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Central Bedfordshire Health and Wellbeing Board

Agenda

Meeting Title:	Central Bedfordshire Health and Wellbeing Board
Date:	Wednesday, 19 October 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. **Chairman's Announcements and Communications**

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

3. **Minutes**

   To approve as a correct record the Minutes of the last meeting held on 27 July 2016 and note actions taken since that meeting.

4. **Members' Interests**

   To receive from Members any declarations of interest.

5. **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
6.	**Improving Outcomes for Frail Older People** To update the Board on progress made across a range of initiatives aimed to Improving Outcomes for Frail Older People.	13 - 20	JO

7.	**Enabling People to Stay Healthy for Longer - An update on the Excess Weight Partnership Strategy 2016 - 2020** The report outlines the partnership strategy and implementation plan to reduce excess weight in adults and children.	21 - 62	MS
8.	**Health and Wellbeing Strategy Performance** To receive the latest performance monitoring of the progress in delivering the priorities in Health and Wellbeing Strategy.	63 - 74	MS

OTHER BUSINESS

Item	Subject	Page Nos.	Lead
9.	**Care Quality Commission Feedback and Report on the Thematic Review of Integrated Care of Older People in Central Bedfordshire** To inform the Board of the key outcomes of the Integrated Care for Older People thematic review undertaken by the Care Quality Commission (CQC).	75 - 116	JO
10.	**Better Care Fund 2016/17** To receive an update on the Better Care Fund Plan 2016/17.	117 - 174	JO/MT
11.	**Sustainability and Transformation Plan 2016-2020** To receive an update on the Sustainability and Transformation Plan 2016-2020.	175 - 182	RC
12.	**Local Digital Roadmap** To confirm the Local Digital Roadmap process for engaging with the Health and Wellbeing Board.	183 - 188	MT
13.	**Bedford Borough and Central Bedfordshire Annual Safeguarding Adults Report** To receive the Bedford Borough and Central Bedfordshire Annual Safeguarding Adults Report.	189 - 246	JO

14. **Board Development and Work Plan 2016/2017** 247 - 252 RC

To consider and approve the work plan.

A forward plan ensures that the Health and Wellbeing Board remains focused on key priorities, areas and activities to deliver improved outcomes for the people of Central Bedfordshire.

To: Members of the Central Bedfordshire Health and Wellbeing Board

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	6 October 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, 27 July 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
Mr M Coiffait	Director of Community Services
Cllr S Dixon	Executive Member for Education and Skills
Mrs S Harrison	Director of Children's Services
Cllr Mrs C Hegley	Executive Member for Social Care and Housing
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

Apologies for Absence: Mr C Ford

Members in Attendance: Cllr P Hollick

Officers in Attendance:		
Mrs P Coker	–	Head of Service, Partnerships - Social Care, Health & Housing
Ms K Conroy	–	Acting Head of Mental Health and Learning Disabilities
Mrs S Hobbs	–	Committee Services Officer
Mrs C Shohet	–	Assistant Director of Public Health
Ms S Stead	–	Area Clinical Lead
Mr M Westerby	–	Head of Public Health

HWB/16/1. **Election of Vice-Chairman 2016/17**

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

Matthew Tait, Chief Accountable Officer, Bedfordshire Clinical Commissioning Group was nominated and seconded.

RESOLVED

that Matthew Tait be elected Vice-Chairman of the Health and Wellbeing Board for 2016/17.

HWB/16/2. **Chairman's Announcements and Communications**

The Chairman welcomed Sarah Stead, Area Clinical Lead from the East of England Ambulance Service NHS Trust to the meeting.

HWB/16/3. **Minutes**

RESOLVED

that the minutes of the meeting of the Central Bedfordshire Health and Wellbeing Board held on 6 April 2016 be confirmed as a correct record and signed by the Chairman.

HWB/16/4. **Members' Interests**

None were declared.

HWB/16/5. **Public Participation**

There were no members of the public registered to speak.

HWB/16/6. **Enabling People to Stay Healthy for Longer - Reducing Premature Mortality from Cardiovascular Disease**

The Board considered a report that outlined the measures being pursued to expand the NHS Health Check programme, focussing in particular on those residents who would benefit most from a Health Check.

The report identified how Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group would support further development of the NHS Health Check delivery. Health checks would be promoted through places like the leisure centres, supermarkets and libraries.

RESOLVED

that the delivery of the recommendations to facilitate greater uptake of an NHS Health Check by staff, patients, customers and stakeholders be supported.

HWB/16/7. **Giving Every Child the Best Start in Life: School Readiness**

The Board considered a report on progress with school readiness.

The expected outcome for every child leaving a reception class was that they would have achieved a Good Level of Development. Early indicative results for 2016 indicated that performance had risen from 64% to 68%, although the latest figure had still to be moderated. A leaflet had been produced detailing the characteristics of school readiness which provided parents with guidance on what they could do to support their child.

The linking of the health checks and 2½ year checks to Early Years Foundation Stage had been piloted in Biggleswade and Sandy and had proved to be successful. Between the 2½ year checks and a child entering Reception at school was a long period of time as children developed during this period and it was felt that an additional milestone was needed during this time. Additional work with practitioners would be carried out in September 2016 to consider an additional milestone with a further report being submitted to the Health and Wellbeing Board on 25 January 2017 with monitoring taking place through the Health and Wellbeing Scorecard.

RESOLVED

1. **that the progress made in giving every child the best start in life for school readiness, be noted; and**

2. **that the Health and Wellbeing Board be updated at their meeting on 25 January 2017 as indicated above.**

HWB/16/8. **Health and Wellbeing Scorecard**

The Board considered a report that set out a proposed scorecard that included a series of indicators that could be used to monitor progress against the four Joint Health and Wellbeing Strategy priorities:-

- 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.

RESOLVED

that the scorecard proposed to indicate progress against the Joint Health and Wellbeing Strategy, be approved.

HWB/16/9. **East of England Ambulance Service NHS Trust**

The Board received a presentation from the Area Clinical Lead on the East of England Ambulance Service NHS Trust's (EEAST) proposed operating model. The presentation explained:

- the current model;
- the case for change;

- the urgent and emergency care model;
- future workforce breakdown; and
- key features and outcomes.

It was unclear what the cost savings of the new model would be, but the Board were advised that investment had to be made to allow the service to save money.

The Bedfordshire Clinical Commissioning Group were working closely with the EEAST on its proposed direction of travel.

RESOLVED

to report back to the Health and Wellbeing Board meeting on 25 January 2017 on the outcome of Bedfordshire Clinical Commission Group's discussions with the EEAST.

HWB/16/10. **Transforming Care - Transformation Plan**

The Board considered a report that provided an update on the development of the joint transformation plan across Central Bedfordshire, Luton, Bedford Borough and Milton Keynes. The report also set out the three year transformation plan for transforming care for children, young people and adults with learning disabilities and/or autism.

The final transformation plan had been submitted to NHS England on 11 April 2016. All four local authorities would be responsible for reporting back to their own individual Health and Wellbeing Boards.

The Board expressed concerns about the financial support available to support the transformation over the next three years. This would inhibit the ability to take the Plan forward. The Board agreed that representations should be made reflecting this concern.

RESOLVED

1. **that the joint three year plan be approved in principle as there would need to be an ability to flex the plans to take account of the outcome of the engagement work stream across the footprint during 2016/17;**

2. **noted that as this was a joint plan with Central Bedfordshire, Bedford Borough, Luton and Milton Keynes, it would be subject to approval and sign off through each of the organisation's governance arrangements; and**

3. **to authorise representations registering the Board's concerns about funding support to deliver the Plan.**

HWB/16/11. **Sustainability and Transformation Plan 2016-2020**

The Board considered a report that set out the requirement for every health and care system to come together to create a local blueprint for responding to the NHS's Forward View. The NHS Shared Planning Guidance for 2016/17 – 2020/21 required local areas to produce a five year, place-based Sustainability and Transformation Plan (STP).

Central Bedfordshire was part of the Bedfordshire, Luton and Milton Keynes (BLMK) footprint and was working with neighbouring local authorities, Clinical Commissioning Groups, the three acute hospitals and other significant NHS providers. The STP would seek to address:

- the health and wellbeing gap;
- the care and quality gap; and
- the finance and efficiency gap.

The draft STP had been submitted and would be reviewed nationally by NHS England and NHS Improvement. In the meantime, work would continue locally to develop the five key priorities of the Plan:

- illness prevention and health improvement;
- primary, community and social care;
- secondary care;
- digitisation; and
- demand management and commissioning.

The Board would receive an update at the next meeting on 19 October 2016.

RESOLVED

1. **that the requirement for a place-based health and care Sustainability and Transformation Plan be noted;**

2. **that the approach to developing the Sustainability and Transformation Plan for the BLMK Footprint be endorsed; and**

3. **that the five priorities for the BLMK Footprint be endorsed.**

HWB/16/12. **Better Care Fund Plan 2016/17**

The Board considered a report that provided an update on the development and submission of the Better Care Fund (BCF) Plan for 2016/17. The report also set out the BCF Quarter 4 performance return to NHS England and narrative on progress.

The BCF Plan 2016/17 would focus on three key schemes to help deliver improvements, cost efficiency, more streamlined pathways of care and to meet the national conditions. The three key schemes were:

- out of hospital care;
- prevention; and
- protecting social services.

The 2016/17 BCF Plan would be accredited on a regional basis by a panel consisting of NHS England and Local Government representatives. Early indications were that the Central Bedfordshire BCF Plan would be approved with support.

The total BCF pooled fund was £20.534m from Central Bedfordshire Council and the Bedfordshire Clinical Commissioning Group. A Section 75 Agreement had been drawn up as part of the requirement of the amended NHS Act 2006. It was proposed to amend the recommendations to authorise the Chairman of the Health and Wellbeing Board to sign off the Section 75 Agreement.

RESOLVED

1. **that the BCF plan for 2016/17 that was submitted on 5 May 2016, with approval from the Chairman of the Board, be endorsed;**

2. **that the core elements of the plan including themes, national conditions, metrics and the assurance process be noted;**

3. **that the expected outcome of the assurance process be noted;**

4. **to authorise the Chairman of the Health and Wellbeing Board to approve and sign off the Section 75 Agreement for the 2016/17 fund; and**

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

HWB/16/13. **Board Development and Work Plan 2016/2017**

The Board considered the updated work programme for 2016/17.

RESOLVED

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

- **to receive an update on the Sustainability and Transformation Plan 2016-2020 - 19 October 2016;**

- **to receive an update on the discussions between the Bedfordshire Clinical Commission Group and the EEAST – 25 January 2017;**

- **to receive an update on Giving Every Child the Best Start in Life: School Readiness – 25 January 2017;**

- **to receive an update on the Transforming Care – Transformation Plan following the implementation of phase 1 - 29 March 2017;**

- **the Health and Wellbeing Scorecard would be submitted to every meeting; and**

- **the integration of Health and Social Care in Central Bedfordshire – to be timetabled.**

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

Chairman …….

Dated ……..

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Improving Outcomes for Frail Older People
Meeting Date:	19 October 2016
Responsible Officer(s)	Julie Ogley Director Social Care Health and Housing, Director of Social Care, Health and Housing
Presented by:	Julie Ogley Director Social Care Health and Housing, Director of Social Care, Health and Housing

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

1. **note progress towards delivering improved outcomes for frail older people; and**
2. **agree on any additional action that the Board would like to take to accelerate the impact on outcomes and to deliver the priorities set out in the Joint Health and Wellbeing Strategy.**

Purpose of Report	
1.	This report updates the Board on progress made across a range of initiatives aimed to Improving Outcomes for Frail Older People.

Background	
2.	Improving Outcomes for Frail Older People is one of the priorities of the Health and Wellbeing Board and its vision for care and support for frail older people which is person-centred, safe, cost and clinically effective. The Joint Health and Wellbeing Strategy sets out some key actions required to deliver improved outcomes.
3.	Following the refreshed strategy in April 2015, two outcomes were identified within this priority: 1. enabling older people to stay well at home for longer 2. helping people with dementia and their carers to feel supported to manage their dementia.

	The key issue to be tackled is to reduce isolation and loneliness in older people.
4.	The Health and Wellbeing Strategy sets out the following key actions: • Ensure that people know where they can go to get help and support. • Promote volunteering and other opportunities to share knowledge, skills and experience e.g. time banking, for people of all ages to promote intergenerational activities. • Use the valuable information from Silver line to enable us to provide support in the areas where it is needed most. • Provide choice in the accommodation available for older people, ensuring that developments promote social inclusion. • Promote local social opportunities outside the home such as health walks, library, leisure and educational activities.
5.	The Health and Wellbeing Board received an update in June 2015. The update outlined the work of the Silver Line, a charity which offers support to older people in the form of a free helpline and telephone support to isolate people using volunteers.

Progress to Date	
	Information, Advice and Support
6.	Central Bedfordshire Council has now commissioned 'Advice Central' to provide social care information and advice to general population residents of Central Bedfordshire. Advice Central assists with delivering advice and information associated to care and support to those who do not want to contact the Council or whose level of need is low (this is more about prevention than dealing with high needs) or who are not sure where to go or who to contact about their enquiry and need an access point to explore their enquiry.
7.	The Just Ask bus delivered by Healthwatch Central Bedfordshire travels throughout Central Bedfordshire to bring information, support and advice from a wide range of partners to local communities.
8.	Silver Line is continuing to offer support to Central Bedfordshire residents, providing befriending and information on local activities. A number of residents also now act as Silver Line telephone volunteers to lonely people outside of CBC.

	Good Neighbour and Village Care Schemes
9.	The Good Neighbour and Village Care Scheme network coordinated by the Bedfordshire Rural Communities Charity provides comprehensive coverage across Central Bedfordshire. The Schemes which are focused around supporting older people continue to expand. There are 36 Schemes, with 925 volunteers. Many of the recipients are isolated older people and many of the volunteers are also older people.
10.	Between April and June 2015, the schemes reported 3464 jobs where people phoned for help. 767 residents contacted the groups and there were 129 new callers in the period.
11.	Transport remains the main issue with which callers required help, making up the majority of total jobs carried out. A total of 2234 journeys were undertaken and most of the journeys were for medical transport.
12.	The Good Neighbour and Village Care Schemes also organise many other social opportunities for local people and also enable people to continue to take part in social activities and everyday tasks such as shopping. Local groups organise a variety of social events such as teas, dances, outings, chair based exercise sessions and regular walks for older people.
13.	The schemes also work with a range of other partner organisations to provide early intervention and preventive services, such as Town Councils, the Fire Service, Public Health, Department of Work and Pensions, and Practice Based Commissioning Groups to deliver falls prevention, crime prevention, benefit take-up, and support in emergency situations such as extreme weather conditions and health issues such as winter flu vaccinations**.**
14.	Some examples of customers outcomes of the VCS/GNS schemes are: **Case study 1:** several groups have reported on how they have given lifts to frail and elderly residents wanting to vote in the referendum. These residents would not have been able to get to the polling stations to express their views without the good neighbour group volunteers. They also appear to have preferred the social outing to vote compared to the idea of registering to obtain a postal vote sent to them at home. **Case Study 2:** A volunteer has added another dimension to her regular Wednesday visit to an older, largely housebound lady. As well as the usual chat over a cup of tea, the volunteer is now reading to the lady (who has macular degeneration and very limited vision) entertaining her with anecdotes from the autobiography of the volunteer's grandfather. He served in India where the lady also lived during her youth so she is very interested in all the detail.

15.	The expansion of the Good Neighbour and Village Care Schemes into more urban areas remains challenging. Consequently, additional funding has been made available and targeted to developing services in Dunstable and the surrounding areas.
16.	The existing scheme in Dunstable was until recently coordinated by the town Council and offered one to one befriending rather than the wider range of services offered by the other schemes. The Bedfordshire Rural Charities Commission is engaging with the communities in Dunstable to relaunch the scheme to offer these wider services.
	Local Social Opportunities Outside the Home
17.	**Day Opportunities for Older People** - A better offer for day opportunities is being developed and is likely to result in closer links with Housing, Libraries and Leisure in order to expand opportunities for people to meet each other where they live and in their neighbourhoods.
18.	**Timebanking** - There are now two operational Timebanks, one in Upper Caldecott and the second in Ampthill and Flitwick. A third scheme in Leighton Buzzard is about to launch.
19.	**Support for Carers** - Support for carers is available through carers cafes, befriending services and now through 2 carers lounges based in Bedford and Luton and Dunstable Hospitals.
20.	**Dementia friends** - As at July 2016, there are now 110 dementia champions and 2132 friends across Central Bedfordshire.
21.	**More people accessing health walks and leisure activities** - Since April 159 older people have participated in Activity 4 Health 50+ sessions. Other activities for older people including: Walking Football, Health Walks, Seated Exercise, Table Tennis, Badminton and Active Life have attracted some 840 attendances since June 2016.
	Independent Living and Extra Care Accommodation
22.	The building of new extra care housing schemes and community hubs will provide further opportunities to create spaces where people can meet and engage in social activities. Two new schemes have opened this year, Priory View in Dunstable and Greenfields in Leighton Buzzard, increasing the number of schemes to 6 and the capacity of extra care by 168 to 301 apartments. The new schemes in particular offer the wider community facilities and places to socialise and meet other people, thus combating loneliness. Many of the new residents have expressed how they now feel less isolated by living within these schemes.

	Measuring Impact
23.	A good measure for determining the effectiveness of these services is through the Adult Social Care Survey. The survey seeks to learn about how effectively services are helping service users to live safely and independently in their own homes, and the impact that these services are having on their quality of life. The result of the 2015/16 survey was published in September.
24.	The results relating to the summary measures suggested above for Central Bedfordshire based on the returns by 365 residents are: In terms of information and advice, some 74.5% said that they found it easy or fairly easy to access advice (nationally 53.5%)(Q12). Adult social care users reporting that they have as much social contact as they would like had decreased to 44.9%, compared to 45.8% when last measured, but 2.9% (5.6% nationally) reported that they felt socially isolated (Q8). 29.1% said they did not leave their home, (26.4% nationally) and an additional 21.5% said they were not able to get out to all the local places they wanted to. (Q18) In terms of depression and anxiety 55.7% (46.8%nationally) said they were not anxious or depressed, 39.1 (45.1%nationally) were moderately anxious /depressed and 5.9% (8.1% nationally) were extremely anxious/depressed. This is a marked improvement on previous figures.(Q14b) 88% of people receiving services said they helped them to feel safe, which is above the CBC target set last year (79%), and above the national average of 85.4%.

Reasons for the Action Proposed	
25.	The Health and Wellbeing Board (HWB) has a statutory duty to promote integration. Improving Outcomes for Frail Older People is one of the priorities of the Joint Health and Wellbeing Strategy.
26.	Improving Outcomes for frail older people is central to the delivery of the Better Care Fund Plan for Central Bedfordshire and also consistent with the strategic direction of the Sustainability and Transformation Plan.
	Conclusion and Next Steps
27.	Some important improvements have been made to improve outcomes for frail older people. However further work is still needed to secure delivery of the priorities and commitments of the Health and Wellbeing Board. Some of this is evidenced in the report following the Thematic Review undertaken by the Care Quality Commission in Central Bedfordshire in December 2015 (Building bridges, breaking barriers).

28.	There is a commitment from all partner agencies to address the major challenge of improving quality of care by joint working and the integration of service commissioning and provision.
29.	There is clear recognition of the need for partnership working across statutory and non-statutory agencies, in order to secure real improvements and better quality of life for frail older people. The aim is to achieve more rapid diagnosis and response in care management through better integration and development of seamless pathways of care across acute, community, mental health, social care and the community and voluntary sector.
30.	Work currently underway as part of the Better Care Fund Plan deliverables on Redesigning integrated care pathways for falls, stroke, enhanced care in care homes and multidisciplinary working will contribute towards delivering improved outcomes for people. A separate update on key deliverables is also tabled at this Health and Wellbeing Board meeting.
31.	The focus locally is to ensure greater integration of health and care services through more joined up working across the various care professionals. A multidisciplinary approach is being developed. This includes identifying those people who may need care and support early and ensuring that they are supported. This includes frail older people in Care Homes and preventing admission to hospital, where appropriate.
32.	The intention is to continue to increase the number and scope of Village Care Schemes and to develop wider opportunities for community involvement and volunteering using the voluntary and community sector.
33.	Securing this requires a clearer understanding of the resources available and a convergence of those resources, where appropriate, to provide care and support to frail older people and those with complex care needs.

Issues	
Governance & Delivery	
34.	Improving outcomes for frail older people is one of the priorities within the Joint Health and Wellbeing Strategy.
35.	There is clear alignment with the Better Care Fund Plan and the emerging priorities of the Sustainability and Transformation Plan.
36.	Responsibility for the delivery of the outcomes rests with Director for Social Care, Health and Housing and the Director of Commissioning of the Clinical Commissioning Group.
Financial	
37.	None identified for this report.

Public Sector Equality Duty (PSED)	
38.	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 Julie Ogley

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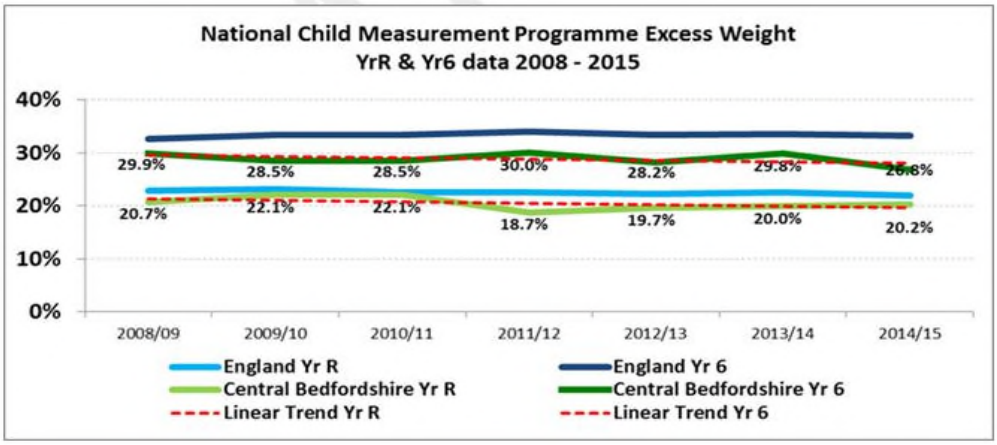
Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Enabling People to Stay Healthy for Longer – An update on the Excess Weight Partnership Strategy 2016 - 2020
Meeting Date:	19 October 2016
Responsible Officer(s)	Muriel Scott, Director of Public Health
Presented by:	Celia Shohet, Assistant Director of Public Health

Action Required:

1. **The Health and Wellbeing Board is asked to endorse and support the Excess Weight Partnership Strategy.**
2. **To consider the implementation plan for the Strategy.**

Executive Summary	
1.	The report outlines the partnership strategy (Appendix A) and implementation plan (Appendix B) to reduce excess weight in adults and children. The strategy brings together, coordinated and focused contributions of all partner organisations. By aligning our efforts an environment can be created across Central Bedfordshire which supports every child, young person, adult and older person to achieve and maintain a healthy weight. It identifies how Central Bedfordshire Council, Bedfordshire Clinical Commissioning Group and partner organisations can work together to increase the impact of the strategy by facilitating the involvement of other stakeholders e.g. schools, GPs. The recommendations of the strategy are being taken forward through the Excess Weight Implementation Group which is made up of representatives from all partners who contribute to the strategy.

