DoH, 2009, NICE, 2013). Half of fallers are likely to have a further fall within the next 12 months. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling therefore has an impact on quality of life, health, and health and social care costs (NICE, 2013). • Over a third of women and one in five men in the UK have one or more bone fractures because of osteoporosis in their lifetime (NOS, 2013). A hip fracture remains the most common cause of accident related death, with a 20% mortality rate within 4 months and a 30% mortality rate within a year (DoH, 2009). Approximately half of those people who were previously independent become partly dependent following a hip fracture, with one third becoming totally dependent. An estimated 10% of older people that suffer a hip fracture are likely to require admission to a care home as a result of their injury (DoH, 2009). • In excess of 95% of hip fractures are fall related and over 90% of hip fractures occur in older people with osteoporosis. Falls and osteoporosis are inextricably linked, both in their consequences and in the patient group who most suffer these outcomes, therefore approaches to fracture prevention must address both the force of the fall, the incidence of falling and bone fragility. • BCCG is seeing an increase both in admissions for injuries due to falls and admission for hip fractures, rates that were once below the national average are now similar to national rates and showing an increasing trend. • Service gaps in the current BCCG falls and fracture prevention pathway need to be addressed with evidence based services to reduce this upward trend in the harm caused to individuals from falls and the cost to the health and social care system.			
Objectives	• To commission a fracture liaison service (FLS) for the BCCG population – A FLS is a multidisciplinary service responsible for the secondary prevention of osteoporotic fractures through case finding. The role of the FLS is to systematically identify, treat and refer to appropriate services all eligible patients over 50 years of age who have suffered fragility fractures with the aim of reducing their risk pf subsequent or secondary fractures. • To commission expansion of the physiotherapy led falls group to cover central Bedfordshire and commission strength and balance classes across BCCG. The strongest evidence for preventing and managing falls is for participation in an exercise programme as part of a multi- factorial assessment and intervention plan. • Fewer falls, to see a reduced recovery time for people who have fallen, reduction in hospital length of stay			
Scope	Within Scope	• Development of FLS at two main acute providers, BHT, L&D • Expansion of physiotherapy led falls group to CBC population. • Commission strength and balance classes across BCCG		
	Outside Scope	• Development of FLS at other BCCG commissioned acute providers • Other acute providers outside of BHT and L&D		
Constraints	There will be 9 month lead in time to commission FLS. A new service is being commissioned and will require significant work up, however stakeholders are supportive, National Osteoporotic Society FLS Implementation Toolkit being used to inform business case development and financial modelling.			
Assumptions	• Stakeholder support and business case approval • Additional funding approved.			
Risks	• FLS development at L&D may not be supported by LCCG (lead commissioner). • Difficulty in demonstrating impact to project due to coding and data recording	Mitigation	• Achieve aligned approach across the two CCGs and via the SRG's established governance • Discussion with provider to address coding and recording issues.	
Deliverables	• Project Initiation Document (PID) and business case approval for FLS - July 2016. • Expansion of physiotherapy led falls group and strength and balance classes - October 2016 • Service specifications for above – August 2016 • Implementation plan for above – October 2016 • CBC expansion of Urgent Homes and Falls Response Service into care homes – April 2016 • Identification of falls champions in care homes – April 2016			
National Conditions	• Investment in Out of Hospital NHS Services • Reduction in unplanned admissions	National Metrics • Reduction in unplanned admissions • Emergency admissions due to falls (local)		

BOSCARD Matrix: Enhanced Care in Care Homes **Theme: Protecting Social Care Services**