Background	
2.	**Adult Excess Weight prevalence**:- • In England the percentage of overweight and obesity (the combination of these two categories is called excess weight) is 63.8%. • In Central Bedfordshire this figure is 69.1% and is statistically higher than the England average. However an update of the data (first published in 2014) is anticipated shortly. **Child Excess Weight prevalence**:-  NCMP Excess Weight YrR & Yr6 2008 – 2015. Trend data over a 7-year period from 2008 shows a slight downward trend for Year R and Year 6 for excess weight. **Causes of Excess Weight**. Physiological, psychological, social and environmental factors all contribute to overweight and obesity in individuals, communities and wider society. Although personal responsibility in relation to diet and physical activity levels, plays a crucial part in weight gain, so does the 'obesogenic' environment in which we live, with its abundance of energy dense food, motorised transport and sedentary lifestyles (Foresight, 2007). The excess weight partnership strategy was developed from June 2015 – March 2016 to ensure that the factors from the Foresight Report are addressed by relevant partners.

3.	The Board has not had any previous consideration of the specific proposal.
Detailed Recommendation	
4.	The Excess Weight Partnership Strategy has 4 priorities. 1. Creating positive environments which actively promote and encourage a healthy weight. 2. Giving all children and families the best start in life and supporting them in achieving a healthy weight and lifestyle. 3. Empowering adults and older people to attain and maintain a healthy weight. 4. Enabling practitioners working in Central Bedfordshire to have a meaningful discussion about weight in a confident and effective manner.
5.	The Excess Weight Implementation Group includes representatives from all partners who contribute to the strategy across both Central Bedfordshire and Bedford Borough. The detailed action plan is appended but some of the key actions are outlined in paragraphs 6-9. The Group will meet twice a year and progress is assessed by updating the Action Plan following each meeting. The Public Health Co-ordinator for excess weight will also have separate meetings as and when required with partners regarding current work and actions.
6.	To create positive environments which actively promote and encourage a healthy weight, the implementation plan will focus on: • Increasing access to healthier food choices within the proximity of schools, workplaces and places of education with residential accommodation. • Ensuring that local planning and policy decisions have a focus on preserving and creating healthier environments, which provide opportunities for physical activity and healthier food choices. • Increasing the provision of healthier food options in new and existing food establishments e.g. premises, workplaces, leisure facilities. • Increasing the number of residents accessing green spaces, communal areas for physical activity and sustainable travel choices.

7.	To give all children and families the best start in life and supporting them in achieving a healthy weight and lifestyle the implementation plan will focus on: • Reducing the number of pregnant women who gain excess weight during pregnancy. • Reducing the number of children starting school who fall into the excess weight category. • Reduce the prevalence of excess weight in school aged children and young people. • Increase the number of families using active travel i.e. cycling to work. school/for leisure.
8.	To empowering adults and older people to attain and maintain a healthy weight the implementation plan will focus on: • Reduce the prevalence of excess weight in all adults. • Reduce the prevalence of excess weight in specific groups of vulnerable adults. • Increase the number of safe and accessible opportunities to be active and eat healthily. • Increase senior buy-in and increase the number of professionals who are aware of recommendations for health and are able to support the population specifically target groups.
9.	To enable practitioners working in Central Bedfordshire to have a meaningful discussion about weight in a confident and effective manner the implementation plan will focus on: • Ensuring consistent and accurate healthy weight and lifestyle communications to all partners. • Supporting employees in the workplace to improve lifestyle habits.

Issues	
Governance & Delivery	
10.	The Healthy Weight Strategic Group will continue to steer the implementation and evaluation of the strategy and action plan. Progress against actions will be demonstrated through the performance measures within the Health and Wellbeing Board Performance Report.

Financial	
11.	The implementation of the Excess Weight Strategy will be delivered through existing budgets and funding streams. There is some short term additional funding from the public health strategic reserve for a Project Officer to implement the new Healthy Options Food Award Scheme
Public Sector Equality Duty (PSED)	
12.	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

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Presented by Celia Shohet

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Appendix A

Excess Weight Partnership Strategy

2016-20

Foreword

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

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

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

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

Cllr Maurice Jones
Executive Member for Health
Central Bedfordshire Council

Dr Chris Marshall
Assistant Clinical Deputy Chair and
Chair of the Leighton Buzzard Locality
Bedfordshire Clinical Commissioning Group

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

Introduction

i) Why do we need to tackle excess weight?

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

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

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

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

ii) What we want to achieve

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

iii) Our Priorities

Our four priorities for tackling excess weight are:

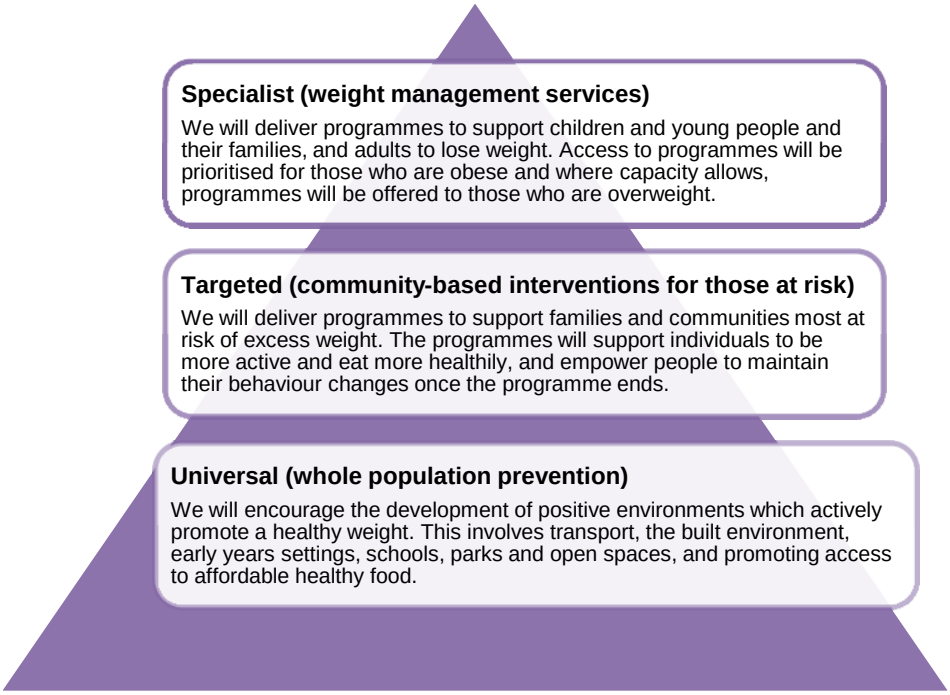
1. Creating positive environments which actively promote and encourage a healthy weight.

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

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

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

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



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

iv) What will success look like?

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

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

The Four Priority Areas

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

Why it's important:

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

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

What will success look like?

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

Baselines to be established in 2016/17.

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

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

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

Why it's important:

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

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

What will success look like?

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

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

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

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

Why it's important:

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

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

What will success look like?

1. A 1% year on year reduction in the prevalence of excess weight in all adults from a baseline of 69.1% to bring us in line or below the England average. (currently 64.6%)
2. A reduction in the prevalence of excess weight in specific groups of vulnerable adults (BME, men, pregnant women).

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

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

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

Why it's important:

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

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

What will success look like?

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

Baselines established in 2016/17 for each success measure

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

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

Appendix 1: Current Partnership Activity across the 4 Priority Areas

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

Prevention

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

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

Prevention

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

Management

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

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

Prevention

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

this with restaurants and HFT.

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

Management

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

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

Prevention

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

Appendix 2: Detailed Local Excess Weight Picture

i) Definition

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

ii) Measurement of 'Excess Weight'

a) Adults

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

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

Table 1: BMI classification for Adults

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

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

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

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

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

b) Children and Young People

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

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

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

iii) Prevalence of 'Excess Weight'

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

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

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

a) Prevalence: Children and Young People

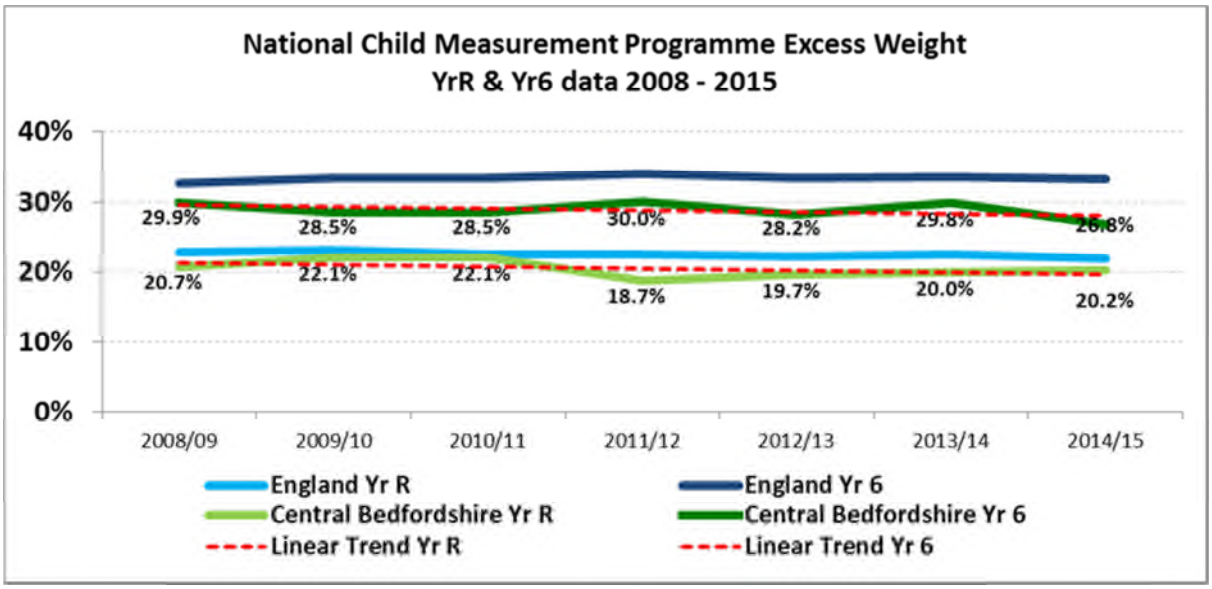
The latest NCMP data (14/15)[4] is shown in the table below:

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

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

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

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



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

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

b) Prevalence: Adults

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

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

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

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

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

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

iv) Causes of Excess Weight

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

v) Risks associated with 'Excess Weight'

a) Children and Young People

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

b) Adults

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

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

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

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

[7] independent of genetic factors

Central Bedfordshire

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Appendix B

Countywide Excess Weight Partnership Strategy

Implementation Plan 2016/17

Action at risk of not being completed within timeframe	R
Action in progress and within timescale	A
Action completed	G

The purpose of this implementation plan is not to performance manage individual contracts. It will:

- Include new projects and initiatives – it does not include 'business as usual'
- Identify and address challenges and needs which have been raised as a result of the Excess Weight Partnership (EWP) strategy
- This plan will be updated on a quarterly basis

Priority 1: Environment

Outcome 1.1: Increased access to healthier food choices within the proximity of schools, workplaces and places of education with residential accommodation

Responsible officer(s)	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
Nutrition and Dietetics – Bedford Hospital	Review and implement the Food and Health Strategy. Review food available across Trust and make recommendations accordingly.	By end of March 2017	Some food provision tied into contracts out	To be updated by Dietitians at BHT including CQINS.	Strategy reviewed and signed off. Recommendations in place.	A

Outcome 1.2: All local planning and policy decisions have a focus on preserving and creating healthier environments, which provide opportunities for physical activity and healthier food choices

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
Children's services – CBC	Children Centres to apply for 106 contributions (funding) for individual projects e.g. covered buggy area to promote walking to CCs.	By end of March 2017	106 contributions not allocated to Children's Services.	To be updated following meeting on 22nd Sept.	Projects identified, implemented and monitored quarterly through environment audit.	A
Planning Policy/ Management – BBC Planning Management – CBC	Ensure Local Plan includes policies to encourage walking and cycling, public open spaces and green infrastructure links. Also ensure Local Plan includes: design guide, reference to CIL spending.	By end of March 2017		Ensure all relevant partners are involved in the development of the local plan. Ensure relevant partners are involved in the planning process from the outset.	Record the number of developments where active designs are included.	A
	Develop a Supplementary Planning Document (SPD) to assess new planning applications for A5 premises within 400m of schools, including opening times.			Public Health and Planning teams (BBC and CBC) to meet with Medway Council on 03.08.16. CBC and Public Health to create policy for emerging Local Plan.	SPD in place. Number of applications for A5 use with amended opening times.	A
	Ensure Health Impact Assessments are completed for relevant developments.			CBC to identify training provider and obtain quotes.	Training completed.	A
Sport Development – BBC	Steer investment in interventions by using activity data and community needs assessment.	By end of March 2017		Applications to Police Funding. Application to extend 'Just Turn Up' (JTU) initiative.	Activity data	A
Sustrans (in BB and CB)	Complete new best practice guides	By end of March 2017		In draft.	Best practice guidelines in place.	A
Transport Policy – BBC	Apply transport policies to new developments including Cycle Parking Guidelines and Highway Design Guide (HDG). Record annual contribution of CIL to strategic cycle network improvements.	End 2016		Highway design guide consultation being planned with adoption currently scheduled for end 2016. Continue to build joint case in the context of https://www.gov.uk/government/publications/active-travel-a-briefing-for-local-authorities Sustrans officer strongly engaged in Bike IT work and mutually supportive work with Travel Plan Officer.	Adopt HDG by end 2016 and monitor resultant impacts and process improvements. Processes and system embedded.	A

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
	Negotiate cycling and walking improvements. Host Sustrans officer to promote cycling and walking activity.					A
Transport strategy – CBC	Ensure new Local Travel Plan includes new/revised strategies to influence levels of physical activity.	By end of March 2017		Application for STARS funding applied for.	Funding successful, programme will begin in Sept 2017?	A
Sustrans (for BB and CB)	Encourage Travel Plans for workplaces	By end of March 2017		Promote joint working with Sustrans to businesses Engage economic development in relation to new proactive links with business. Creation of welcome packs providing sustainable travel details and advice. Expand principle cycle vouchers for residents, bus pass for a week trial.	Number Travel Plans for Work Places. Number of welcome packs distributed. Number cycle vouchers distributed. Outcomes of bus pass trial.	A

Outcome 1.3: An increase in the provision of healthier food options in new and existing food establishments e.g. premises, workplaces, leisure facilities

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
Children's Services (Early Help) – BBC	Ensure children centres have healthy food policies.	By end of March 2017.		In Draft?	Number of children centres with a healthy food policy.	A
Environmental Health – BBC and CBC	Implement a 'Healthier Options' Food Business Award Scheme.	By end March 2017		Secure funding for licence fee and a countywide Project Support Officer.	9 food businesses in each LA to gain award.	A
	Review the Heartbeat Award.				Heartbeat Award updated and implemented	
Environmental Health – BBC	Set up an automated system for food businesses to access information on healthier food choices/the healthy food award scheme.			Develop automated system.	Number businesses accessing information and scheme.	A
Leisure, Libraries, Countryside access –	Countryside access to investigate opportunity to discuss food options	By end of March 2017		Awaiting update following meeting on 22nd Sept.	Menus offer a healthy option.	A

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
CBC and BBC	with site 'Operational Partners'. Ensure parks cafés provide refreshments that include healthier options.				Businesses signed up to Food Business Award Scheme.	
Sport Development – BBC	Investigate whether leisure premises have a healthy options catering commitment for vending machines and canteens.			Once a Healthy Food Business Award has been formalised, work with Fusion to ensure all sites achieve an award.	Number of facilities with award.	**A**

Outcome 1.4: An increase in the number of residents accessing green spaces, communal areas for physical activity and sustainable travel choices

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
Policy lead – BCCG	Review the BCCG Physical Activity policy.	By end of March 2017		Awaiting updates following meeting on 22nd Sept.	Policy reviewed and adopted.	**A**
Children's Services – CBC	Travel Hub to disseminate a wide range of travel information to parents.	By end of 2016.		Update required.	Alternative travel options are promoted to parents.	**A**
Parks – BBC	Use S106 funding to improve sports facilities across Council green spaces.				Funding accessed, projects identified and subsequently evaluated.	**A**
Sport development – BBC	Encourage the use of open spaces for recreation and activity.			Meeting with Lawn Tennis Association to look at possible Tennis court use/management to allow sustainability and wider access. Promote walking and cycling at leisure centre sites and sessions.	Increase in the number of tennis courts used by the general public. Number of awareness sessions and participants.	**A**
Leisure, Libraries, Countryside Access – CBC	Develop 'Friends' of groups to participate in self-management of the countryside/ sites as part of health and wellbeing.	By end of March 2017.		Monitor and record engagement in number of people participating in 'Friends' group.	Groups established. Number of participants.	**A**

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
Sustrans – BBC and CBC	Provide cycle rides and special themed rides. Develop volunteer network to lead rides and walks.	By end of March 2017.		Continue to run events relating to walking and cycling in Bedford.	Number of events Number of engagements Volunteer network in place. Rides and walks initiated. (number?)	**A**
	Engage with all partners to ensure that the safety, health and wider transport benefits of walking and cycling are clearly understood and communicated in all contacts (MECC).			Apply for MECC training via BBC.	Number of staff trained in MECC.	**A**
	Support the completion of the Green Wheel.			Parks and open spaces to link with Green Wheel. Explore potential for green infrastructure as part of routes to school and connection to green space.	Green wheel completed.	**A**
	All expansion schools will have Transport Assessment/Statements which will identify opportunities for improving and increasing cycle facilities and walking routes.			Awaiting update.	Number schools completed Transport Assessment.	**A**
	Record numbers of people walking (Inner Cordon and APS).			Collect scheme specific data. Continue to develop broader transport monitoring.	Scheme data.	**A**

Priority 2: Children

Outcome 2.1: A reduction in the number of pregnant women with BMI of 25 – 29.9 at time of midwifery booking and Outcome 2.2: A reduction in the number of pregnant women who gain excess weight during pregnancy

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
0 -5 Health Visitors – SEPT CHS	Increase the number of pregnant women who are referred/signposted to BeeZee Bumps, via antenatal contact. Ensure that mother's weight is discussed at ante-natal and post-natal home visits.	By end of March 2017.	Information from midwifery at BHT and L&D patchy.	Awaiting updates.	Number of eligible women referred.	R
	Deliver Bump Birth and Baby stuff programme in partnership with CC's across Bedfordshire.	By end of March 2017.	Parents not engaged. Unable to access sessions during the day.	Awaiting updates on number of programmes completed.	All Children Centres are able to offer programme.	A
Midwifery – BHT	Signpost pregnant women to Aquanatal and other physical activity classes.	By end of March 2017.	Women may not be able to attend due to cost.	Map existing, relevant activity sessions for pregnant women. Liaise with Sport development/ physical activity providers to develop literature. Is this also L&D?	Numbers of women signposted.	A
	Provide Midwifery sessions in travelling communities.	By end of March 2017.	Travellers may not engage.	Engage with traveller communities.	Number of sessions delivered. Number of mothers attended.	R
Children's Services – CBC and BBC, Health Visitors – SEPT and Midwifery	Deliver the Bump, Birth & Baby Stuff in the evenings to ensure accessibility for more service users.	By end of March 2017.		Awaiting updates on number of programmes completed.	Evening sessions arranged and delivered. Number of attendees.	A

Outcome 2.3: A reduction in the number of children starting school who fall into the excess weight category

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
0-5 Health Visitors – SEPT; Early Years CBC	Implement integrated assessment at 2-2½ years.	Sept 2016		Roll out programme on track from September 2016.	Referrals to Henry Programme.	

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
and BBC					Early Help Assessments for weight management. Refer to dietetics.	A
0-5 Health Visitors – SEPT	Implement Family Partnership model for vulnerable mothers and families.	By end of March 2017.		Continue planning stage.	Model in place	A
Children's Services (Early Help) – BBC and CBC	Monitor sessions on healthy eating and physical activity delivered in Children Centres. Co-deliver 2-2½ year review with Health Visiting.	By end of March 2017.		Awaiting updates following meeting on 22nd Sept.	Integrated checks offered to 100% of eligible families.	A
Leisure, Libraries, Countryside Access – CBC	Increase participation uptake of Xplorer family activities.	By end of Sept 2016.		To be updated with numbers of programme and families taking part.	Number of people who attend the activities.	A
Transport Policy –BBC	Develop travel plans with early years settings.			Working with 2 pre-schools and planning to work with Stewartby.	Number travel plans. Number engagements.	A

Outcome 2.4: A reduction in the prevalence of excess weight in school aged children and young people

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
5-19 School Nurse teams	Follow up calls to parents after excess weight NCMP letters have gone out.	Annually (academic year) Quarterly		Website is going live in October 2016. Calls followed up and increased number of referrals to BZB.	Completion.	A
	Launch of website with NCMP and BeeZee Bodies information.				Completion.	R
	Increase referrals to BZ Bodies.				Number of referrals	A
BCCG	Commission ELFT, jointly with LCCG, to provide a specialist community eating disorders service.	By end of March 2017.		Explore how the third sector could support the development of a wider agenda around issues sometimes associated with children and young people.	Number of referrals to ELFT.	A
Sport Development – BBC	'Just Turn Up' (JTU) staff to work with local schools/colleges to provide further			JTU staff to continue to work closely with the school staff to	Record work with local schools/colleges to provide further	G

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
	extracurricular clubs.			become well known by the students as sporting ambassadors. Engage in the direct link to schools to offer affordable after school activities.	extracurricular clubs.	G
Sustrans – CBC and BBC	Continue to deliver 'Bike It' in 27 schools across CBC.	Quarterly reporting		Funding approved to continue scheme until March 2018. Additional schools will be identified and contacted to take part from Sept 2016 onwards.	Number of new schools who engaged with the programme in Sept 2016.	A
	Implement and evaluate 'Bike It' in schools in Bedford Borough.			The 'Bike It' Officer will work intensively with a minimum of 9 local primary schools, whilst continuing to support 4 schools that have been engaged in Bike It in the last year.	Reporting of activities in schools Number pupils engaged	A
Transport Policy – BBC	Support Bikeability in schools.	By end of March 2018.		Bikeability promoted through Travel plans for years 4-6.	Number of schools with Bikeability	A
	WOW-Walk Once a Week		Requires significant funding	Explore implementation of a Bedford Borough Award Scheme.	Number of schools with Award.	A
	Support schools to develop school travel plans and record this.			Business case submitted for approval for school access and online portal mode-shift.	Robust recording system in place enabling regular monitoring.	A
Transport Strategy – CBC	Develop more voluntary travel planning with schools to compliment Sustrans work. Update Sustainable Modes of Travel to School Strategy and adopt in spring 2016.	By end of July 2016.		Awaiting updates following meeting on 22nd Sept.	MOTTOS adopted.	A
Education – CBC and BBC GAP		By end of 2016.		Meeting to be arranged with Education to discuss further input.		

Outcome 2.5: An increase in the number of families using active travel i.e. cycling to work/school for leisure

No additional actions identified for this section as it is included throughout the plan.

Priority 3: Adults

Outcome 3.1: A reduction in the prevalence of excess weight in all adults

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
BCCG	To improve the pathway into the tier 3 service by making it less fragmented and more direct. Piloting direct referrals from Busy bodies into tier 3.	To be completed within 2 months ??		Awaiting updates.	Number referrals from BZ Bodies into Tier 3	A
	Working with NHS England to transfer Tier 4 Severe and Complex Obesity Services from an NHS England Commissioned Service to CCG commissioned.	To be completed within 2 months ??				
ELFT	Work with BCCG colleagues to include in service specifications with providers.	By end of March 2017				A
Adult Services – BBC	Fusion: Stroke rehabilitation via physical activity	Quarterly		Service restructure underway to aid monitoring and reporting.	Measure the volume of referrals and number of gym memberships.	A
	Carers in Bedfordshire run training courses on nutritional values of food.				Number of courses delivered and attendance.	A
Nutrition and Dietetics – BHT	Provide evidence based information and resources around the perception of healthy weight.	By end of March 2017		Awaiting updates.	Number of people advised.	A
Sport Development Leisure – BBC	Increase awareness and referrals to BeeZee Bodies programmes.			Offer reduced rates (50% off) on Re-active 8 courses for those referred via BeeZee bodies.	BZ Bodies to record number participants signposted.	A
	Work in partnership with BeeZee Bodies to co-develop/deliver elements of relevant programmes.			JTU Tough Fitness Bootcamps have absorbed men who have completed the Gutless boot camps and then been looking for similar new sports.	Number of people signposted and take up Fitness Bootcamps.	A
	Provide information and resources to improve perception of professionals and the public, of what a healthy weight looks like.			JTU role models and ambassadors to continue providing information about healthy weight.	Number of ambassadors and role models in place.	A

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
	Work with Viking Kayak Club to purchase specialist Kayaks for those with excess weight.			In development	Number of new Kayaks.	A
	Offer BMI and blood pressure checks/tests each month as part of the ongoing twice weekly over 70s sessions.			Looking at this as an extension of the work with new staffing arrangements	Number of checks conducted	A
Countryside Access – CBC	Increase uptake from GPs to Activity4Health Scheme.	By end of November 2017.		Awaiting updates for Quarter 2.	Number of referrals.	A
Sustrans – BBC	The BikeIt officer to provide a walk for mums after they have dropped off their children at school.			These walks are currently being discussed with schools	Attendance numbers.	A
	Provide 'Active families', Cycle Confidence courses and teaching adults to cycle sessions.			43 people have shown interest in the cycle lessons and 12 beginner, 4 confidence and 2 families have paid the £5 deposit and will be having a lesson shortly.	Number adults learning to cycle	A

Outcome 3.2: A reduction in the prevalence of excess weight in specific groups of vulnerable adults

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
Adult Services – BBC	Deliver weekly lifestyle and fitness sessions at St Bedes.			Activity Coordinator to identify qualified professional to deliver diet and nutrition information.	Number of attendees attending sessions.	A
Sport Development – BBC	Ensure that services are available at locations which will be appealing and accessible to the target groups identified.			Grow the Wellbeing provision to extend bespoke activities to the groups most in need i.e. dementia, carers, mental health clients etc.	Number facilities offering free use. Number of people attending sessions. Number of people regularly attending sessions.	A
	Work with the Foundation Team at Bedford College to offer vulnerable adults sport opportunities.				Number vulnerable adults engaged.	R
Sustrans – CBC	Develop walking groups with MIND	By end of		Awaiting updates.	Number of groups and participants	A

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
		March 2017.				
Sport Development – BBC	Provide and monitor accessible JTU activity sessions.			Work in the 6 most deprived wards to develop programmes.	Number of programmes in place. Number of participants.	**A**

Outcome 3.3: An increase in the number of safe and accessible opportunities to be active and eat healthily

Outcome 3.4: An increase in senior buy-in and an increase in the number of professionals who are aware of the recommendations for health and are able to support the population specifically target groups

No additional actions identified for this section as it is included throughout the plan.

Priority 4: Everybody's business

Outcome 4.1: A workforce that is competent and confident and understands the significance of their contribution to the excess weight agenda and
Outcome 4.3: Consistent and accurate healthy weight and lifestyle communications to all partners.

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
Children's Services (Early Help) – BBC	Train staff to implement the Making Every Contact Count (MECC) approach.	By end of March 2017.		Public Health to deliver MECC training.	Numbers MECC trained.	A
0-5 Health Visitors – SEPT and 5-19 School Nursing – SEPT	Ensure all staff have received training from BZB in raising the issue of weight.	By end of March 2017.		BZB to deliver training.	Number trained.	A
Midwifery – BHT and L&D	Ensure midwives are trained and feel confident to deliver healthy weight messages.	By end of March 2017.		Use Start4life and C4L information to support discussions.	Number of midwives delivering messages.	A
Voluntary Organisations for Children, young people & families – BBC and CBC	Staff to undergo MECC training.	By end of March 2017.		Public Health to deliver MECC training	Number trained.	A
	Provide healthy weight and lifestyle communications to all voluntary organisations via monthly newsletter.	Ongoing.		Develop newsletter and circulate.	Newsletters regularly produced and circulated.	A
Sport Development – BBC	Staff to undergo MECC training. To further upskill workforce and train all coaches on the database in working with Mental Health in Sport. Advise the council to offer all employees regular Mindfulness training.			Public Health to provide MECC training	Number trained.	A
Sustrans – BBC	Staff to undergo MECC training.			Public Health to provide MECC training	Number trained in MECC	A

Outcome 4.2: Employees are supported by their workplace to improve lifestyle habits

Responsible officer	Action	Timeframe	Barriers	Progress and next steps	Measure	RAG
Workplace Health & Safety (SWAP group) – CBC	Engage with Facilities Management regarding canteen services which are available as part of contract management. Develop new calendar of events which promote healthy lifestyles for staff for 2016/17. Develop an overarching employee wellbeing strategy for CBC.	By end of March 2017.		Arrange meeting with provider. Spring Into Action – lunchtime walks programme launched in March 2016. Develop calendar of events.	Healthy options promoted more prominently. Staff feedback. Numbers of people who take part and continue to engage in activities. Collate data at 3 months and 6 months.	A
Facilities Management – BBC	Introduce the Heartbeat Award to BBC Council canteen. Provide 25-50% healthy snacks in vending machines.				Number of healthy choices purchased from vending machine.	A
University of Bedfordshire and Public Health – BBC	Complete Workplace Health Survey.			BBC survey has just been disseminated. Use outcomes to inform future activity.	Number of employees completed survey. Introduction of a workplace intervention.	A
Sustrans – CBC and BBC	Implement and evaluate a workplace project.	By end of March 2017.		Awaiting updates following meeting on 22nd Sept.	Number of engaged businesses and employees.	A
Human Resources/ Workplace Development – BBC	Provide and evaluate a range of health-related workshops/briefing sessions for employees to highlight health issues and concerns.			12 Wellbeing Champions recruited. The group have created an action plan to establish their immediate priorities.	Number workplace health champions and range of activities offered.	A
	Create a Wellbeing Champions infrastructure to provide appropriate support, guidance and direction (First point of contact).			Wellbeing Champions to attend relevant health-related workshops	Number workshops attended	A
	Review outcomes in the workplace – follow up evaluation to highlight successes.				Evaluation of scheme	A

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Health and Wellbeing Strategy Performance
Meeting Date:	19 October 2016
Responsible Officer(s)	Muriel Scott, Director of Public Health
Presented by:	Celia Shohet, Assistant Director of Public Health

Action Required:

1. **To review the scorecard and assess the progress in delivering the Joint Health and Wellbeing Strategy.**
2. **To consider the areas for further focus arising from the performance in each of the Priority Areas, outlined in paragraphs 5-8.**

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 includes the key measures providing an indication of progress. The indicators show encouraging outcomes in the priority areas of giving every child the best start in life. There is more of a mixed picture for enabling people to stay healthy for longer indicating more focus on areas such as preventing and managing diabetes and the delivery of Healthchecks. There is also a mixed picture for both improving outcomes for frail older people and ensuring good mental health and wellbeing at every age. There are a number of areas showing poorer outcomes than the challenging targets set.

Background	
2.	The 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.
3.	To understand the size of the challenge the scorecards include, where possible, the number of residents affected by the issues is 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.
4.	The targets within the scorecard are those already agreed and in some cases these are part of contractual arrangements. In some instances there are no targets set e.g. hospital admissions. It has been agreed that future iterations of the scorecard will include benchmarking data where available to allow the board to make performance comparisons.

Detailed Recommendation	
5.	**Ensuring good mental health and wellbeing at every age** Regular performance measures for population mental health and wellbeing are limited; however the Emotional Wellbeing Survey was undertaken in Central Bedfordshire earlier in 2016 and involved over 4,000 young people. This survey together with national data has driven a focus on improving the mental wellbeing and emotional resilience of young people. It is recommended that the output of this work is included in the report to the Board in January 2017 regarding the CAMH transformation plan, taking a wider view of progress in this area. The board received an update on progress to improve emotional wellbeing and self esteem throughout life with a focus on younger people, at its meeting in April 2016. The scorecard reveals that excellent progress has been made on reducing the waiting times for the Child and Adolescent Mental Health (CAMH) service which now stands at 11 weeks rather than 18 weeks, however faster progress towards the 5 week target by March 2017 would be highly desirable and the Board will continue to closely monitor this. Recovery rates for those adults completing psychological therapies is good but the Board will want to see a significant increase in the proportion of people who enter these services initially.

6.	**Giving every child the best start in life** There are encouraging signs that outcomes in this priority are moving in the right direction with some either at or near target. The indicators for both the assessment of maternal moods and for the integrated 2-2.5 year review are expected to be at target by the end of quarter 4 in 2016/17, it is therefore recommended that the Board take a close interest in their progress. It is also recommended that the outcomes for people affected by drugs and alcohol and living with children are kept under close review. If outcomes in this area do not continue to improve then this should be considered for further focus. The data for school readiness will be published shortly and an update to the Board is planned in January 2017.
7.	**Enabling people to stay healthy for longer** The outcomes in this area show that there is a particular issue with the proportion of the adult population who are either overweight or obese (together known as excess weight), which in turn impacts upon both the prevalence of diabetes and rates of premature mortality for cardiovascular disease. Action to tackle excess weight is outlined in the partnership strategy and it is recommended that the Board continue to monitor progress of its implementation. The rising rates of diabetes and low proportion of people with diabetes meeting their treatment targets is of concern. It is therefore recommended that the Board request a more detailed discussion at a future meeting to understand the issues and action required.
8.	**Improving outcomes for frail older people** The majority of outcomes in this area are closely monitored and form part of the Better Care Plan. It is recommended that the Board continue to monitor progress against the dementia diagnosis rate (which is outside the Better Care Plan) and assure itself that people with dementia and their carers feel supported to manage their dementia.

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)**

_____

Presented by Celia Shohet

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.

		Latest Data	Latest Data	Target	Current Status
	Proportion in need accessing psychological therapies	May 16	2.02 %	15.00 %	▲
	CAMHs waiting for intervention for more than 18 weeks	Jul 16	0.0 %	0.0 %	★
...	Hospital admissions for mental health 0-17 years	Dec 15	73.4		n/a
...	Hospital admissions for self-harm 10-24 years	Dec 15	358.9		n/a
...	Emotional wellbeing of looked after children	Jun 16	14.4	13.0	▲
	Recovery rates for those completing psychological therapies	May 16	52.4 %	50.0 %	★
...	Premature mortality (<75 years) in adults with serious mental illness	Dec 13	1,232		n/a
	Proportion of adults in contact with secondary mental health services in paid employment	Sep 15	6.5 %	13.2 %	▲

▲ Target missed by 10% or more ● Target missed by less than 10% ★ Target achieved

The proportion in need accessing psychological therapies is currently significantly below the target with a projected year end rate of 13%. East London Foundation Trust (ELFT) launched the IAPT (Psychological Therapies) website on 10th August which will enable self-referral to the service but the CCG has requested a detailed recovery plan

There are no young people waiting for Child and Adolescent Mental Health (CAMH) interventions for more than the current target of 18 weeks. The waiting times for the Community Mental Health team has reduced to 11 weeks and a further reduction to 5 weeks planned by March 2017. ELFT are now providing 7 day crisis service to provide quicker response and support to A+E with discharges back to community to prevent hospital admissions. In addition a community eating disorders specialist service is now established within ELFT to prevent hospital admission and improve longer term outcomes through earlier specialist management.

Hospital admissions for self-harm 10-24 years are being considered by the Suicide prevention steering group which has been established to develop pathways for reducing self-harm. In addition Schools link workers have been commissioned from ELFT to support schools with managing depression, anxiety and self-harm management.

Emotional Wellbeing of looked after children is measured through average SDQ scores which is above the target of 13. Maintenance of emotional well being for children is achieved through referral to and intervention by CAMHS and further enhanced through having stable placements, consistency of social worker, life story work and care plans that are addressing their needs.

The target has been met for recovery rates for those completing psychological therapies.

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Health & Wellbeing Board

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.

		Latest Data	Latest Data	Target	Current Status
...	Smoking at the time of delivery (L&D deliveries only)	Mar 16	19.9 %	15.0 %	▲
...	Breastfeeding rate 6-8 weeks	Jun 16	52.0 %	50.0 %	★
...	Early access to antenatal care (all L&D deliveries)	May 16	83.7 %	90.0 %	●
...	Mothers who receive a maternal mood review by the time the infant is 8 weeks	Jun 16	56.9 %	90.0 %	▲
...	Successful completions (opiates) of clients who live with children under 18	Jun 16	11.0 %	9.6 %	★
...	Successful completions (alcohol) of clients who live with children under 18	Jun 16	38.5 %	39.2 %	●
...	No. of Domestic Abuse incidents reported	Jun 16	845		n/a
...	Children who received an integrated 2-2.5 year review	Jun 16	70.5 %	90.0 %	▲
...	Number of disadvantaged 2 year olds placed in early education/childcare	Jun 16	602	767	▲
...	School readiness - % of children achieving a good level of development at the Early Years Foundation	Sep 15	64 %	69 %	▲

▲Target missed by 10% or more ●Target missed by less than 10% ★Target achieved
NB. School Readiness: - % of children achieving a good level of development at the Early Years Foundation tolerance is 5%

The outcomes relating to babies having the best start in life are encouraging, with improved performance against almost all indicators and the target for breastfeeding has now been achieved. Targets have not yet been met for early access to antenatal care and this is being investigated by the CCG. The rate of improvement for the assessment of maternal moods is also very encouraging and the provider is confident that they will achieve the target of 90% in Q3 of 2016/17.

The outcomes relating to parents not being affected by drug or alcohol abuse, domestic abuse and mental health show a mixed picture. The rate of successful completions for drug treatment for people living with children is improving and is now in the top quartile for performance. The rate of successful completions for alcohol treatment for people living with children is also improving and approaching the top quartile for performance. The number of domestic abuse incidents has increased but it is not possible to ascertain whether this is a true increase in incidents or reflective increased confidence to report incidents.

The outcomes related to children arriving at school ready to learn is encouraging with more children having their integrated health and education review, although this is not yet at target, the increased uptake is expected to continue. The number of disadvantaged 2 year olds placed in early education / childcare remains high level with over 80% of families taking up the offer. Whilst the target has not been met, Central Bedfordshire compares well to Statistical Neighbours and the Region. The published school readiness figures are for 2015 and outcomes for Central Bedfordshire were improving but below the England average.

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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.

		Latest Data	Latest Data	Target	Current Status
...	Smoking prevalence 18+	Oct 15	17.5 %		n/a
...	Adult Excess Weight	Jul 14	69.1 %	68.1 %	●
...	Percentage of adults classified as inactive	Jan 16	22.7 %	23.3 %	★
...	Health Checks Delivered % of Target	Jul 16	67.24	100.00	▲
...	Recorded diabetes	Nov 15	6.0 %	5.3 %	▲
...	% people with diabetes meeting all 3 treatment targets (blood sugar, blood pressure & cholesterol)	Feb 15	37.4 %		n/a
...	Premature mortality	Dec 14	283	276	●
...	Premature mortality for cardiovascular disease	Dec 14	61.9	58.9	●
...	Premature mortality for respiratory disease	Dec 14	24.2	23.7	●
...	Premature mortality for liver disease	Dec 14	11.7	13.1	★

▲ Target missed by 10% or more ● Target missed by less than 10% ★ Target achieved

The outcomes to reduce the number of people developing long term conditions as a result of lifestyle behaviours show a mixed picture.

The proportion of people who are inactive is improving and above the England average with a number of initiatives in place to enable residents to increase access facilities and services which allow them to lead more active lives.

The proportion of adults whose weight puts their health at risk, is above the England average and the Excess Weight Partnership Strategy sets out a number of actions to reduce this.

Healthchecks should facilitate the early identification of those individuals who are at risk of cardio-vascular disease but currently the targets for delivery are not being achieved. A community provider is being commissioned to extend the accessibility of Healthchecks, particularly for vulnerable and hard to reach groups.

In terms of people being supported to manage their long term condition, the focus within the scorecard is around diabetes. The proportion of residents affected by diabetes is increasing and rates in Central Bedfordshire are statistically significantly above the deprivation decile, driven largely by levels of excess weight. However once diagnosed the proportion of people meeting their treatment targets is worse than England and therefore remains an area of focus for the CCG.

Premature mortality rates are falling generally and are in line with similar authorities.

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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.

		Latest Data	Latest Data	Target	Current Status
...	Total non-elective admissions into hospital (general & acute) all-age per 100,000 pop (Monthly)	Aug 16	833	771	
...	Permanent Admissions of Older People (65+) to residential & nursing care homes (BCF)	Aug 16	161.0	485.3	
...	Proportion of 65+ still at home 91 days after discharge from hospital	Aug 16	90.3	95.5	
...	Emergency hospital admissions due to falls (65+) per 100,000	Mar 15	2,016		
...	Dementia diagnosis rate (65+)	Jun 16	56.1 %	58.7 %	
...	Social isolation-Adult carers who have as much contact as they would like	Mar 14	41.0 %		n/a
...	Delayed transfers of care (days) from hospital per 100,000 pop.	Jul 16	158.4	144.0	

▲Target missed by 10% or more ●Target missed by less than 10% ★Target achieved

Outcomes for improving outcomes for Frail Older People (many of which form part of the Better Care Plan metrics) show a mixed picture, with some being close to the target and others below target. This reflects the ongoing challenge of meeting the needs of an aging population with increasingly complex needs.

Permanent admissions of older people (65+) to residential & nursing care homes remain a focus of the Better Care Plan Schemes with a number of actions in place including scrutiny of packages of care to ensure that all alternatives have been explored to help people to remain in their own homes. The development of more independent living (extra care) accommodation will help to mitigate admissions into residential care.

The proportion of people aged 65+ still at home 91 days after discharge from hospital currently only reports on the Council's reablement service and as such the picture on the effectiveness of all reablement service is incomplete. An agreement has now been reached with the Community Health Services Provider (SEPT) for access to this data.

Emergency hospital admissions due to falls (65+) per 100,000 increased for the year 2014/15 which pre-dates some of the local initiatives put in place to prevent people being admitted to hospital after a fall and also to prevent subsequent falls. A Project for improving the Falls Service has been mobilised as part of the BCF Plan for 2016/17. Improvements will continue to be monitored by the BCF Commissioning Board.

Dementia diagnosis rate (65+) are improving but currently remain below target however the CCG are in the process of identifying a clinical lead to support the strategic planning in relation to dementia services. In addition East London Foundation Trust (ELFT) are currently reviewing the number of referrals made by GP practices and for those with low activity, will undertake some targeted work around understanding why the activity is low and to support with increasing the number of referrals into the Memory Assessment Service (MAS).

Delayed transfers of care from hospital is a summary measure of all local hospitals and therefore often masks high or low performing hospital trusts, this is expected to be rectified by the next scorecard. Work is currently underway to standardise the discharge process which would help reduce delays.

Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	CQC Feedback and Report on the Thematic Review of Integrated Care of Older People in Central Bedfordshire
Meeting Date:	19 October 2016
Responsible Officer(s)	Julie Ogley, Director of Social Care, Health & Housing Central Bedfordshire Council

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

1. **note the publication of the CQC Report on the Thematic Review of Integrated Care of Older People; and**
2. **note the work that is going on locally to secure better and more integrated care for older people.**

Purpose of Report	
1.	To inform the Health and Wellbeing Board of the key outcomes of the Integrated Care for Older People thematic review undertaken by the Care Quality Commission (CQC).

Background	
2.	As part of a programme of thematic work, the Care Quality Commission undertook a project to explore how well care is organised and coordinated for older people, and how this affects their experience of care. The review involved a number of different systems across England, with Central Bedfordshire being one of these systems.
3.	The review ultimately aims to improve older people's experience of integrated care and support. It will add value by: • Making recommendations for providers and commissioners about improving the delivery of high quality integrated care for older people, at a local and national level. • Improving CQC's understanding of how well different care services work together across systems, pathways and sectors with a view to improving our 'business as usual' regulatory approach.

4.	A review team of three carried out fieldwork activity in Central Bedfordshire from 4 December to 10 December 2015. The review investigated services for older people over the age of 75 who had suffered a stroke or fractured neck of femur (commonly associated with a fall) in the past 12 months.
5.	The Review sought to examine how effectively health and social care providers are coordinating care for older people and whether providers are communicating and sharing information effectively to support good integration. It did this by: • Looking for examples of good and outstanding care, identifying barriers which prevent older people receiving integrated care and propose actions that national and local providers can take to address poor integrated care for older people. • Requesting information from commissioners which will help to understand the wider context to older people's experience of health and social care at the local level.
6.	The review team comprised two CQC regulatory inspectors and a specialist advisor from community care. They were supported on a number of days by the CQC specialist clinical advisor for older people. They facilitated the focus groups and interviewed and case tracked people at the Luton and Dunstable Hospital. The CQC engagement team made some initial contact with support agencies and hosted a workshop.
7.	During the onsite review CQC inspectors and advisors undertook: • case tracking of 4 people with fractured neck of femur; • case-tracked 20 sets of notes across different care settings including domiciliary care, mental health services, residential care, GP practices and hospitals; • interviewed two GPs, one practice manager and one receptionist. and also spoke with the lead geriatrician at Luton and Dunstable Hospital; • held two focus groups with health care professionals and social care staff to discuss a hypothetical case study; • interviewed staff from the commissioning services within the CCG; • interviewed staff working in health care, residential services, domiciliary care, and staff from the Community Mental Health; • held a separate meeting with strategy leads from all sectors and gave a presentation and heard their feedback about integrated care;

	• made contact with Carers in Bedfordshire and attended the AGM of Age UK Bedfordshire; and • gave a high-level feedback to the key members of the Health and Wellbeing Board.
Patient Feedback	
8.	At the high level feedback, the Inspectors reported that on the whole people were positive about their experience of the different services they encountered following their event. “People told us they were given a choice of hospitals and the treatment they had received had been very good. No concerns were raised about the care people received whilst in hospital.
Building Bridges, Breaking Barriers – National Report	
9.	A national report on the findings of the thematic review across the eight sites was published on 13 July 2016.
	Looking at how services were working together for older people, the national review found that: • There was widespread commitment to delivering integrated care. • There were still many organisational barriers that made it difficult for services to identify older people who were at risk of deterioration or an unplanned emergency admission to hospital. • There were examples of joint working in delivering health and social care, but these were often inconsistent, short-term and reliant on partial or temporary funding and goodwill between different providers. They were not a mainstream part of the way in which services were planned or delivered around older people. • Monitoring and evaluation was often not carried out locally or was insufficient. • The lack of connection between services often resulted in older people and their families or carers needing to take responsibility for navigating complex local services. This could result in people 'falling through the gaps' and only being identified in response to a crisis. • Older people often had multiple care plans because professionals did not routinely link together and share information. • Older people were not routinely involved in decision making about their needs and preferences.