Background	• The Care Home population represent some of the most vulnerable patients/residents with complex health and social care needs; the majority are frail older people and a significant number will have dementia or significant memory problems. • The number of people residing in care homes in Bedfordshire is 3022; the residential and nursing home population (2470), represents 7% of the total Beds CCG population aged 75+ • The Central Bedfordshire Care Homes scheme was initiated during 15/16 as a key mobilisation area in response to rising non-elective admissions; this year it will be expanded and strengthened • There is agreement across the system that care homes could play a key role in preventing NELs and reducing DTOCs • Anticipate improved outcomes by introducing a framework of support that provides enhanced care to reduce conveyance to hospital			
Objectives	• Understand the profile of emergency admissions from care homes in terms of patient and spell volume, distribution across care homes, cost, clinical condition, day and time profile • Investigate current health and social care services configuration and support to care homes • Identify factors contributing to avoidable admissions and determine what changes are needed to reduce this • Identify what role care homes could play in reducing DTOCs and work to implement this • Explore the ability of general practice to provide extended support to care home • Encourage care homes to accept hospital discharges seven days a week • Provision of enhanced care in care homes • Improve patient outcomes by reducing length of stay in hospital and the frequency of admissions into hospital			
Scope	Within Scope	Residential homes (21), nursing homes (12) and learning disability homes (28) in Central Bedfordshire.		
	Outside Scope			
Constraints	• Limited access to shared system for timely exchange of patient data across providers will affect the response			
Assumptions	• That general practice will be willing to take on extended responsibility for care home residents/patients subject to sufficient remuneration • That there will be sufficient intent (and contractual level) within care home providers to promote the acceptance of weekend discharges from hospital			
Risks	• Ability of care homes to recruit and retain appropriately qualified staff	Mitigation	• On-going work with Beds & Herts Workforce development partnership on transformation programme, focusing on recruitment and retention, training, support for existing staff and news ways of working. Including generic work and Super Carer roles. • Ongoing work to making Caring profession a career of choice	
Deliverables	• Produce profile of emergency admissions from Care Homes – May 2017 • Delivery of falls prevention training in care homes to reduce non elective admissions – April 2016 • Completion of recommendations from 15/16 programme of care homes visits – ongoing monitoring and review • Review of GP and Clinical Pharmacy support to care homes - September 2016 • Production of a plan to support enhanced care in care homes – September 2016 • Implement pro-active approach to admissions avoidance within care home contracts – April 2017			
National Conditions	• Joint assessment and care planning • 7 day working and unplanned admissions • Reduced delays of transfer of care	National Metrics • Reduction in unplanned admissions • Emergency admissions due to falls (local)		

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	**Board Development and Work Plan 2016 -2017**
Meeting Date:	27 July 2016
Responsible Officer(s)	Richard Carr
Presented by:	Richard Carr

Action Required: **That the Health and Wellbeing Board:**

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

Executive Summary	
1.	To present an updated work programme of items for the Health and Wellbeing Board for 2016 -2017.

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

Work Programme	
4.	Attached at Appendix A is the currently drafted work programme for the Board.
5.	The Board is now requested to consider the work programme attached and amend or add to it as necessary. This will allow officers to plan accordingly but will not preclude further items being added during the course of the year if Members so wish and capacity exists.

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

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

Appendices:
A – Health and Wellbeing Board Work Programme

Presented by Richard Carr

Work Programme for Health and Wellbeing Board

Ref	Issue for Decision	Intended Decision	Indicative Meeting Date	Documents which may be considered	Lead Director(s) and contact officer(s)
1.	Improving outcomes for Frail Older People	To receive an update on progress towards the Joint Health and Wellbeing Strategy priority *(Reducing loneliness and isolation to improve wellbeing in older age).*	19 October 2016		Julie Ogley, Director of Adult Social Care, Health and Housing Contact officer: Jane Moakes, Head of Commissioning
2.	Director of Public Health's Annual Report	To receive the Director of Public Health's Annual Report 2016.	19 October 2016		Muriel Scott, Director of Public Health Contact officer: Sanhita Chakrabarti, AD Public Health
3.	Care Quality Commission Thematic Review	To receive the Care Quality Commission thematic review.	19 October 2016		Julie Ogley, Director of Public Health
4.	Enabling People to Stay Healthy for Longer - Reducing Premature Mortality from Cardiovascular Disease	To update the Board on the Excess Weight Strategy.	19 October 2016		Muriel Scott, Director of Public Health Contact officer: Celia Shohet, AD Public Health

5.	Welfare Reform/ESA claimants	To make the Board aware of residents who are in receipt of the ESA benefit in order that it may consider what steps should be taken to help such individuals into the workplace.	19 October 2016		Sue Harrison, Director of Children's Services and Marcel Coiffait, Director of Community Services Contact officer: Peter Fraser, Head of Partnerships, Community Engagement and Youth Support and Christine Knox, Employment and Skills Service Manager
6.			25 January 2017		
7.			29 March 2017		