	• Older people and their families or carers did not routinely receive clear information about how their health and social care would be coordinated, in particular if there were changes in their circumstances or if there was an unplanned or emergency admission to hospital. • Local leaders achieved integrated person-centred care by working closely across health and social care services to share information, reduce duplicated efforts and use resources more effectively.
10.	The report summarised that the thematic review reflected the challenge that delivering integrated care represents. That there were still many organisational barriers that it difficult for services to identify older people who were at risk of deterioration or unplanned admission to hospital in a timely manner. This included a lack of consistency in the use of assessments and in the sharing of information.
11.	There were also examples of joint working in the delivery of health and social care. Successful initiatives were set up by local practitioners to encourage and enable joint working. While some were more substantial, many were often short-term or reliant on partial or temporary funding and goodwill between providers. They were not a mainstream part of the way in which services ere planned or delivered around older people.
12.	The CQC review recognised and highlighted as good practice, the valuable contribution of volunteers in the Village Care Schemes, who support more than 720 people through 40 independent 'Good Neighbour' and 'Village Care' Schemes.
Report Recommendations	
13.	The Report recommended that: • Health and social care leaders should develop and agree a shared understanding and definition of what integrated care means for the population in their local area, and then work towards delivering this shared aim. • NHS England and Association of Directors of Adult Social Services (ADASS) should lead on developing an agreed methodology and data set for identifying people at risk of admission to secondary care or deterioration. • Older people should be meaningfully involved in making informed decisions about their care needs and care planning – in particular about the outcomes that are important to them – based on the existing national and local guidance. • Commissioners and providers in an area should ensure that information and support for older people and their families or carers is available, and this sets out connections between services, and how the people's accessibility needs will be met.

	• The National Quality Board, in partnership with the National Information Board, develop and share a set of validated data metrics and outcomes measures for integrated care with person-centred outcomes at the heart of decision making about service provision and based on a consistent, shared view and definition of integration.

Reasons for the Action Proposed	
14.	The Care Quality Commission (CQC) is the independent regulator of health and social care services in England. Its role is to make sure that health and social care services provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements.
15.	Central Bedfordshire Health and Wellbeing Board area is one of eight areas selected based on a review of data about geographic areas, demographic characteristics, and areas where integrated care for older people appears to be good and poor.
16.	The Thematic Review is consistent with the priorities of Joint Health and Wellbeing Strategy for Central Bedfordshire for improving health, wellbeing and reducing health inequalities.
	Conclusion and next steps
17.	The local review highlighted some concerns around hospital discharge arrangements. As Central Bedfordshire does not have a district general hospital within its boundaries, local people use up to eight surrounding hospitals. This requires better care coordination, both for discharge coordination and ensuring timely and good quality community based care. This is one of the key areas of the Better Care Fund (BCF) Plan for Central Bedfordshire and work is going as part of the BCF and the Sustainability and Transformation Plan to put more robust systems in place.
18.	The focus locally is to ensure greater integration of health and care services through more joined up working across the various care professionals. A multidisciplinary approach is being developed. This includes identifying those people who may need care and support early and ensuring that they are supported.
19.	An LGA Peer Review of reablement and rehabilitation services has ben commissioned and will take place in October. This should help to improve the joined up offer for residents of Central Bedfordshire.

Issues	
Governance & Delivery	
20.	The Health and Wellbeing Board oversees the delivery of the Joint Health and Wellbeing Strategy.
Financial	
21.	None identified as part of this report.
Public Sector Equality Duty (PSED)	
22.	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.
23.	Are there any risks issues relating Public Sector Equality Duty **No**
24.	If yes – outline the risks and how these would be mitigated

Source Documents	**Location (including url where possible)**
Building Bridges Breaking Barriers	http://www.cqc.org.uk/buildingbridges

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Presented by Julie Ogley, Director of Social Care, Health & Housing

Appendix

Appendix one: Building Bridges, Breaking Barriers – National Report

Care Quality Commission

Building bridges, breaking barriers

How care is integrated across health and social care and the impact on older people who use services, and their families and carers

JULY 2016

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation.

Caring – treating everyone with dignity and respect.

Integrity – doing the right thing.

Teamwork – learning from each other to be the best we can.

Contents

Foreword

People deserve consistently good care regardless of where they are treated and how complex their needs are.

People with complex needs, and who need care from a range of different services, often say they are very satisfied with the care they receive from each individual care provider. However, given that many of them move between services or care professionals, their care often becomes fragmented. This can have an impact on their experience and their overall care.

When staff from different services talk to each other and share information effectively, people experience better, safer care. When they don't, care can become disjointed and it is ultimately the person receiving care who suffers.

As our older population is growing, it is more important than ever that care systems work together. Older people typically have the most complex care needs and consequently receive care from more than one provider and in multiple settings.

Effective integrated care has been a widespread, national policy ambition and commitment for many years. The Government, in its 2015 Comprehensive Spending Review, re-confirmed this ambition for integration between health and social care services by 2020. While there are many examples of local leaders improving the quality and efficiency of care for people through integration, we still see too much of a gap between the national ambition and the experience of people using services in their local area.

The NHS Five Year Forward View, through its new care models vanguard programme and other national initiatives, provides a significant opportunity to make this ambition a reality.

As one of the few national bodies with an explicit remit across health and adult social care services, CQC has an ability and duty to support this opportunity and use it to develop the way we carry out our own work.

CQC has therefore strengthened its programme of work to look at how well services work together, and started a programme to look at how the way we regulate could respond to new ways of providing care, and how we could assess the overall quality of care in an area.

We have an important contribution to make as the lead agency responsible for the independent assessment of the quality of care across health and social care, and encourage the improvement, innovation and transformation of how care is provided.

We hope this report will help the professionals who are responsible for improving processes and systems for the benefit of people using their services.

David Behan
Chief Executive

Carer's story

"As a family, we experienced first hand just how difficult and stressful it can be to get the right care for a loved one.

When my mother-in-law had a stroke, the initial care she received in a specialist unit was excellent. But when she left hospital and then suffered another stroke, moving my in-laws closer to my husband and I proved to be a mammoth task.

The GP she was under took forever to send her notes, even though it was just a matter of emailing a file. I had to chase and, in the end, beg for information about her medication.

Then the trust she was under refused to give her medication to cover the period in which she was relocating. Her new GP wouldn't prescribe anything for her until she had visited the surgery – madness. We agreed that my mother-in-law would visit the surgery the day after she arrived (very tricky as she finds it extremely hard to move around). As soon as we saw the doctor he said he would have visited her in the home if he had realised how immobile she was!

We have also had problems with information not being passed on. On two occasions when my mother-in-law was taken to hospital by ambulance, the GP was not informed of the incidents or that her medication had changed. I had to call the GP, explain what had happened and discuss the new prescription.

It also fell to me to organise the referral letters from the GP for physiotherapy, speech therapy and her prescriptions. I am not medically minded and I found it very difficult to keep having to ask what I needed to do next. The ringing around took forever and often all I could do was leave messages on answerphones.

I really feel that if my mother-in-law had one person helping us to organise the care that she needed it would have been a much smoother transition.

We are a year on and I feel I have learned so much about the care for elderly people. The help is there, it just needs to be accessed. This is where the difficulty lies.

My mother-in-law is very lucky to have a caring, loving family around her. If she was alone I doubt very much that she would have got the care that she needed."

Daughter-in-law
Older person's carer

Summary

We conducted this thematic review to improve our understanding of how well health and social care and support services work together to meet the needs of older people, and how this affects people's experiences of care.

The review also enabled us to independently assess the current state of integrated care within fieldwork sites, to develop and pilot tools and methods to support future reviews of coordinated care and to inform CQC's approach to the new models of care that are emerging.

We gathered evidence from a range of sources, undertook site visits and spoke with older people and their carers to understand how integration across services affected their experiences of care.

To support providers and commissioners in improving the quality of care for older people, we looked for examples of where care was effectively coordinated and identified barriers that prevent it from working well.

We found many initiatives that aimed to deliver integrated care. We saw some good practice, and in many cases considerable drive from providers and commissioners to improve the way services work together. Yet we did not find many examples of it working really well. There was considerable variation in the care provided and in the experiences and outcomes for older people.

It is challenging to define exactly which integrated care systems are most effective. There seems to be no 'best way' of integrating care – improvements are often focused at multiple levels in the health and social care system and are developed locally rather than nationally.

Across the eight sites we reviewed, our findings related to both how services were working together and the impact this has on older people's experiences. Looking at how services were working together for older people, we found that:

- Reflecting the challenge that delivering integrated care represents, there were still many organisational barriers that made it difficult for services to identify older people who were at risk of deterioration or unplanned admission to hospital in a timely manner. This included a lack of consistency in the use of assessments and in the sharing of information.
- There were examples of joint working in the delivery of health and social care. Successful initiatives were set up by local practitioners to encourage and enable joint working. While some were more substantial (as set out in the good practice examples in this report), many were often short-term or reliant on partial or temporary funding and goodwill between different providers. They were not a mainstream part of the way in which services were planned or delivered around older people.

- Monitoring and evaluation of many of the initiatives in place to improve integration within areas was not carried out locally or was insufficient. The methods used were varied and typically measured the effectiveness of initiatives or interventions rather than the overall system of care in an area.
- There was widespread commitment to delivering integrated care and a belief that it is improving. However, local leaders still struggle to translate this commitment into an understanding for staff about how services work for older people across a local area, and within organisations, and how they can collectively provide integrated care.
- Older people often had multiple care plans as a result of professionals not routinely linking together and sharing information. There was also a widespread lack of knowledge among professionals of how care plans should be written and reviewed.
- The lack of connection between services often resulted in older people and their families or carers needing to take responsibility for navigating complex local services. This could result in people 'falling through the gaps' and only being identified in response to a crisis.
- Older people and their families or carers were not routinely provided with clear information about how their health and social care would be coordinated, in particular in the event of unplanned or emergency admission to hospital or changes in their circumstances.

Substantial progress is still needed to achieve our collective ambition for integrated care across England.

We found that where integrated, person-centred care succeeded, local leaders worked closely across health and social care services to share information, reduce duplicated efforts and use resources more effectively.

Using the opportunities now available through the NHS Five Year Forward View new care models vanguard programme, the Sustainability and Transformation Plans, and other initiatives, we believe other leaders can achieve this ambition too. Based on our findings, we recommend:

Locally, **health and social care leaders** build on the opportunities offered by initiatives such as the NHS Five Year Forward View vanguards and the development of Sustainability and Transformation Plans to develop and agree a shared understanding and definition of what integrated care means for their population in their local area, and then work towards delivering this shared aim.

NHS England and ADASS lead on developing an agreed methodology at a national and local level across health and social care for identifying people who are at risk of admission to secondary care or deterioration, underpinned by a clear data set.

Commissioners and providers meaningfully involve older people in making informed decisions about their care needs and care planning – in particular about the outcomes that are important to them – based on the existing national and local guidance.

Commissioners and providers in an area ensure that information and support for older people and their families or carers is available and that this sets out what details of what services are available, connections between different services, and how the people's accessibility requirements will be met.

The **National Quality Board**, in partnership with the **National Information Board**, develop and share a set of validated data metrics and outcomes measures for integrated care. These should have person-centred outcomes at the heart of decision making about service provision and be based on a consistent, shared view and definition of integration.

Introduction

"Integration across the NHS, public health and social care is a key means to achieving improvement in the quality of services and people's experience of them. An integrated system of leadership is required in order to implement an integrated system of care."

Hard Truths: The Journey to Putting Patients First, Department of Health, January 2014

People in England are living longer, and the number of people aged 65 and over in the UK is projected to rise by over 40% in the next 17 years to nearly 17 million.[1]

Many older people live with multiple long-term health conditions and need to access care from a range of providers (for example, hospitals and care homes).[2] And many have medical conditions that can mean after a hospital stay, different care providers need to be involved in the person's discharge, so that they can return home with support or move to a care home setting.[3]

The Nuffield Trust's latest estimate (for 2015/16) was that two fifths (£46.56 billion) of the NHS budget was spent on people over the age of 65.[4] Local authorities' expenditure on social care for people over the age of 65 was £7.2 billion (2014/15 figures).[5] It is estimated that, by 2018, an additional £5 billion may be required to support the ageing population and increased number of people living with long-term conditions.[6]

As our older population grows and the health and social care system needs to find more efficient ways of delivering care and reduce costs, it is more important than ever to make better use of resources, reduce duplication of effort, and work with people to empower them in their health and social care services.

The Government and health and social care organisations have identified integrated care as a key step in responding to this changing environment.

Numerous organisations, including The King's Fund, have produced reports that demonstrate how integrated care can improve people's experience and outcomes and deliver efficiencies in care.[7]

In addition, integrated care can empower individuals and communities to manage their own health and wellbeing and is central to delivering effective services for people with long-term conditions.[8] However, when it goes wrong, particularly when people are discharged from hospital, the impact can be significant.[9]

Older people are particularly vulnerable when transitioning between different points of care. Addressing the national variation in delayed transitions could help reduce unnecessarily prolonged hospital stays and avoid inappropriate admission to acute inpatient care, long-term

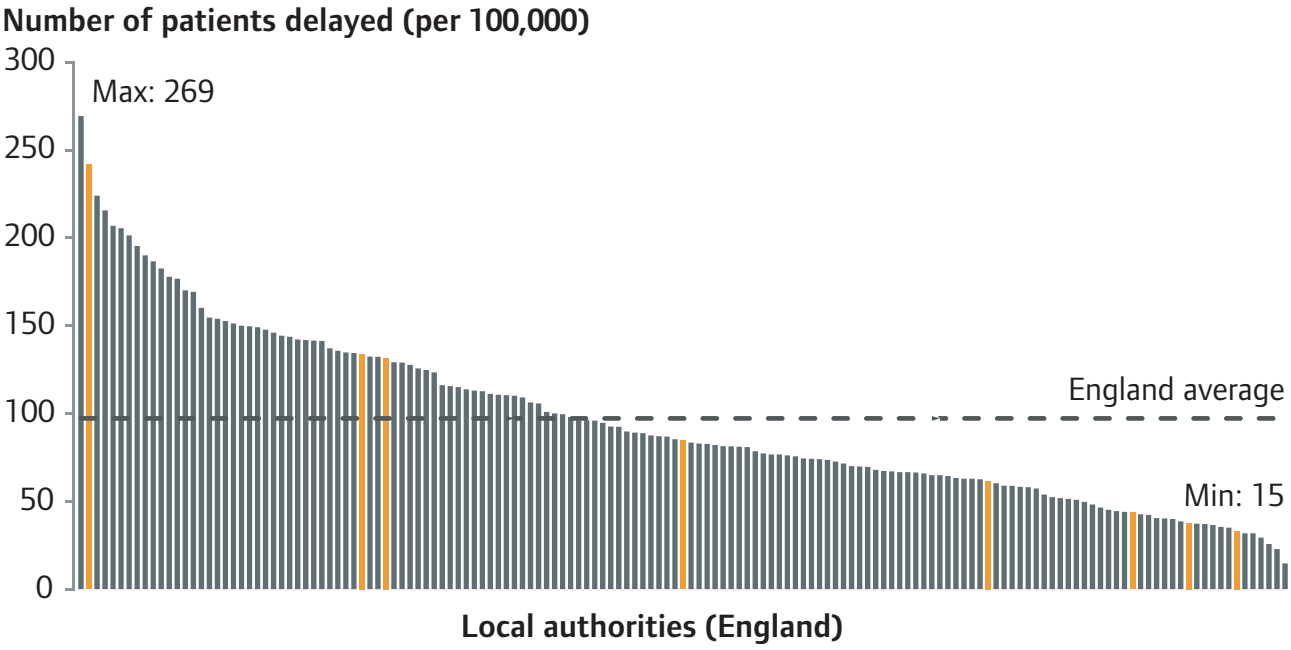
residential care or continuing NHS inpatient care.[10]

There is a need for metrics to be established to monitor and evaluate the performance of integrated care to help identify where things are going well and where improvements are needed. While NHS Five Year Forward View vanguard sites are to publish a suite of data metrics to monitor and assess performance, these metrics are yet to be finalised.[11]

The Better Care Fund[12], which incentivises the NHS and local government to work more closely together, has begun publishing collected metric results that address elements of integrated care, such as delayed transfers of care (DToC). A delayed transfer occurs when a patient is ready and safe to leave hospital care, but is unable to do so. FIGURE 1 highlights the national variation around DToC. Variation in care, particularly for older people, can mean losing muscle condition, and potentially losing the confidence to remain living independently.[13]

Defining integrated care metrics can support benchmarking against peers and monitoring against national trends, improve care coordination and inform regulators, other national agencies and researchers.[14] An example of a currently available metric specific to older people is 'the percentage of people aged 65+ who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation'. In 2014/15 this varied from 65% to 100% across England (FIGURE 2).[15]

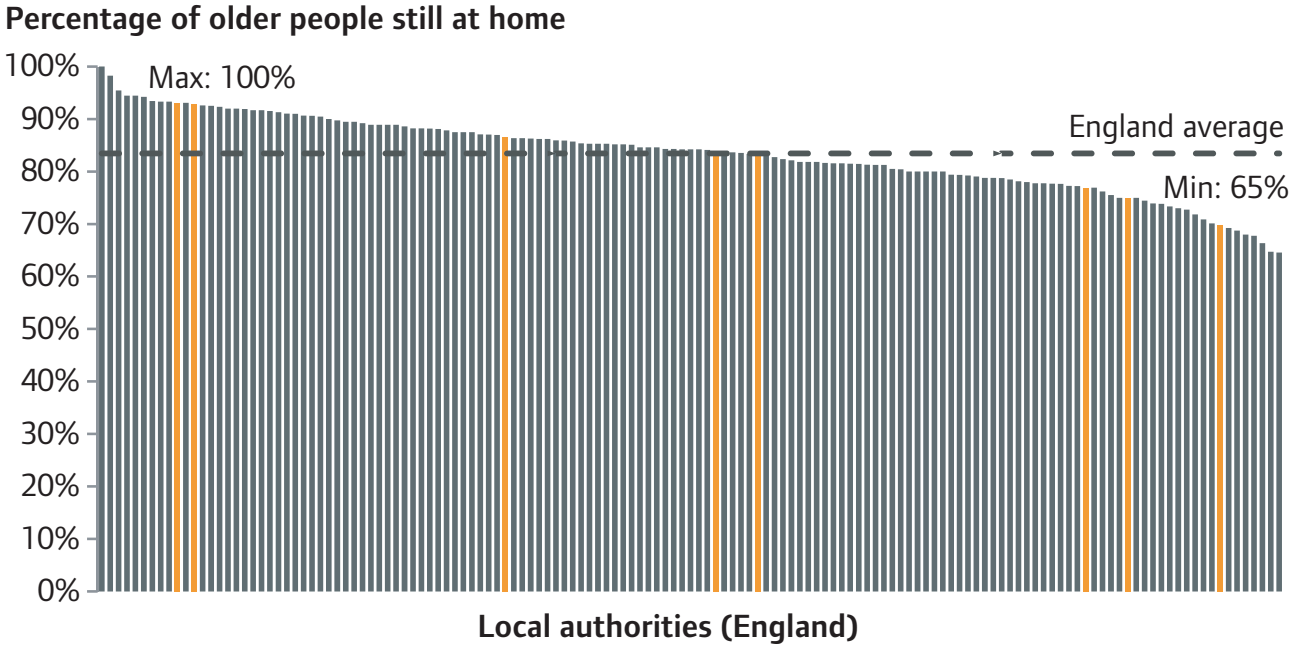
FIGURE 1: THE NUMBER OF PATIENTS WITH DELAYED TRANSFERS OF CARE, BY LOCAL AUTHORITY IN 2015



Note: Yellow shaded columns represent the fieldwork areas visited

Source: NHS England, Delayed Transfers of Care, January to December 2015; population source: Health & Social Care Information Centre (HSCIC) GP registered population, July 2015.

FIGURE 2: THE PROPORTION OF OLDER PEOPLE (65+) WHO WERE STILL AT HOME 91 DAYS AFTER DISCHARGE FROM HOSPITAL INTO REABLEMENT/REHABILITATION SERVICES BY LOCAL AUTHORITY, 2014/15



Note: Yellow shaded columns represent the fieldwork areas visited

Source: Health & Social Care Information Centre (HSCIC) NHS Outcomes framework, 2014/15.

"Integrated care is not about structures, organisations or pathways, nor about the way services are commissioned or funded. It is about individuals and communities having a better experience of care and support, experiencing less inequality and achieving better outcomes."

Integrated Care and Support: Our Shared Commitment, National Collaboration on Integrated Care and Support, May 2013

Despite some improvements, care is still fragmented with unclear lines of referral and communication within and between organisations – a problem that is magnified when people have multiple medical conditions.[16] The NHS Five Year Forward View stresses the need to integrate care: the vanguard programme is developing new models of care, and the Sustainability and Transformation Plans are bringing together local health and social care providers and commissioners. The NHS Five Year Forward View made particular recommendations that new models of care must pay attention to identified barriers and facilitators, and must drive coordinated care forward.

The aim of this review was to independently assess integrated care within the fieldwork areas, build on existing information to better understand older people's experiences of integrated care and add value by:

- Improving our understanding of how well different health and social care and support services work together across systems and pathways to meet older people's needs, and how this affects the quality of care they receive.
- Making recommendations for providers and commissioners to improve the quality of care for older people through delivering coordinated care that focuses on the needs and requirements of the person, at a local and national level.
- Informing CQC's regulatory approach, including how we measure and assess the quality of care across pathways, population

groups, and new models of care that will emerge over the next few years, in line with CQC's strategy.

This review predominantly covered older people with complex needs or co-morbidity. For the purpose of scoping this review, and in recognition that different definitions exist across healthcare, people aged 65 and over were included in the fieldwork, except for case tracking, where the selection criteria was refined to only include those aged 75 and over.

CQC defines integrated care using the definition produced by National Voices and Think Local Act Personal and adopted by the Department of Health in 2013: "I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together services to achieve the outcomes that are important to me."[17]

The supporting 'I statements' were developed further with the needs of older people in mind.[18] We used these publications to inform the development of themes and key lines of enquiry for this thematic review.

"A key test of whether we have got safe, compassionate care right is the care we provide for older people, who can often be the most vulnerable patients, and those most in need of care that is properly joined up and well managed."

Hard Truths: The Journey to Putting Patients First, Department of Health, January 2014

How we carried out the review

We worked with an expert advisory group who provided advice and guidance throughout the review, and with a range of health and social care providers who helped us to understand people's experiences.

We reviewed existing literature, including evidence from our comprehensive inspections, consulted with stakeholders and considered current policy and initiatives relating to integrated care.

We selected eight health and wellbeing board areas to cover different areas and demographic characteristics, as well as a range of providers with differing performance against relevant pathway metrics, such as delayed transfers of care and falls recovery (for example figures 1 and 2). We included some areas that were involved in initiatives to explore new models of care.[19,20]

We developed our approach with external stakeholders and worked with two health and wellbeing board areas during the pilot stage. We used findings from the pilot to refine the draft assessment framework and fieldwork activity.

We carried out the fieldwork for this review between October and December 2015 in the following eight areas:

- Bristol
- Cambridgeshire
- Camden
- Central Bedfordshire
- Hammersmith and Fulham
- Portsmouth
- Stockton-on-Tees
- Wakefield.

Housing, diet, employment, social status and environmental factors all play a part in the lives of older people when providing health and social care to meet their needs. However, details of how these affect older people's health and lifestyle were beyond the remit of this review.

We used a detailed assessment framework to structure interviews and discussions with people, carers and staff during our fieldwork. Our assessment was built around four key questions.

1. **Identification and prevention**
   How are older people with complex needs, or at high risk of deterioration in their health or social situation, identified?

2. **Person-centred assessment and planning**
   Do older people always have a person-centred, holistic assessment that forms the basis of a care plan which meets their physical, emotional, spiritual, social and practical needs, and is the plan regularly reviewed and updated?

3. **Coordination**
   Is care coordinated effectively to ensure that the older person is at the centre of their care – including when they have multiple or complex needs or vulnerabilities?

4. **Recognition and management of change and wellbeing**
   Do services and professionals recognise when the care required for an older person changes and how do they manage this change in an integrated way?

We have presented our findings by the first three key questions. What we found in relation to question 4 was relevant to the other areas of the review. Therefore we have integrated these findings throughout the report.

Each fieldwork team was led by two CQC inspectors, and for the majority of sites was also supported by an Expert by Experience (person with experience of using a particular service or caring for someone who uses a type of service) and a specialist professional advisor (senior clinician or professional who assists in CQC inspections).

We reviewed care records and spoke with people, their carers and the professionals who provide their care. We worked with a range of voluntary and community organisations to gather further feedback from older people and their families or carers. We held focus groups with a range of staff involved in care for older people.

We received feedback from stakeholders including local Healthwatch organisations, Age UK, overview and scrutiny committees and networks of older people, and carers organisations such as Carers UK.

We attempted to determine whether better coordinated services create better outcomes for people. We did this by using nationally available outcome data to develop questions that we asked during our inspections.

We used our Section 48 powers under the Health and Social Care Act 2008 to request information from clinical commissioning groups and local authorities to comment on commissioning.

We worked with others in the health and social care system to identify recommendations for national and local stakeholders based on our evidence.

We also considered findings from other CQC thematic reviews to increase our understanding of common issues:

- 'Quality of care in a place' found that leaders and partners across an area need to recognise their role in system leadership and the benefits of working closely together to achieve an agreed common goal. It also found that there is an ongoing focus to developing a common language across the area, and that partners should continue to monitor whether initiatives are being implemented successfully.
- 'End of life care' highlighted that a coordinated approach can facilitate early identification of people approaching the end of their life, and that effective sharing of information across services is essential for meeting people's needs and preferences.
- The 'Review of dementia care' found that arrangements to share information between care homes and hospitals were not good enough. Often, relevant information was not shared or acted on when people were moved between care homes and hospitals. As a result, their needs were not being met.
- The thematic study of 'People's involvement in their own care' encouraged providers to focus on personalised care plans – written with people, for people, and reflecting their wishes throughout their care journey; sustained and supported involvement of families and carers, and coordination of people's involvement in their care as they move between services.

Findings

Overall, we found that many of the providers across the fieldwork sites were committed to developing and delivering coordinated care.

We found examples of local health and social care professionals working across organisations and putting arrangements in place to make sure that people moving between services receive coordinated care. This included implementing various coordination systems, using integration tools and providing specific services to older, or at-risk, people. The good practice examples provided throughout this report share some of the initiatives we saw.

Where we found poor integration of health and social care, leaders had not created a culture in which the organisations could work together. We found that standardised assessment tools were not used consistently, there was a lack of understanding of how to use care plans, and information was poorly shared across organisations, which left older people and their carers having to navigate the system themselves at times of stress and crisis.

A number of initiatives, strategies and systems offered real opportunity to begin the process of delivering coordinated care in local areas.[21] These approaches actively involved older people and their families or carers. They also included the collection of comprehensive information and ways to share it across providers in a timely manner.

However, the quality and effectiveness of these initiatives and strategies was assessed through local monitoring and some small scale evaluations. The methods were varied and typically measured the effectiveness of initiatives or interventions rather than the overall system of care in an area. Nationally, this poses a question as to how we can assess whether new service models are effective.

For this review we selected areas based on, among other factors, their performance in selected possible integrated care metrics - particularly those that performed notably better or worse against the average.

Retrospectively, we compared how these areas performed across the metrics against the findings from the fieldwork to examine if we could identify measures of integration. Across the sites and metrics there was a mixed picture, with fieldwork findings not in line with the data, which indicated that the metrics chosen were not able to represent what we saw through our fieldwork. At the time this review was undertaken, we also did not see a noticeable difference between sites where new models of care were being piloted and those where they were not. This outcome is not surprising, as the new models of care were still being implemented at the time of the fieldwork.

1. Identification and prevention

KEY FINDINGS

- Reflecting the challenge that delivering integrated care represents, there were still many organisational barriers that made it difficult for services to identify older people who were at risk of deterioration or unplanned admission to hospital in a timely manner. This included a lack of consistency in the use of assessments and in the sharing of information.
- There were examples of joint working in the delivery of health and social care. Successful initiatives were set up by local practitioners to encourage and enable joint working. While some were more substantial, many were often short-term or reliant on partial or temporary funding and goodwill between different providers. They were not a mainstream part of the way in which services were planned or delivered around older people.
- Monitoring and evaluation of many of the initiatives in place to improve integration within areas was not carried out locally or was insufficient. The methods used were varied and typically measured the effectiveness of initiatives or interventions rather than the overall system of care in an area.

"I have had lots of falls and fractures and no follow up. I only get treatment for the fracture. There may be other issues for me as I was weak and there was no plan in place to help this."

(Older person)

There was an overall consensus across providers that they had made improvements to identifying and reviewing people with complex needs, or at high risk of deterioration. Providers told us that the improvements had enabled services to identify people at risk and support them to live in accordance with their wishes, and had helped individuals to move from unplanned to planned care.

However, we did not always find strong evidence to support these beliefs. Although there was some indication that local monitoring and small scale evaluations were undertaken, the methods varied and often measured the effectiveness of specific initiatives or interventions rather than the overall system of care in an area.

Identification and review

There was a mixed picture of how older people with complex needs, or at high risk of deterioration in their health or social care circumstances, were identified. While many providers were proactive in their efforts to identify and review older people at risk, others were more reactive. It is important that professionals and staff in individual services are aware of this when thinking about how they provide care and coordinate services and share information across a local area.

Professionals who took a proactive approach regularly reviewed the needs and wishes of older people. They shared information with each other, and held ongoing discussions in which actions and outcomes were negotiated and agreed between various professionals, older people and their families or carers.

Services that were proactive had a culture of identifying and reviewing people to avoid unplanned emergency admissions and readmissions to hospital.

Similarly, some commissioners told us that they look at the health needs of their local population so that multi-disciplinary teams can identify people at high risk of 'poor outcomes' such as unplanned admission to hospital or moving into long-term care.

GOOD PRACTICE EXAMPLE

The North of England Commissioning Support Unit currently uses a tool known as RAIDR (reporting analysis and intelligence, delivering results) to identify the most vulnerable 2% of people.

It extracts data from secondary and primary care and combines this to determine if someone is at high, medium or low risk of admission to hospital.

RAIDR was developed in collaboration with GPs, integrating previously isolated data sources into a single tool. It is now being used across 40 clinical commissioning groups (a patient population of almost 11 million) to inform decision making.

In contrast, some staff in care homes, and those working in domiciliary care, had a more reactive approach to identifying and responding to risk and complex needs. In these settings, people at risk were generally identified and reviewed when an external health professional (such as a GP or district/community nurse) visited.

Assessment tools

Not all providers routinely used standardised assessment tools for identifying and reviewing older people at risk. However, among those who did, we were concerned by how effective the tools were. The results did not always automatically link to care planning and it was not normal practice for information to always be shared following assessments.

We found a range of practices in place that reflected the different priorities, accountabilities and professional cultures that health and social care professionals in different settings have.

In some cases, providers were aware that a range of assessments were being undertaken in different settings and that they were not compatible with each other or being shared. In others, there was a lack of knowledge as to what additional assessments may have been undertaken in other settings.

It was striking that health and social care professionals reported that information from assessments was not routinely shared and information from other assessments was not always requested. This sometimes resulted in older people having to provide information repeatedly, having multiple tests and assessments and having multiple care plans for different services.

When information was not shared, there was a significant inconvenience to older people and sometimes a cost of duplication. However, most importantly, this also means that there was a risk that decisions about older people's care and support (including medicine and care plans) were sometimes made on the basis of partial or incorrect information.

When older people are identified as being at risk of unplanned hospital admissions or of deterioration in their health, they should be added to GP practice frailty registers. This should trigger information sharing to support coordinated case management and early intervention across the range of relevant health and social care professionals. However, the extent to which this happened varied. In some cases, we were told that this did not always happen or when it did it was not done in a systematic way. Some providers were more connected than others and some tended to rely on more informal means of identification and review.

GPs have a key role in the identification of older people at risk and in the wider healthcare landscape. Therefore, we gathered information from GPs about their views on standardised assessment tools and how they used them. Many GPs reported using the most commonly used standardised assessment tools. However, even among GPs who used these, some had reservations about doing so because they did not know whether they had been formally validated or accredited.

We found that GPs were not using existing standardised assessment tools systematically and that some did not believe the tools were effective or useful and preferred to use their clinical judgement. We also heard that some of the existing tools took too long to implement and were challenging to administer in the time GPs had with patients.

Many GPs in the areas covered by this review had signed up to the Directed Enhanced Services initiative to reduce hospital admissions by identifying the top 2% of the most vulnerable older people. However, where people were identified as being at risk, we found little evidence of meaningful changes for people and none of the people we spoke with knew that they had been identified.

Some GPs commented that the resources they had available to respond to their patients' health issues were insufficient and felt that they did not have enough time to implement tools and undertake care planning in a way that would be meaningful for all of their patients.

GOOD PRACTICE EXAMPLE

North Tees and Hartlepool NHS Trust has assigned 16 beds to a frailty service that takes people from A&E or ambulatory care services.

While people in need of longer-term care go to an elderly care ward, a specialist physician is on call to identify where an alternative to hospital admission could be found. This enhanced assessment makes sure that people are given a diagnosis and their needs are identified, and it enables people to be treated and discharged more quickly.

The aim is for this type of enhanced assessment to eventually be available in the community.

Data sharing

We were concerned that information relating to identifying older people at risk of deterioration or unplanned hospital admission was not routinely shared across local areas.

While funding opportunities significantly improved the way data was collected and shared, staff shortages and lack of effective linkages between staff in different organisations created a considerable barrier. Staff attitudes and a lack of awareness of data sharing tools were also key factors. There were also examples where barriers to sharing information related to information governance, IT incompatibility or concerns over data security and confidentiality.

Where data was not routinely shared between staff and providers, the responsibility for ensuring continuity of care was left to the person or their carer. There is an obvious risk to relying on non-clinical people to relay important information about their medical history, and from the person's perspective it can be very frustrating to be asked the same questions by different clinicians and providers.

"Telling the same story again and again becomes draining and you end up just wanting to get out ASAP. How can a professional come to an appointment without some information?"

(Older person)

GOOD PRACTICE EXAMPLE

Hammersmith and Fulham Clinical Commissioning Group has been working with local providers to develop a new model of care that initially focuses on older people. Communication has been improved between general practices and community services and steps are being made to move to a single clinical record system.

Organisations within the area have also introduced information sharing agreements to support electronic communication and coordination. A multi-million pound IT investment has allowed GPs to share medical records online with hospitals and community services to improve people's care and clinical safety.

GOOD PRACTICE EXAMPLE

Currently, 75% of primary care records and all community health and mental health care records provided by Solent NHS Trust are recorded on one electronic system.

Access to a shared clinical record means that people can be triaged by phone by a professional who has full access to the patient's notes, regardless of where they are registered.

In the future, it will be able to offer electronic referral and discharge processes for practices on the same system. And it will make it quicker and easier for practices to refer, and make sure that discharge notes are fed back directly into a person's own medical records.

The system has also enabled practices to share the provision of weekend clinics.

Working together

We were told of several examples where local and national initiatives had been put in place over many years to develop coordinated working across health and social care providers.

Some examples included coordinated pathways for people with particular conditions (for example, stroke or hip fracture). We were also told of examples relating to people with dementia, and initiatives to tackle loneliness and isolation, where we saw evidence of joint working between hospitals, GPs, specialist community teams and voluntary sector organisations. Such initiatives were enabling multidisciplinary teams to work together to review and plan people's care across multiple organisations. These often involved organisations from the voluntary sector working in partnership.

Initiatives for coordinated care at a local level, through joint working, were often described as disconnected. They were also driven by temporary funding or incentives and by outputs rather than outcomes. Some initiatives also showed little evidence of having been jointly developed and formally evaluated. The evaluations undertaken were not always done in a robust way and were usually focused on specific initiatives or interventions as opposed to measuring the effectiveness of the overall system of care in an area. It also appeared that lessons were not generally learned and evidence was not shared.

Care homes were often able to access information on preventative activities such as falls clinics and balance classes through GPs or a 'single point of access'. However, the information was not always used and some providers were unaware that it existed.

GOOD PRACTICE EXAMPLE

NHS Camden Clinical Commissioning Group has an established 'Frail and Elderly Programme' to help older people in Camden receive responsive and coordinated care.

The programme uses a frailty register to support GP practices to improve how vulnerable frail people in the community are identified. In a year, the number of people on the register increased from 854 to over 1,500.

The action taken in response to those on the frailty register has reduced A&E attendances by 58% and avoidable unplanned admissions by 22%.

GOOD PRACTICE EXAMPLE

Cambridgeshire and Peterborough Clinical Commissioning Group has established a 'Joint Emergency Team' (JET) and 'neighbourhood teams' to support older people.

JET provides a rapid response for people over 65 who need support to access urgent care but do not need to go to hospital. The neighbourhood teams have brought together GP services, acute care and mental health services so that people using adult community services, and patients over 65 years old, have their care delivered by teams working together, rather than being seen separately by each service.

2. Person-centred assessment and planning

KEY FINDINGS

- There was widespread commitment to delivering integrated care and a belief that it is improving. However, local leaders still struggle to translate this commitment into an understanding for staff about how services work for older people across a local area, and within organisations, and how they can collectively provide integrated care.
- Older people often had multiple care plans as a result of professionals not routinely linking together and sharing information. There was also a widespread lack of knowledge among professionals of how care plans should be written and reviewed.

Care plans

"My care plan does make a big difference, without it I would not be getting the help and support I need. My care plan helps me to stay at home. To me the care plan makes all the difference in the world."

(Older person)

To support people with complex needs, care plans are expected to be designed with the person – based on their needs, values, preferences and goals.

Despite the many years that care plans have been in use, we found there was a considerable lack of clarity as to what care plans are; what they should include; when they should be produced and reviewed; and what their purpose is.

Care plans were commonly described as being primarily about what actions health and social care professionals were taking, such as number of visits or descriptions of procedures. It was not the case that plans were always focused on setting out how services and support was being provided to ensure people's goals and preferences were being delivered. They also did not routinely include details of how older people had been involved in developing or reviewing their care plan.

It was common for older people to have multiple care plans, with the type and detail of information varying across plans. In these instances we were concerned that information was not routinely shared with different care providers and in some cases had resulted in conflicting information across the care plans.

Often existing processes or systems in different organisations made it harder for staff to make good use of care plans. Health and social care professionals reported difficulties in producing single coordinated care plans and support. One of the main reasons given for this was the range of IT systems that are used across different providers.

"Professionals should sit around a table to discuss a patient's care plan and have a key document that is available to everyone. This is about health talking to social care but also about health talking to health."

(Older person)

Providers often made decisions about the care plan according to their own priorities, accountabilities and professional cultures, instead of providing people with a coordinated package of care, designed with the person and their carer(s), and aligned to meaningful outcome measures.

Professionals reported spending a lot of time seeking information about people from across different services, which is an inefficient use of resources. For example, there were differences between domiciliary, residential and other

care settings as to whether they saw hospital discharge sheets or letters. Some said they never saw them but those who did said they were often significantly delayed after discharge.

Different types of health and social care providers often had very different ideas about what care planning was and how it should be put into practice.

For example, urgent care services did not always have appropriate details associated with older people and patient notes were not always added to their medical records. Where they were added they were often out of date which made it difficult to develop care plans.

GP care plans also had varied levels of detail and were not seen as an effective document in the wider health and social care system. We also found very little evidence that GPs were sharing care plans with other providers.

GOOD PRACTICE EXAMPLE

'Connecting Care' is an IT system designed to share local care records in Bristol, North Somerset and South Gloucestershire. The project provides clinicians and practitioners with a summary of information about a person which includes:

- the GP record (including contact, diagnoses, medications and allergies)
- contacts with out-of-hours, hospital, community and social care support
- notes from community nurse visits and appointments
- information about end of life wishes.

People's involvement in care planning

The attitudes of health and social care staff towards involving people in decision making appeared to have an impact on the ways in which care plans were developed.

Nationally, just 65% of people aged 65 and over with a care plan, who took part in the 2015 GP patient survey, said they helped to put their written care plan together (a decrease from 66%, for 2014).[a,b] Additionally, the 2015 NHS inpatient survey responses revealed that only 59% of patients of the same age group were 'definitely' as involved as they wanted to be in decisions about their care and treatment, up from 56% in 2014.[c,d]

We found that the delivery of person-centred care and Personal Health Budgets were being promoted in some areas. Personal Health Budgets are funds to support identified health and wellbeing needs, planned and agreed between the person and their local NHS team so that people with long-term conditions and disabilities have greater choice and control over the healthcare and support they receive. However, there was also evidence that some staff were concerned about people being able to make decisions about their care and support, and the associated risks.

a. Calculated by NHS England, **GP Patient survey 2015**, (based on 15,624 responses from people aged 65+ with care plans)

b. Calculated by Picker Institute Europe, NHS England, **GP Patient survey 2014**, GP Patient survey 2014 (based on 9,110 responses from people aged 65+ with care plans)

c. Calculated by CQC, **NHS inpatient survey 2015**, based on 48,594 responses from patients aged 65+)

d. Calculated by Picker Institute Europe, **NHS inpatient survey 2014**, (based on 19,481 responses from patients aged 65+)

"I've recently been sent a care plan from my GP, however it is not simple to understand and not very informative. I would rather have my own input into my own care plan and flag my vulnerabilities, such as my allergy to penicillin, rather than having something that somebody cannot understand if they find me in an emergency"

(Older person)

GOOD PRACTICE EXAMPLE

Central Bedfordshire has a well-established 'Good Neighbour and Village Care Scheme Network'. The Council funds the Bedfordshire Rural Communities Charity to develop and set up new schemes and support existing schemes.

At the time of the review, there were 40 independent schemes, each of which is self-sustaining, run wholly by local volunteers with running costs being met through donations and local fund raising.

Through these schemes, individuals are supported by their local community to maintain their independence and wellbeing and remain in their own home for as long as possible. Types of support include providing transport to older people for hospital appointments, support with shopping and reducing social isolation.

The schemes currently support over 720 residents, using more than 800 volunteers, and typically carry out 3,100 tasks every quarter. They are seen as a real strength and promoted by people and healthcare professionals in the area.

3. Coordination

KEY FINDINGS

- The lack of connection between services often resulted in older people and their families or carers needing to take responsibility for navigating complex local services. This could result in people 'falling through the gaps' and only being identified in response to a crisis.
- Older people and their families or carers were not routinely provided with clear information about how their health and social care would be coordinated, in particular in the event of unplanned or emergency admission to hospital or changes in their circumstances.

Care coordination

We saw examples of coordinated working and were told about clear pathways, referral methods between services, and systems to communicate and share data. However, these were not always perceived to be effective. There was a clear feeling of disconnect between local strategy documents and the reality of what it felt like for people using the services.

We were told that it was often the case that several different teams within an area delivered services with seemingly similar remits (for example re-enablement, falls prevention, rehabilitation and enablement, and rapid intervention). Without coordination and communication, this situation could result in a lack of understanding of how care and support is delivered and who is responsible.

A system that becomes difficult to navigate is likely to result in inefficient use of resources and relies on people or their family or carers, to coordinate care themselves.

In some areas, older people and their carers did not always know about relevant services that were available. It appeared that a lack of information sharing among health and social care professionals often left some older people 'lost in the system' between services.

"A patient had come into hospital as an emergency admission after fracturing their hip. They were known to mental health services because of their dementia but information on their fall/fracture was not passed on. A falls prevention care plan was put in place but not included as part of the discharge record. There was no evidence that information was shared with the community falls team to help identify them as at risk and minimise further falls. They also had a pressure area care plan completed in hospital which was not communicated to their GP on discharge and the pressure area care plan was not shared."

(Provider)

The explanations we were given for poor coordination and integration were often specific to each sector. Staff lacked understanding of other providers and did not appreciate their differing priorities, pressures and accountabilities. People working in primary and social care expressed strong views about the way in which staff in hospitals focused on what they needed to do and did not pay sufficient attention to others. Hospital staff said the same about primary and social care providers.

Leaving hospital

Although we were made aware of initiatives to improve older people's transfer of care from hospital, in practice we saw delays in discharge from hospital, poor information for the receiving provider, and a lack of clarity of who was responsible for facilitating older people's hospital discharge.

Nationally, the NHS acute inpatient survey 2015 found that of respondents aged 65 and over, only 61% felt they 'definitely' received enough support from health or social care professionals to help them recover and manage their condition after leaving hospital.[e]

> **"I didn't even know he was going to be going home so I hadn't brought his clothes for him to go home in."**
>
> (Carer)

As an example, when people's care transferred from hospital to community services (and vice-versa) we were told about a lack of coordination and of different services acknowledging each other's pressures.

A key issue was communication around discharge planning. Some staff felt there was a degree of inconsistency in communication between hospital wards and discharge teams and between hospital teams and social care and community based teams.

Care home and domiciliary care staff told us that they were often not given information that they considered important when a person returned home from hospital. This was sometimes relatively basic, such as a person's weight, but sometimes more critical, such as changes to medication. Some staff reported that they did not automatically receive the information they needed and always had to request it. Others reported that it could be delayed by a significant period. This would result in staff having to make decisions about medication and care without being in possession of up-to-date and comprehensive information about the person, their care needs and their preferences.

Domiciliary care agencies told us that when a person's medication was changed by the GP or hospital, they were often not made aware. GPs said that they had no system in place that would tell them if medication was being administered by a domiciliary care agency, which can pose a serious risk to a person's treatment.

There was a lack of notice and planning around discharge and delayed transfers of care, which could have a significant physical and emotional impact on a person's care, as well as on their family and friends.[22]

Hospital transport was a specific area of concern. People who were ready to go home were often waiting for extended periods to leave hospital and agencies were not always on hand to support the person on discharge, particularly when this had been delayed but not communicated.

This was a particular issue in care homes and domiciliary care during 'out of hours' periods and at weekends when they needed notice and particular information to receive an older person into their care safely. Hospital staff were not always aware of this and did not appear to take responsibility for ensuring that the discharge process extended beyond leaving hospital and returning home or to another care setting.

People's experience of coordination

> **"Once your care plan is established, care is coordinated because everyone knows what is going on. Occasionally there is a blip, but a phone call remedies the problem."**
>
> (Older person)

While we found that particular aspects of a person's care may have a named coordinator – such as a stay in an acute hospital or during the first week or month following a social care placement – the experience of moving between services or using multiple services, as is the case

e. Calculated by CQC, **NHS inpatient survey 2015**, (based on 27,049 responses from patients aged 65+)

for many older people, was generally much more diverse, patchy and confusing.

"I have a lot of health problems and everything has been explained to me, but how do I know that the health professionals communicate with each other about my health problems?"

(Older person)

This often left older people and their family, or carers, to navigate within and across services. It was not uncommon to find examples where people reported that there was no single named person in hospital or in the community who took the lead on their care or transition to other settings. This resulted in people having to repeat themselves or have multiple assessments.

"Every doctor or other person who came to see me asked the same questions."

(Older person)

This was not only inconvenient for people and their carers, but could be dangerous as there is a reliance on people to accurately report their medical history and understand changes to their medication – this could potentially result in life threatening implications and is clearly not a good use of limited resources.

GOOD PRACTICE EXAMPLE

The Integrated Commissioning Unit (ICU) is a joint initiative between Portsmouth City Council and NHS Portsmouth Clinical Commissioning Group.

It aims to deliver efficiencies across departments and improve outcomes for vulnerable adults, children and families in the local area. They commission whole life pathways by joining up services and looking at a wide range of factors that affect health and wellbeing.

Improved outcomes include people being assessed in the right environment at the right time, a significant reduction in complaints and challenges from patients and families, increased efficiency in managing the market across residential, nursing and complex end of life provision and embedding a recovery focused approach across health and social care for people with mental health problems.

GOOD PRACTICE EXAMPLE

NHS Wakefield Clinical Commissioning Group and Wakefield Council, along with other NHS providers and voluntary organisations, are bringing care closer to home in a programme called 'Connecting Care'.

Groups of GP practices are working with a team of community nurses, social care staff, therapists and voluntary organisations to organise services around the needs of the people registered with their practices.

Connecting Care hubs provide a coordinated service for people who are most at risk of becoming ill, such as those with long-term conditions, complex health needs and people who have been in hospital following an emergency or operation.

Early evaluation suggests 'Connecting Care' is proving popular with staff and patients within the system.

GOOD PRACTICE EXAMPLE

Imperial College Healthcare NHS Trust is working in partnership with other health and social care providers in Hammersmith and Fulham to provide the Community Independence Service (CIS).

The CIS provides a single point of referral for older people, preventing them from having to go into hospital, with a rapid response service. It also supports people recovering after a hospital stay, helping them to regain their independence and get better in their own homes.

The service is provided by a team that includes GPs, a social worker, hospital consultant, community matron, nurses and therapists, a health and social care coordinator and a person's case manager.

GOOD PRACTICE EXAMPLE

In April 2015, NHS Camden CCG launched the 'Care Navigation Service'. It is provided by Age UK Camden to support patients in accessing voluntary and community services that help them to self-manage their conditions. It also supports vulnerable people to get the right health and social care to meet their needs.

The service is aimed at patients over the age of 60 who are either frail or identified as being at high risk of becoming frail. Patients may have long-term conditions, had an emergency admission to hospital in the last year, or are not engaging with health and social care services.

Six care navigators offer support with case management, multi-disciplinary team meetings and complex referrals.

In less than a year, the service has received referrals from over 30 practices and has seen almost 600 patients.

The service is highly rated - 83% would recommend the Care Navigation Service to others in their situation. Sixty-six percent of patients felt strongly that the service had helped their carer too.

Recommendations

Integration and coordination is essential to providing safe, effective care. People's experiences and outcomes can be improved through coordinated involvement of multiple professionals across local organisations.

As people become older, they should continue to have meaningful opportunities to participate in decisions about their care. As care typically becomes more complex due to multiple long-term health conditions and the use of multiple providers, it is essential that care is coordinated, structured and delivered to meet people's needs.

We found that integrated, person-centred care works best where local leaders worked closely across health and social care services to share information, reduce duplicated efforts and use resources more effectively. We found that in the areas where we conducted in-depth fieldwork, there was an over reliance on the commitment and enthusiasm of those delivering care rather than looking for ways to support sustainable change at system level.

Using the opportunities now available through the NHS Five Year Forward View new care models vanguard programme, the Sustainability and Transformation Plans and other initiatives, we believe other leaders can achieve this ambition too. Based on our findings, we believe they are most likely to be successful if they follow and implement the recommendations set out in this report.

RECOMMENDATION 1

Locally, **health and social care leaders** build on the opportunities offered by initiatives such as the NHS Five Year Forward View vanguards and the development of Sustainability and Transformation Plans to develop and agree a shared understanding and definition of what integrated care means for their population in their local area, and then work towards delivering this shared aim.

In practice, this means that:

- All health, social care and community based organisations within an area agree and implement a shared language and definition for integrated care.
- Collective and individual leadership in all organisations demonstrates clear ownership and responsibility for integrated care within their area.
- Commissioners and providers address duplication of care plans within the system.
- Commissioners take the lead in supporting emerging new models of care and ensure services in the future are based on a clear understanding of the current and projected population needs and services available.
- Commissioners and providers ensure that innovations are properly evaluated and learning from validated models is shared and, where appropriate, adopted across the system. They will also consider how to evaluate innovations at a national level.
- Information governance policies and procedures for sharing information across local areas are developed and adopted, and all staff understand their responsibilities. Commissioners and providers should give consideration to how information can be shared electronically, particularly about the most vulnerable people.

RECOMMENDATION 2

NHS England and Association of Directors of Adult Social Services (ADASS) lead on developing an agreed methodology at a national and local level across health and social care for identifying people who are at risk of admission to secondary care or deterioration, underpinned by a clear data set.

In practice, this means that:

- NHS England, ADASS, and commissioners and providers across the health and social care sector should develop a consensus to identify people at high risk of admission to secondary care or deterioration. People should be identified by the whole system, rather than by individual providers. Information is shared across organisations and with the person and their carer(s).
- NHS England, ADASS, commissioners and providers make sure that meaningful outcomes are set for people who are identified as being 'high-risk'.

RECOMMENDATION 3

Commissioners and providers meaningfully involve older people in making informed decisions about their care needs and care planning - in particular about the outcomes that are important to them – based on the existing national and local guidance.

In practice, this means that:

- Commissioners and providers develop a shared consensus on the use of person-centred care plans. This should be based on the guidance in the Care Act 2014. Ideally a care plan should be recognised and used by all providers of health and social care, it should aid transition through the system, reduce duplication, inform everyone of emergency action to be taken and be owned by the person and their carers.
- Commissioners and providers make sure that people and their carers are meaningfully involved in, and are able to influence local changes to the system in a measurable way.
- Care plans involve input with the older person (or their family or carer if they do not have capacity). Otherwise they should be described as treatment or management plans.
- CQC will adapt its methodology so that we assess whether national and local guidance is being followed.

RECOMMENDATION 4

Commissioners and providers in an area ensure that information and support for older people and their families or carers is available and that this sets out what details of what services are available, connections between different services, and how the people's accessibility requirements will be met.

In practice, this means that:

- Commissioners ensure that access to services is effective and aids transition through the system, rather than creates delays.
- Commissioners and providers ensure that older people receive appropriate and accessible information and support to allow them to navigate a complex system safely.
- CQC supports innovation to improve coordinated care and the development of new models of care.
- CQC explores transitions of care, including medicines management, in more detail to improve our understanding of its impact on safety.

RECOMMENDATION 5

The **National Quality Board**, in partnership with the **National Information Board**, develop and share a set of validated data metrics and outcomes measures for integrated care. These should have person-centred outcomes at the heart of decision making about service provision and be based on a consistent, shared view and definition of integration.

In practice, this means that:

- Specific performance and outcome measures, to assess the quality and effectiveness of integrated care across an area, are developed and embedded into local processes. These will measure and monitor the impact of integrated care on health and wellbeing outcomes for people. Although integrated care is difficult to measure and evaluate, steps must be taken towards achieving this and learning from national integrated care initiatives must be taken into account.
- The National Information Board data development programme, as part of its strategy for 2020, gives regard to promoting integrated care measurement by:
  - Linking a greater number of datasets to improve our understanding of how integrated care is, and the outcomes that are achieved.
  - Exploring an integrated care survey. This should take into account work being undertaken by CQC in 2016/17 to understand how to survey people's experiences of integrated care.
- CQC, working with NHS Digital, NHS England and vanguard sites, will develop metrics and outcome measures in line with the development and testing of our regulatory and inspection frameworks for providers, local areas and new models of care.

Acknowledgements

We would like to thank Northumbria and West Hertfordshire Health and Wellbeing Boards, who agreed to be pilot sites for this review and the following Health and Wellbeing Board areas that we visited in the review:

- Bristol Health and Wellbeing Board
- Cambridgeshire Health and Wellbeing Board
- Camden Health and Wellbeing Board
- Central Bedfordshire Health and Wellbeing Board
- Hammersmith and Fulham Health and Wellbeing Board
- Portsmouth Health and Wellbeing Board
- Stockton-on-Tees Health and Wellbeing Board
- Wakefield Health and Wellbeing Board.

We are grateful for their support in putting us in touch with people and staff, and for providing case records as well as facilities to enable us to hold focus groups and view records.

We would also like to thank the members of our external advisory group for their support and advice during the review:

Organisations in the external advisory group

- Association of Directors of Adult Social Services (ADASS)
- Age UK
- British Geriatrics Society
- Carers Trust
- Carers UK
- Central and North West London NHS Foundation Trust (CNWL)
- Dementia UK
- Disability Rights UK
- Healthwatch England
- The King's Fund
- The Lesbian and Gay Foundation (LGF)
- Local Government Association
- Marie Curie Cancer Care
- Mind
- Monitor
- National Voices
- NHS England
- NHS Benchmarking Network
- Nuffield Trust
- NW London CCGs (Pioneer Program)
- Picker Institute
- Policy Innovation Research Unit (PIRU)
- Public Health England
- Public Sector Transformation Network
- Race Foundation
- Registered Nursing Home Association
- Salford Royal Foundation Trust
- Salford Royal Infirmary
- Sue Ryder
- The Patients Association
- Think Local Act Personal
- UCL Partners

We are grateful to Age UK Bedfordshire, the 'Aunties Group' of the Angelou Centre in Newcastle, the Older Lesbian, Gay, Bisexual and Trans Association (OLGA), and the attendees of the LGBT Forum York, for organising and attending workshops and focus groups to inform the review.

We received valuable contributions from Age UK, Healthwatch, MindActive, Carers Northumberland, Alzheimer's Society Wakefield and Five Towns, Stroke Association, LiveWell Dementia Hub, Carers Network Westminster Hammersmith & Fulham, and Carers in Bedfordshire.

We would also like to thank the people who were willing to share their stories with us during the review.

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CQC–318–062016

Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Better Care Fund Plan 2016/17
Meeting Date:	19 October 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. **note that Central Bedfordshire's Better Care Fund Plan 2016/17 has received full approval from NHS England;**
2. **note the signing of the Section 75 agreement to create the pooled budget;**
3. **note the Quarter One return on the 2016/17 Better Care Fund Plan to NHS England; and**
4. **note the September 2016 Performance Report.**

Purpose of Report	
1.	To update the Board on the final outcome of the NHS England assurance process for the Better Care Fund Plan 2016/17.
2.	To inform the Board of the sign off of the Section 75 Agreement for the 2016/17 pooled fund.
3.	To be update the Board on the arrangements for managing implementation of the BCF Plan and for monitoring performance current performance against national and local metrics.

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 were 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. 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.
6.	The Health and Wellbeing Board endorsed the 2016/17 plan at their July meeting following its submission in May 2016.
7.	The 2016/17 Quarter One performance return was submitted to NHS England on 9 September (appendix three).
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.	To meet the immediate challenges, within the 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 key schemes are: Out of hospital care; prevention and protecting social services.

Better Care Fund Plan 2016/17	
10.	Central Bedfordshire's BCF Plan 2016/17 was initially "Approved with Support" Following which additional work was undertaken to strengthen areas such as reporting and monitoring in the light of their verbal feedback. As a result of this work, the decision to award full approval to the plan was endorsed by the NHS Executive at their August 18th 2016 meeting.
11.	Central Bedfordshire's Better Care Fund Plan received full approval. Appendix two. A summary of the strengthened reporting framework is set out in Appendix Three.
	Key Delivery Areas and Update
12.	The key delivery areas for the BCF Plan 2016/17 are as follows:
13.	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)
	Section 75 Agreement
14.	The legal framework for the BCF Fund 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.
15.	Section 75 Agreement has now been signed off following full approval for the Plan.
	2016/17 Quarter One Performance
BCF 1 - Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	
16.	Reported as "no improvement in performance". The reduction of non-elective admissions remains challenging. The required target reduction of 1.5% as set out in the Better Care fund Plan was not achieved. The additional projects which were 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.

BCF2 – Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	
17.	Reported as - "on track for improved performance, but not to meet full target" Although on track for improved performance, the target for this measure is not likely to be met. Frailty and dementia remain the most common diagnosis for admissions. .Since April 2015, there were 153 new placements into residential and nursing care against a target of 106. Packages of care are being scrutinised through a panel process to ensure that all alternatives have been explored and that the focus remains on helping people to remain in their own homes. Work is on going to improve hospital discharge coordination and reduce reliance on residential care. Crisis prevention plans with carers are also being put in place. The Council's development of more independent living (extra care) accommodation will help to mitigate admissions into residential care.
BCF3 – Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	
18.	Reported as - On track for improved performance, but not to meet full target. This remains a challenging target.
BCF4 – Delayed transfers of care (delayed days) from hospital per 100,000 population	
19.	Reported as - On track for improved performance, but not to meet full target. The local action plan for DTOCs should help to secure some improvements in this measure. A key project for our BCF is to reduce DTOCs. A number of initiatives like discharge to assess and seven day services in the care provider market should impact on this as well.
BCF5 – Patient/Service user experience	
20.	Patient satisfaction is reported as "on track for improved performance, but not to meet full target" No single measure of integrated care is currently available for this metric on patient / service user experience. The GP patient Survey and other local measures are used to give an indication of patient/service user experience of care. The proportion of people who reported being satisfied with the support they received for managing their Long-term Conditions, in the last six months, improved marginally to 63% in July 2016 compared to 61% in January. Ninety two percent of those who completed the Adult Social Care Survey reported that they were extremely or quite satisfied with the care and support services they received.

	Demand for disabled facilities grant remains high with over £3million of works in progress at the end of Q1. 122 adaptations were completed in Q1, 44 of which were for level access shower/wet room, 24 for access alterations (doors and ramps, etc) and 15 for stair lifts. Despite this high demand, the time taken from referral to DFG approval remains good. Customer satisfaction is up on the 2015/16 outturn.
BCF6 – Rate of emergency admissions for injuries due to falls in persons aged 65+ per 100,000 population	
21.	Reported as "on track for improved performance, but not to meet full target". This is a local measure within the Better Care Fund Plan and is reported annually. The overall outturn for 2014/15 showed an increase in the number of injuries due to falls for people aged 65 and over, although still lower than the England average. In order to incrementally monitor improvements, a number of local measures are also being monitored. The CCG monitors the number of injuries due to falls in people aged 65 and over. In quarter one there were 251 reported injuries across four hospitals. Referrals into the Urgent Homes and Falls Response Service increased in quarter one. The proportion of people remaining self caring improved from 77% at the end of last quarter to 85% in this first quarter of 2016/17. The number of people requiring no further intervention also increased. Improving the Falls Service is one of the key projects of the BCF Plan for 2016/17. Improvements will continue to be monitored by the BCF Commissioning Board.
22.	The Quarter one performance return is attached as Appendix two.
23.	A more detailed breakdown of current performance is provided in the September BCF Performance Report, Appendix four.
	Financial Update Quarter One Income and Expenditure
24.	The profile of the expenditure has been aligned to operational plans and after the first quarter the income and expenditure actuals are in line with those plans.

Reasons for the Action Proposed	
25.	The Better Care Fund Planning Guidance required that the Plan was signed off by the Health and Wellbeing Board itself and by the constituent Council and Clinical Commissioning Group.

26.	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.
27.	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.
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.
	Conclusion and Next Steps
29.	Although achieving the set targets for the supporting metrics remains challenging, there is evidence of improvements in some areas. Mobilisation of the BCF projects has commenced. There is increased uptake of services with more referrals are being made to the Urgent Homes and Falls Response service and the proportion of people remaining self caring improved with fewer people requiring further interventions. Improvements will continue to be monitored by the BCF Commissioning Board.
Issues	
Governance & Delivery	
30.	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.
31.	A review of the role of the BCF Commissioning Board is underway with the intention to create an Integration and Transformation Board. The new Board consolidates the work of the BCF Commissioning Board and the Joint Strategic Commissioning Group. It will continue to have oversight of the BCF delivery on behalf of the Health and Wellbeing Board.
Financial	
32.	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)	
33.	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.
34.	Are there any risks issues relating Public Sector Equality Duty **No**

Source Documents	**Location (including url where possible)**
BCF Plan 2016/17	http://www.centralbedfordshire.gov.uk/health-social-care/better-care-fund/plan-2016-17.aspx

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

Appendices:

Appendix 1 - BCF 2016/17 Q1 return
Appendix 2 - Approval Letter
Appendix 3 - BCF Reporting Framework
Appendix 4 - Performance and Finance Report Quarter One

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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 9th September 2016.

The BCF Q1 Data Collection

This Excel data collection template for Q1 2016-17 focuses on budget arrangements, the national conditions, 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 8 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 BCF Policy Framework 16-17 and BCF planning guidance.
4) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
5) Supporting Metrics - this tracks performance against the two national metrics, a DTOC metric, a Non-Elective Admissions metric, locally set metric and locally defined patient experience metric in BCF plans.

6) Additional Measures - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care.
7) 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 7 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This section requires the Health & Wellbeing Board to confirm if funds have been pooled via a Section 75 agreement. Please answer as at the time of completion.

Have the funds been pooled via a s.75 pooled budget?
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 eight national conditions detailed in the Better Care Fund Policy Framework 16/17 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf) and Better Care Fund Planning Guidance 16/17 (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/) have been met through the delivery of your plan. Please answer as at the time of completion.

It sets out the eight 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 estimated date when condition will be met, 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:

Planned income into the pooled fund for each quarter of the 2016-17 financial year
Forecasted income into the pooled fund for each quarter of the 2016-17 financial year
Actual income into the pooled fund in Q1 2016-17
Planned expenditure from the pooled fund for each quarter of the 2016-17 financial year
Forecasted expenditure from the pooled fund for each quarter of the 2016-17 financial year
Actual expenditure from the pooled fund in Q1 2016-17

Figures should reflect the position by the end of each quarter. It is expected that the total planned income and planned expenditure figures for 2016-17 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) Supporting Metrics

This tab tracks performance against the two national supporting metrics, a Delayed Transfers of Care metric, a Non-Elective Admissions metric, 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 six metrics for Q1 2016-17
Commentary on progress against each 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.

6) Additional Measures

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/Q4 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.

7) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress, reflecting on performance in Q1 16/17.

Better Care Fund Template Q1 2016/17

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

Have funds been pooled via a S.75 pooled budget? If no, date provided?
Yes

3. National Conditions

			7 day services		
	1) Are the plans still jointly agreed?	2) Maintain provision of social care services	3i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	3ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	4i) Is the NHS Number being used as the consistent identifier for health and social care services?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	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 quarter (in-line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes	Yes

4. I&E (2 parts)

		Q1 2016/17	Q2 2016/17	Q3 2016/17
Income to	Plan	Yes	Yes	Yes
	Forecast	Yes	Yes	Yes
	Actual	Yes		
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Expenditure From	Plan	Yes	Yes	Yes
	Forecast	Yes	Yes	Yes
	Actual	Yes		
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Commentary on progress against financial plan:		Yes		

5. Supporting Metrics

		Please provide an update on indicative progress against the metric?	Commentary on progress
	NEA	Yes	Yes
	DTOC	Yes	Yes
	Local performance metric	Yes	Yes
	If no metric, please specify	Please provide an update on indicative progress against the metric?	Commentary on progress
Patient experience metric	Yes	Yes	Yes
	Admissions to residential care	Yes	Yes
	Reablement	Yes	Yes

6. Additional Measures

	GP	Hospital	Social Care	Community	Mental health
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
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

	To GP	To Hospital	To Social Care	To Community	To Mental health
From GP	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health
Progress status	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	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

7. Narrative

Brief Narrative	Yes

Data sharing			
4ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	4iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	4iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	5) Is there 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
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes

Q4 2016/17
Yes
Yes

Yes
Yes

Specialised palliative
Yes
Yes

To Specialised palliative
Yes
Yes
Yes
Yes
Yes
Yes

Specialised palliative
Yes
No

Cover

Q1 2016/17

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; and

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	2
3. National Conditions	36
4. I&E	21
5. Supporting Metrics	13
6. Additional Measures	61
7. 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 the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

National Conditions

Selected Health and Well Being Board: Central Bedfordshire

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight 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 this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes		
2) Maintain provision of social care services	Yes		
3) In respect of 7 Day Services - please confirm:			
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes		
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	Yes		
4) In respect of Data Sharing - please confirm:			
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes		
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	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes		
7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight 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 Review, 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, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. 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. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also 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) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

• To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
• To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

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

The appropriate and lawful 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 consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
• confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
• ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

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 named care coordinator, 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 care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

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

Selected Health and Well Being Board: Central Bedfordshire

Income

Q1 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Total BCF pooled budget for 2016-17 (Rounded)
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	£5,133,482	£5,133,482	£5,133,482	£5,133,482	£20,533,928	£20,533,930
	Forecast	£5,133,482	£5,133,482	£5,133,482	£5,133,482	£20,533,928	
	Actual*	£5,133,482					

Please comment if one of the following applies: - There is a difference between the planned / forecasted annual totals and the pooled fund - The Q1 actual differs from the Q1 plan and / or Q1 forecast	There is no difference between planned and forecasted annual totals and the pooled fund.

Expenditure

Q1 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Total BCF pooled budget for 2016-17 (Rounded)
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	£4,735,483	£4,735,483	£5,060,482	£6,002,482	£20,533,930	£20,533,930
	Forecast	£4,735,483	£4,735,483	£5,060,482	£6,002,482	£20,533,930	
	Actual*	£4,735,483					

Please comment if one of the following applies: - There is a difference between the planned / forecasted annual totals and the pooled fund - The Q1 actual differs from the Q1 plan and / or Q1 forecast	

Commentary on progress against financial plan:	The profile of the expenditure has been aligned to our operational plans and after the first quarter the income and expenditure actuals are in line with those plans

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 and has been rounded to the nearest whole number.

National and locally defined metrics

Selected Health and Well Being Board:	Central Bedfordshire

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Reducing non elective admissions remains a major challenge. There was a marginal increase in the number of admissions in quarter one which makes the target more challenging. The system as a whole is focused on this and our BCF projects which are being mobilised should mitigate this increasing trend.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	The local action plan for DTOCs should help to secure some improvements in this measure. A key project for our BCF is to reduce DTOCs. A number of initatives like discharge to assess and seven day services in the care provider market should impact on this as well.

Local performance metric as described in your approved BCF plan	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:	The rate of admissions due to falls is an annual measure and an area of focus within the Better Care Fund. In order to incrementally monitor improvements, a number of local measures are also being monitored. The CCG monitors the number of injuries due to falls in people aged 65 and over. In quarter one there were 251 reported injuries across four hospitals. Referrals into the Urgent Homes and Falls Response Service increased in quarter

Local defined patient experience metric as described in your approved BCF plan	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?	On track for improved performance, but not to meet full target
Commentary on progress:	The proportion of people who reported being satisfied with the support they received for managing their Long-term Conditions improved slightly from 61% in January 2016 to 63% in July 2016.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
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.

Additional Measures

Selected Health and Well Being Board: Central Bedfordshire

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: 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 Measure: 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 Measure: 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

Other Measures: Measures (4-5)

4. Proposed Measure: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	22
Rate per 100,000 population	8

Number of new PHBs put in place during the quarter	2
Number of existing PHBs stopped during the quarter	2
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	100%

Population (Mid 2016)	277,271

5. Proposed Measure: 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 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Q4 15/16 population figures onwards have 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	31,575

Please provide a brief narrative on overall progress, reflecting on performance in Q1 16/17. Please also make reference to performance across any other relevant areas that are not directly reported on within this template.

Since receiving full approval for our BCF Plan, the S75 agreement has been signed off.

Although achieving the set targets for the supporting metrics remains challenging, there is evidence of improvements in some areas. A Project for improving the Falls Service has been mobilised as part of the BCF Plan for 2016/17. More referrals are being made to the Urgent Homes and Falls Response service and the proportion of people remaining self caring improved with fewer people requiring further interventions. Improvements will continue to be monitored by the BCF Commissioning Board.

Demand for disabled facilities grant is high with over £3million of works in progress at the end of Q1.

Work on developing a digital integrated care record is being taken forward as part of the STP digitisation programme.
Multidsciplinary working is being mobilised. Although there are currently no integrated care teams, some collaborative MDT working is ongoing across two of our localities in Central Bedfordshire and a locality wide collaborative team approach across social care, primary care, community health services, mental health and the voluntary sector is due to go live in the autumn.

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London,
SE1 6LH
E-mail: Andrew.ridley1@nhs.net

To: *(by email)*

Councillor Cllr Maurice Jones, Chair Central Bedfordshire Health and Wellbeing Board
Richard Carr, Chief Executive,
Central Bedfordshire Council
Matthew Tait, Accountable Officer, NHS Bedfordshire Clinical Commissioning Group

22 August 2016

Dear colleagues

BETTER CARE FUND 2016-17

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance. We know that the BCF has again presented challenges in preparing plans at pace and we are grateful for your commitment in providing your agreed plan. As you will be aware the Spending Review in November 2015, reaffirmed the Government's commitment to the integration of health and social care and the continuation of the BCF itself.

I am delighted to let you know that, following the regional assurance process, your plan has been classified as '**Approved**'. Essentially, your plan meets all requirements and the focus should now be on delivery.

Your BCF funding can therefore now be released subject to the funding being used in accordance with your final approved plan, which has demonstrated compliance with the conditions set out in the BCF policy framework for 2016-17 and the BCF planning guidance for 2016-17, and which include the funding being transferred into pooled funds under a section 75 agreement.

These conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These sections allow NHS England to make payment of the BCF funding subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG in your Health and Wellbeing Board area as to the use of the funding.

You should now progress with your plans for implementation. Ongoing support and oversight with your BCF plan will be led by your local Better Care Manager.

Once again, thank you for your work and best wishes with implementation and delivery.

Yours sincerely,

Andrew Ridley
Regional Director, South of England, and SRO for the Better Care Fund

NHS England

Copy (by email) to:

Julie Ogley, Director of Social Care, Health and Housing,
Central Bedfordshire Council
Patricia Coker, Head of Partnerships and Performance
Social Care, Health and Housing, Central Bedfordshire Council
Attu Assan, Interim Director of Strategic Delivery
NHS England – Midlands & East (East)
Anthony Kealy, Programme Director, Better Care Support Team, NHS England

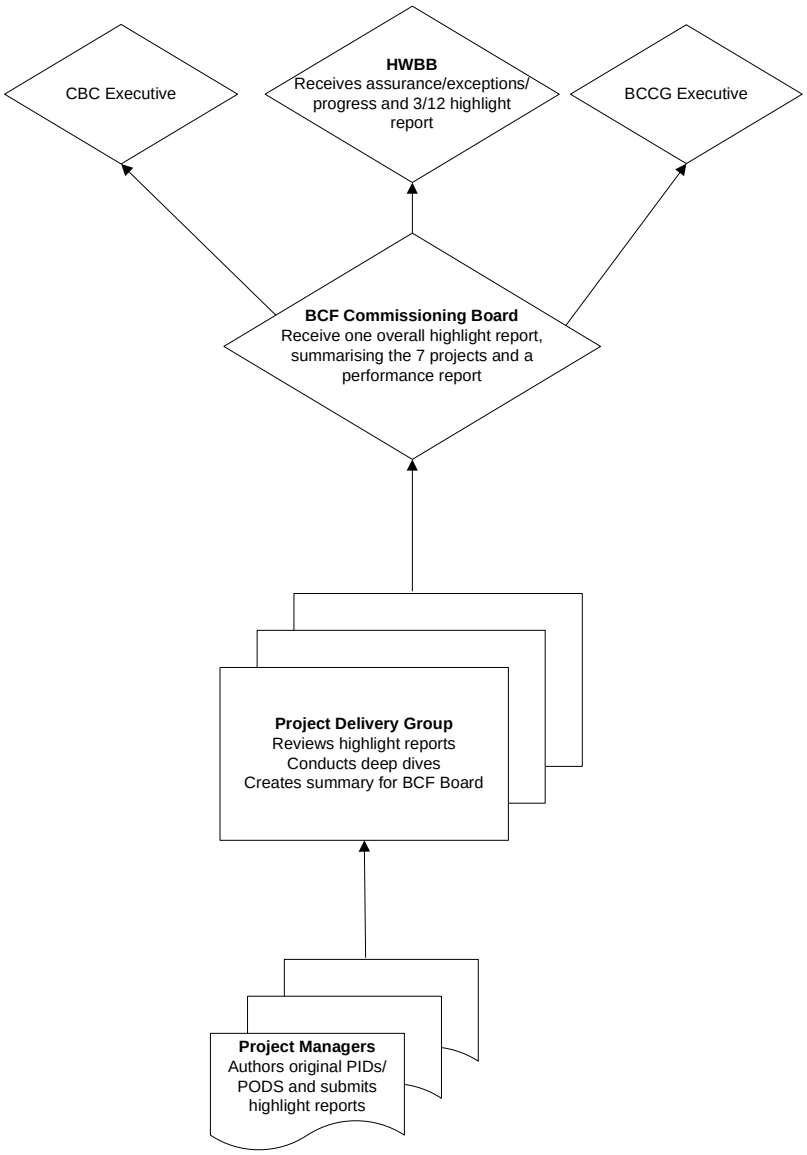
Appendix 3 - Central Bedfordshire Better Care Fund 2016/17 Reporting Framework

Background:

During 2015/16, the BCF Project Delivery Group received regular highlight reports from key areas of the BCF Programme, together with monthly Performance Reports detailing performance against the six BCF metrics. These items were then escalated to the BCF Commissioning Board with any quarterly submissions to NHS England also forming part of the quarterly report to the Central Bedfordshire Health and Wellbeing Board.

2016/17 Reporting Framework:

The reporting structure agreed for 2016/17 is similar in nature to that described above but gives clearer focus to who needs to see the operational data and who needs to review high level information in order to make strategic decisions. The framework also shows the links between BCF structures, the Health and Wellbeing Boards and the wider governance structures of CBC and BCCG.



The reporting framework will begin with each of the seven projects confirming their **project lead/manager.** This lead/PM will be responsible for the production of the initial PID/POD and the monthly highlight reports.

The **Project Delivery Group** will receive the seven highlight reports and, as a result of discussions at this level, will produce a summary highlight report covering all seven projects. It will operate a rolling programme of 'deep dives' into the seven projects, inviting the **lead/PM** to present an update and outline of issues/achievements/risks to the group.

The summary highlight report will be presented to the **BCF Commissioning Board** together with the BCF Performance Report to offer assurance of satisfactory progress or highlight exceptions and risks. This information can also be used, when required, to offer assurance to the Executive Committees of both CBC and BCCG

The Chair and Vice Chair of the **BCF Commissioning Board** will produce quarterly update reports to the Health and Wellbeing Board which will contain a robust narrative that adds context to performance data; highlights quarterly progress and gives guidance on when the impact of BCF initiatives is likely to be demonstrable.

The 2016/17 Highlight Report Template:

The highlight report template has been enhanced to give a clearer indication of the level and type of detail required from the Project Managers/Leads. For example, the progress update section now gives the prompts *'What have been the key achievements this month? What impact has it had? What will be the key focus for the next month?'* – requiring the PM to not just describe what has happened (e.g. three training sessions delivered covering 60 staff) but to focus on why this is important, what impact will it have, how will that enhance patient/customer care etc. It also asks the author to look ahead to the next month so that the reviewing committees can see month on month progression towards the end goal. A section on links to BCF metrics has also been added; this complements the structure of the BOSCARD templates for each project which also links the projects to BCF metrics and national conditions allowing the Board to anticipate the impact of a project's progress on the overall performance metrics. Finally, a section on dependencies and links to other initiatives is included in the 2016/17 template; this recognises that some projects may be aligned to and consequently also being monitored under QIPP structures, have links to the CQUIN agenda or form part of local authority efficiencies. This approach acknowledges that success or failure of projects has a reach beyond the BCF agenda.

A copy of the highlight report is embedded below:

3.2 Blank highlight report v2.xlsx

Agreed schedule of Deep Dives:

During 2016/17, Central Bedfordshire will operate a rolling programme of 'deep dives' into the seven projects, inviting the project lead/PM to present an update and outline of progress to the group.

The purpose of these deep dives is to allow the Project Lead/PM to take the group through progress to date/successes/exceptions/ areas where they may need the members of the group to help unblock barriers etc. It offers project leads access to a group of health and social care colleagues and allows the group to learn more about the projects and see them 'brought to life' via presentation rather than just monthly highlight reports. The Project Delivery Group can then take an informed decision about which achievements and exceptions/risks need escalating to the BCF Commissioning Board.

NHS Bedfordshire Clinical Commissioning Group

Central Bedfordshire

Central Bedfordshire Better Care Fund

Performance and Finance Report Quarter One

September 2016 for the period up to June 2016

Contents

Performance Summary

Ref	Indicator	2016-17 Target (to date)	2016-17 (to date)	RAG rating and trend
BCF 1	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	2284	2401	**R ⇧**
BCF 2	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	121.2	86.6	**G ⇧**
BCF 3	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	95.5%	86%	**R ⇩**
BCF 4	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	372.6	411.3	**R⇩**
BCF 5	Customer/Patient Experience	65.6	62.7	**R ⇩**
BCF 6	Rate of emergency admissions for injuries due to falls in persons aged 65+ per 100,000 population	1,686.4	n/a	n/a

Key:

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

From June 2016 onwards, an updated population figure, provided by NHS England has been used to calculate the rate per 100,000 population. This may influence some of the measures. The revised population is set at 277, 271, up from 272,985.

Finance Summary

The pooled funds have been created via the signing of a S75 agreement between the CGG and CBC.

Income:

Q1 2016/17 Amended Data:

		Q1 2016/17
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	£5,133,482
	Forecast	£5,133,482
	Actual*	£5,133,482

Expenditure:

Q1 2016/17 Amended Data:

		Q1 2016/17
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	£4,735,483
	Forecast	£4,735,483
	Actual*	£4,735,483

The profile of the expenditure has been aligned to our operational plans and after the first quarter the income and expenditure actuals are in line with those plans

Key Messages

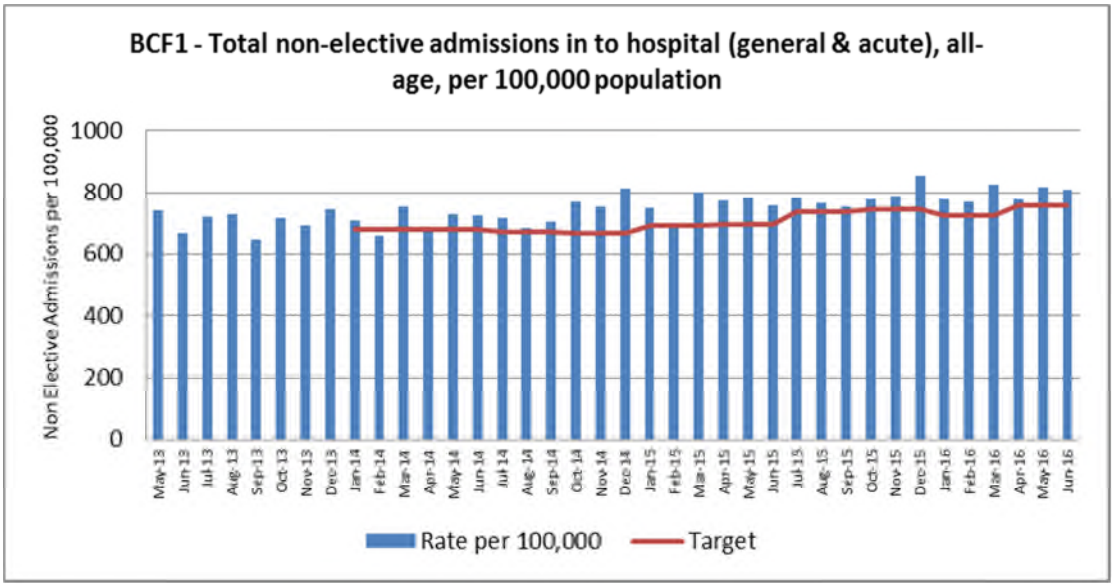
REF	Summary Position	Mitigation Actions
BCF 1	No improvement in performance.The reduction of non-elective admissions remains challenging although there was a slight improvement in Q1 of 2016/17 compared to Q4 of 2015/16.	Additional projects which were mobilised as part of the 2015/16 BCF Plan around 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 continues as part of the BCF 2016/17. More links will be made with the work of the A&E Boards and actions arising from Systems Resilience Groups. Further work will be carried out to understand patient flows.
BCF 2	On track for improved performance, although the target for this measure is not likely to be met. Frailty and dementia remain the most common diagnosis for admissions. Since April 2015, there were 153 new placements into residential and nursing care against a target of 106. Packages of care are being scrutinised through a panel process to ensure that all alternatives have been explored and that the focus remains on helping people to remain in their own homes.	Work is on going to improve hospital discharge coordination and reduce reliance on residential care. Crisis prevention plans with carers are also being put in place. The Council's development of more independent living (extra care) accommodation will help to mitigate admissions into residential care. 165 Independent Living Schemes have come on stream. The Council remains focused on diverting people into more independent living schemes. Investment into reablement, DFG and the Urgent Homes and Falls Response Service is helping to keep people at home. Further work to understand what would stop people being readmitted will be undertaken.
BCF 3	On track for improved performance, but not to meet full target. This remains a challenging target. Data completeness is also challenging.	Work to address data completeness issues is ongoing.
BCF 4	On track for improved performance, but not to meet full target. In Quarter one, there were a total of 893 days for delayed transfers of care across Central Bedfordshire. 598 NHS Days were attributed to the NHS, 123 days were attributed to Social Care Days and 172 Days were jointly agreed as Both NHS & Social Care.	The local action plan for DTOCs should help to secure some improvements in this measure. A key project for our BCF is to reduce DTOCs. A number of initiatives like discharge to assess and seven day services in the care provider market should impact on this as well.
BCF 5	On track for improved performance, but not to meet full	Locality offices are working closely with GP practices to address the issues

REF	Summary Position	Mitigation Actions
	target. The proportion of people who reported being satisfied with the support they received for managing their Long-term Conditions, in the last six months, improved marginally to 63% in July 2016 compared to 61% in January. Ninety two percent of those who completed the Adult Social Care Survey reported that they were extremely or quite satisfied with the care and support services they received. Despite high demand, the time taken from referral to DFG approval remains good. Customer satisfaction is up on the 2015/16 outturn.	raised by the results.
BCF 6	On track for improved performance, but not to meet full target. This is an annual measure, however the CCG monitors the number of injuries due to falls in people aged 65 and over. In quarter one there were 251 reported injuries across four hospitals. Referrals into the Urgent Homes and Falls Response Service increased in quarter one. The proportion of people remaining self caring improved from 77% at the end of last quarter to 85% in this first quarter of 2016/17 The overall outturn for 2014/15 showed an increase in the number of injuries due to falls for people aged 65 and over, although still lower than the England average. .	In order to incrementally monitor improvements, a number of local measures are also being monitored. Falls prevention is one of the key projects for the BCF Plan. A soft launch of the facture liaison service will commence in 2016/17. It will raise awareness within primary care about the need for people 50 and over with a fagillity fracture to be assessed and offered appropriate intervention. Falls prevention training in Care Homes is progressing. 91% (31/34) of CBC Care Homes have attended training. 65% have identified a falls champion. UHFRS now provide in-reach into care homes to prevent falls.

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

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

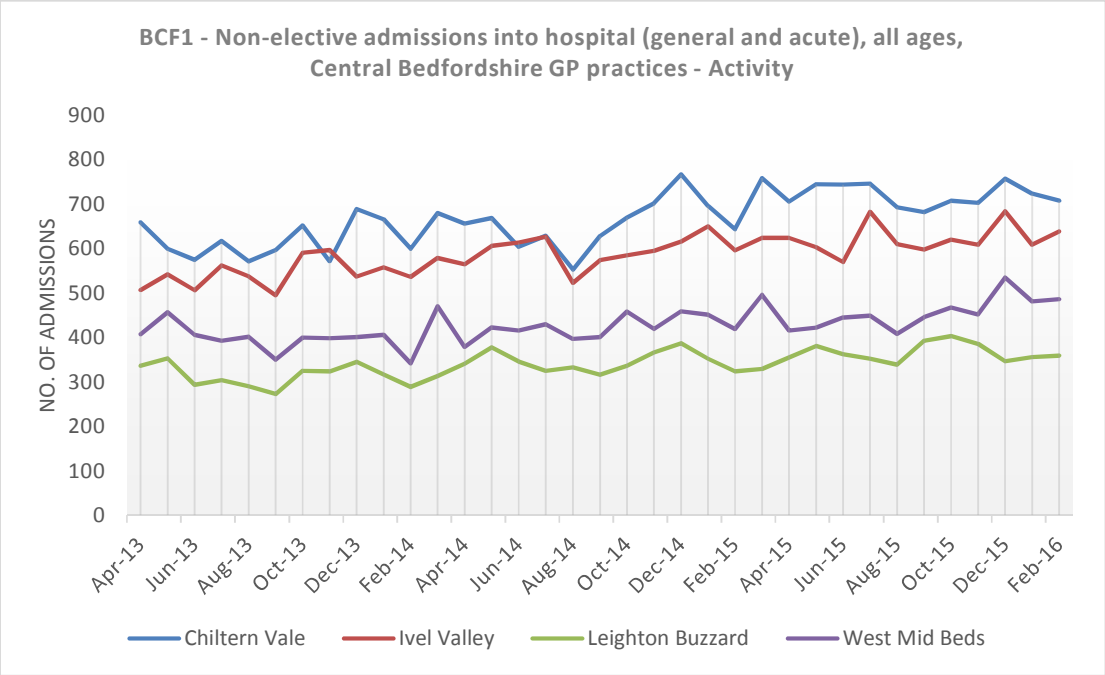
			Current Performance		
Baseline rate (Jan – Dec 14 planned)	Jan – Mar 14	2,040	2,125		
	Apr – Jun 14	2,048	2,143		
	Jul – Sep 14	2,012	2,108		
	Oct – Dec 14	2,011	2,340	Current RAG rating and trend	R ⇧
Pay for Performance Target (Jan – Dec 15)	Jan – Mar 15	2,077	2,240		
	Apr – Jun 15	2,090	2,315		
	Jul – Sep 15	2,213	2,312		
	Oct – Dec 15	2,241	2,422		
Pay for Performance Target (Jan – Dec 16)	Jan – Mar 16	2,179	2,380		
	Apr – Jun 16	2,284	2,401		
	Jul – Sep 16	2,309			
	Oct – Dec 16	2,309			
	Jan – Mar 17	2,227			



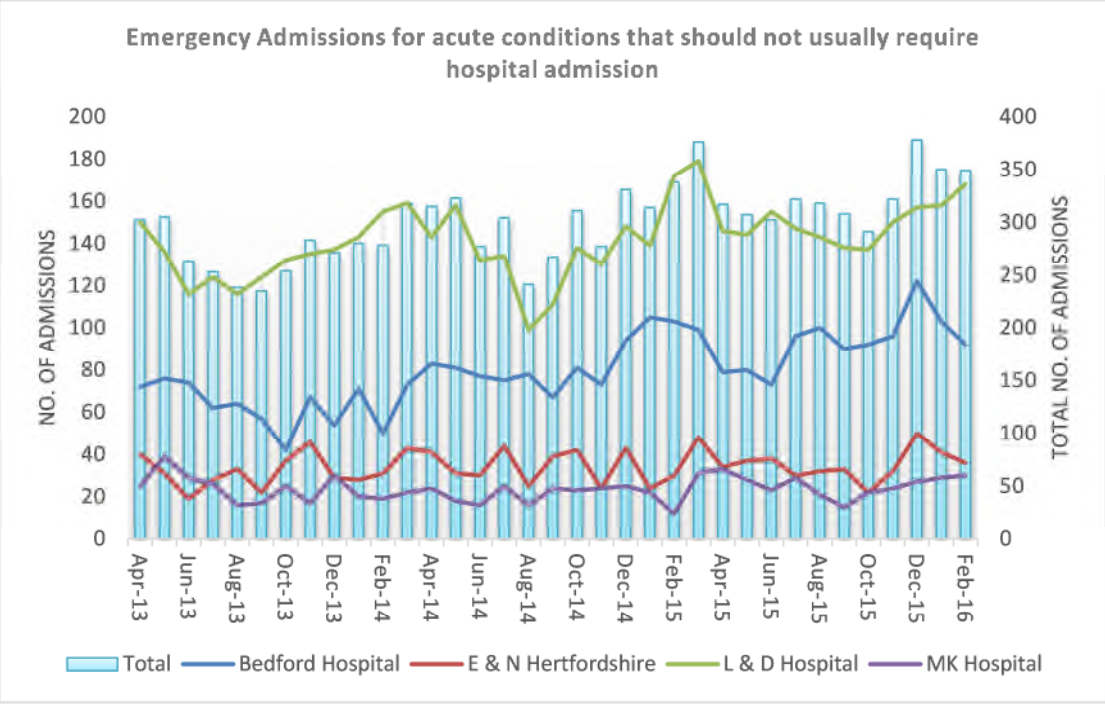
Source: Hospital Activity Data – NHS England

CBC has updated the data to June.

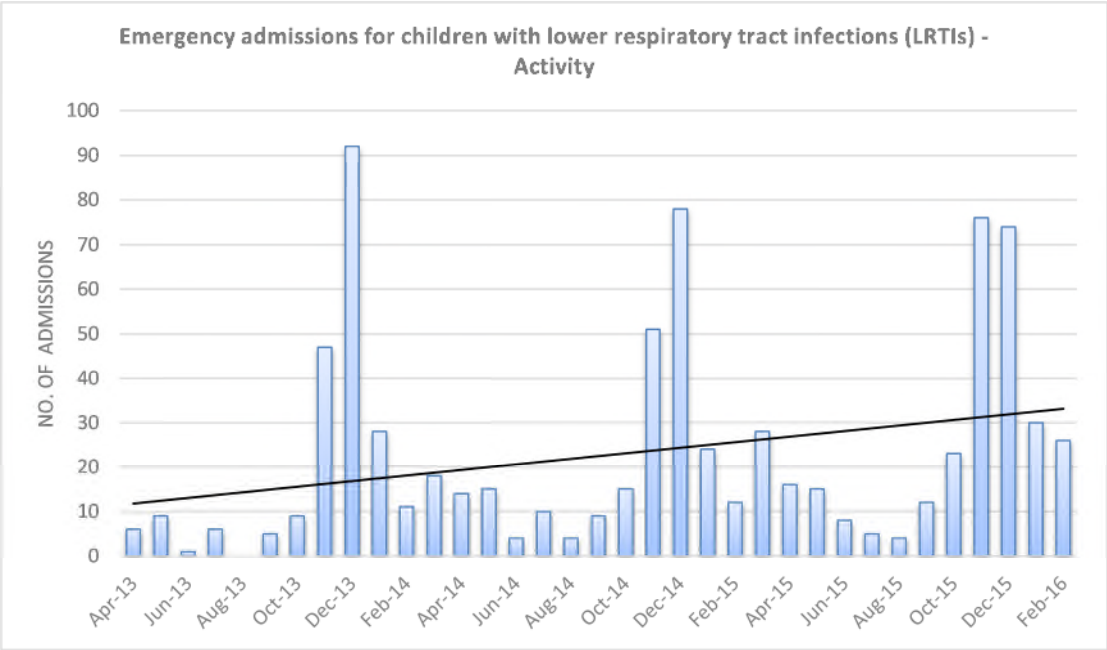
The following 5 tables have only been updated to Feb 2016 because this info is available to Bedfordshire CCG only. CBC does not have access to these breakdowns.



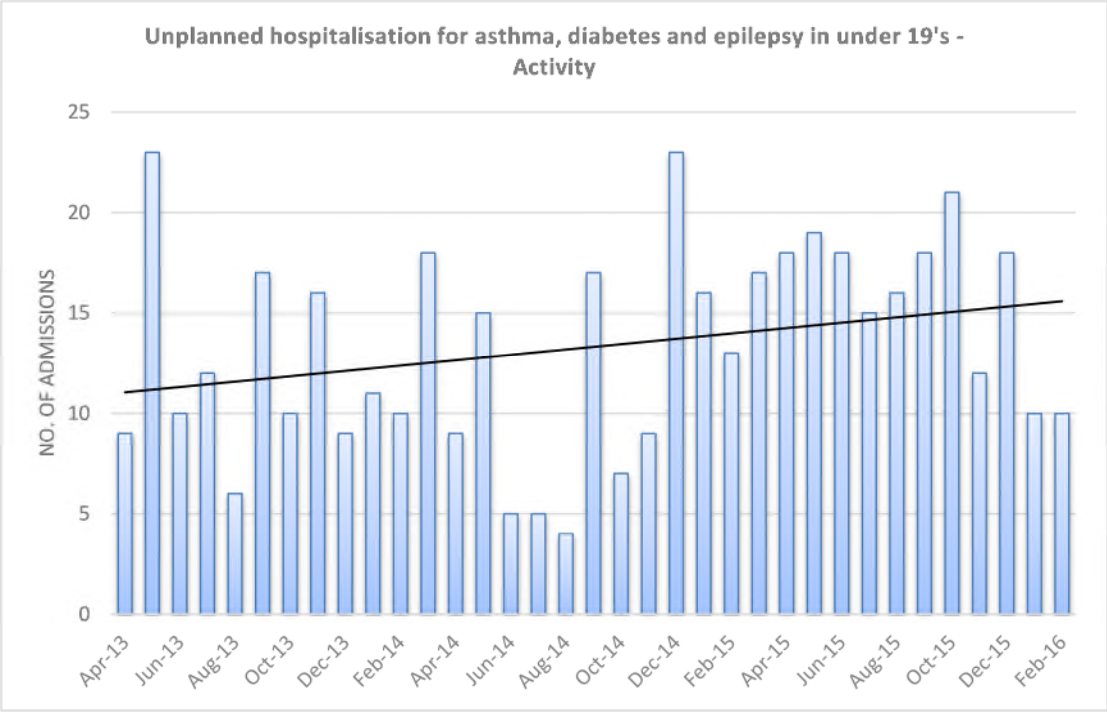
Source: Bedfordshire CCG



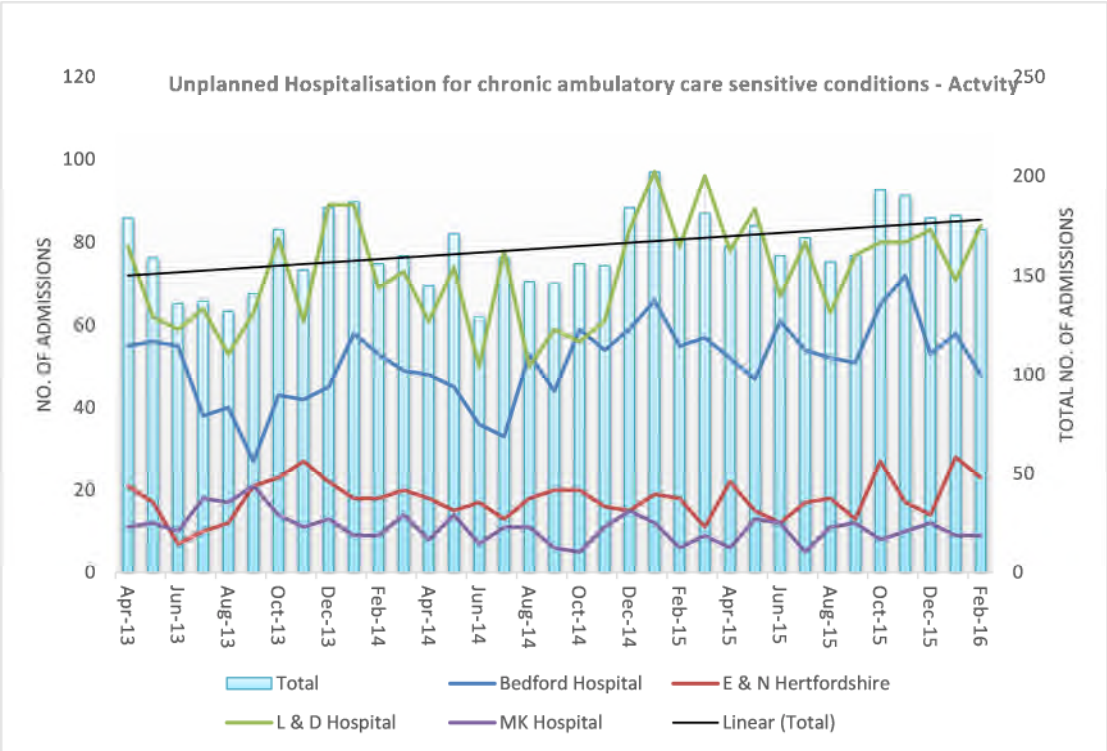
Source: Bedfordshire CCG



Source: Bedfordshire CCG



Source: Bedfordshire CCG

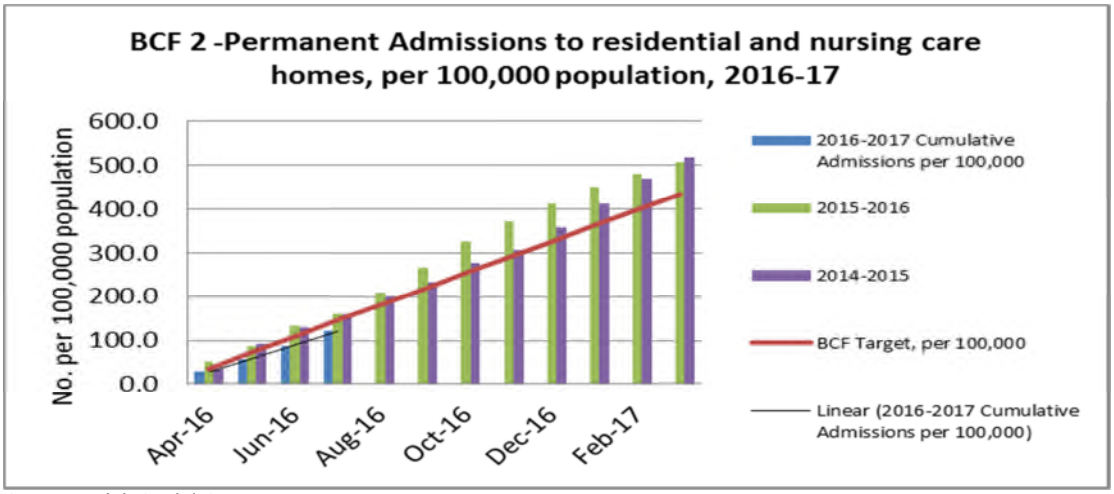


Source: Bedfordshire CCG

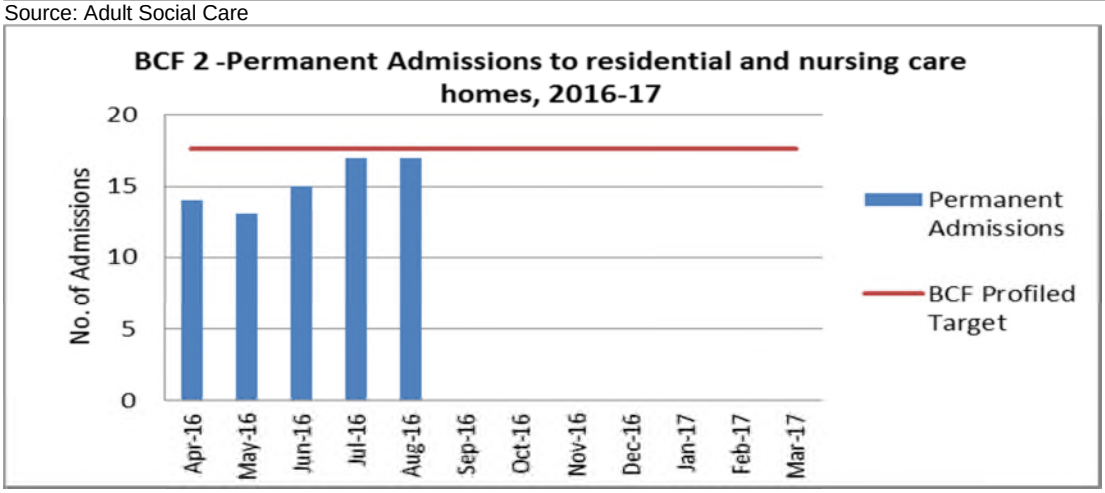
BCF2 - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

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

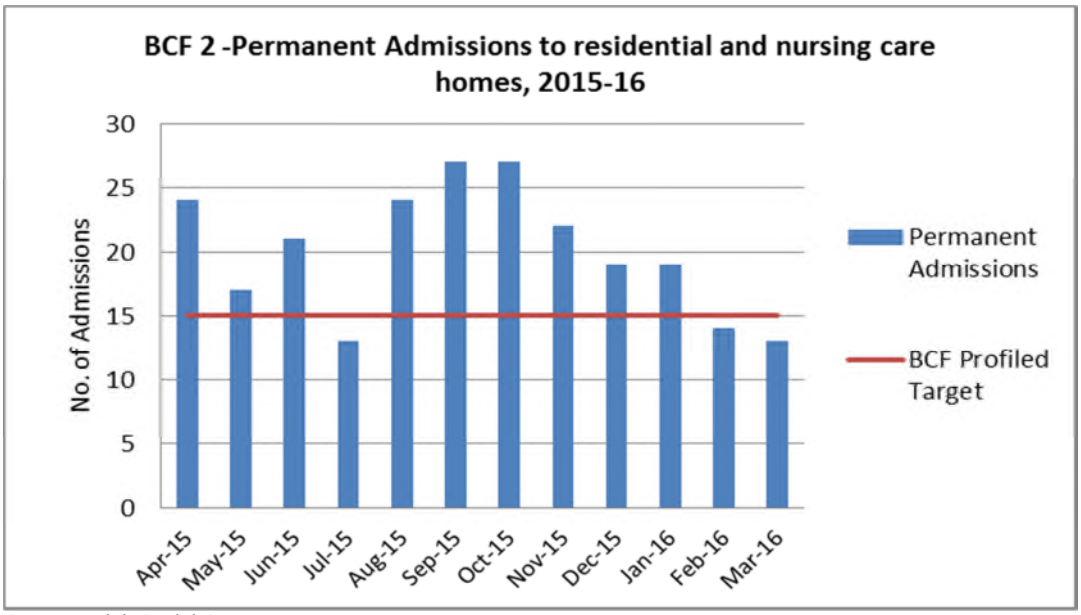
		Target	Actual	Current RAG rating and trend
Baseline Rate (Apr 13 – Mar 14)			529.9	**G ⇧**
2014-15		453.0	519.1	
2015-16		383.5	508.5	
June 2016		121.2	86.6	
2016-17		435.3		



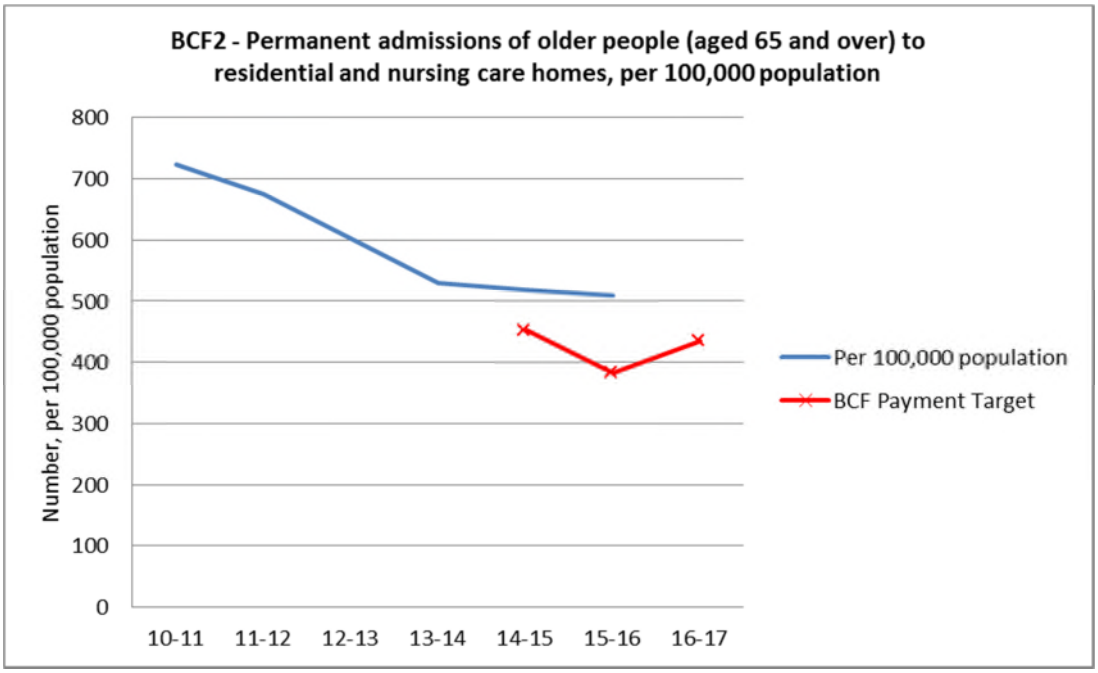
Source: Adult Social Care



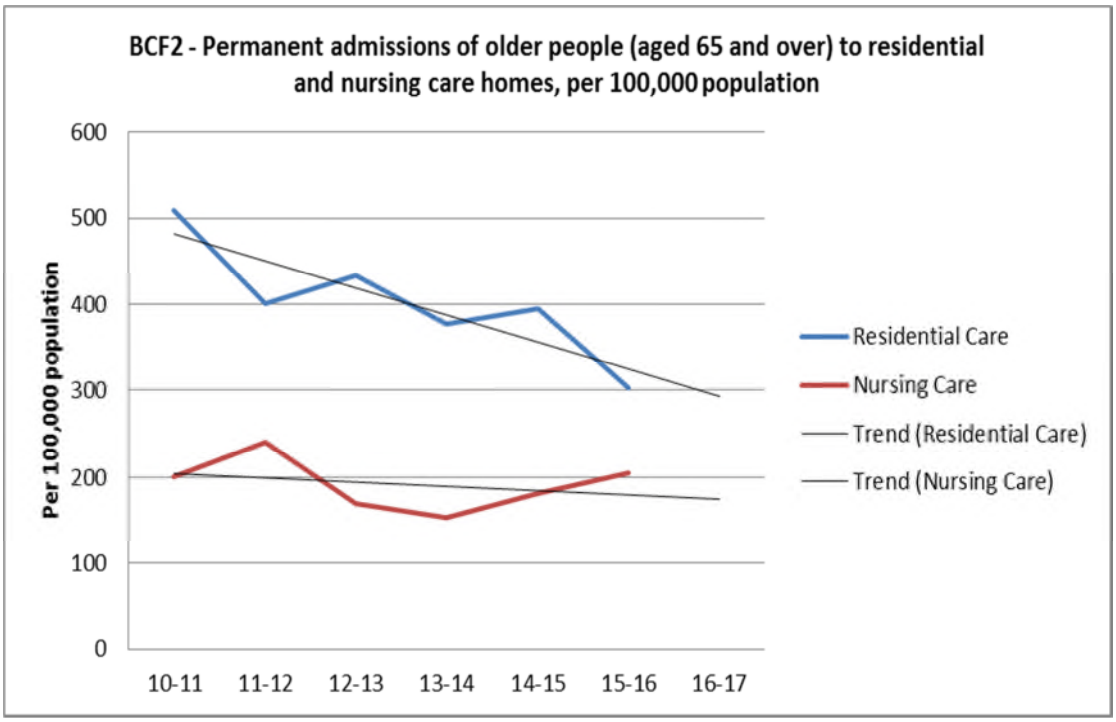
Source: Adult Social Care



Source: Adult Social Care



Source: Adult Social Care

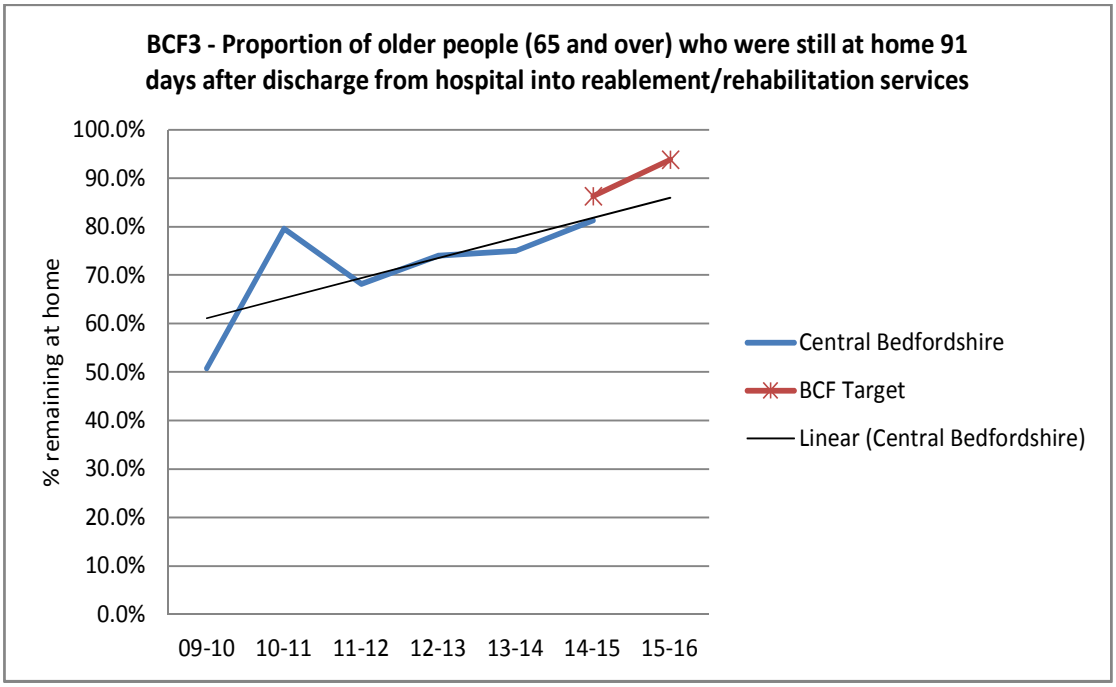


Source: Adult Social Care

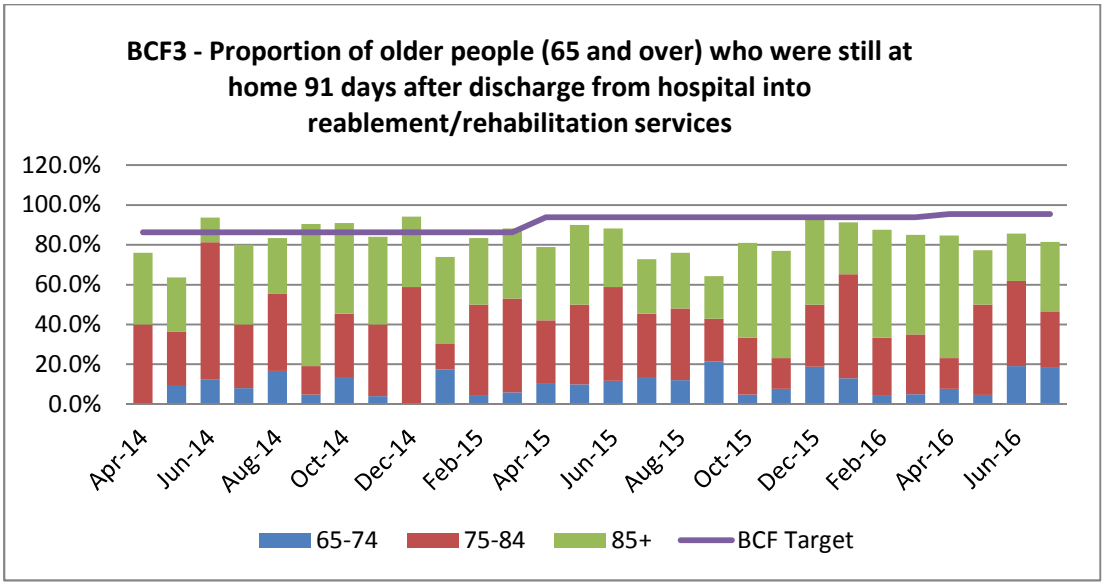
BCF3 - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

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

	Target	**Actual**	**Current RAG rating and trend**
Baseline Rate (Apr 13 – Mar 14)		75.0	**R ⇧**
2014-15	86.3	**86.6**	
2015-16	93.8	**85.0**	
June 2016	95.5	**86.0**	



Source: Adult Social Care

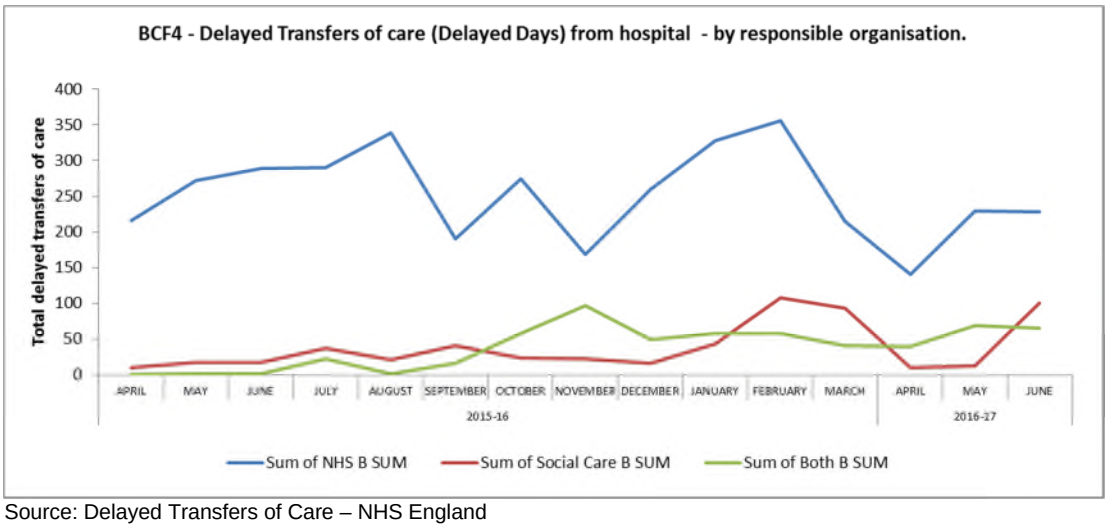


Source: Adult Social Care

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

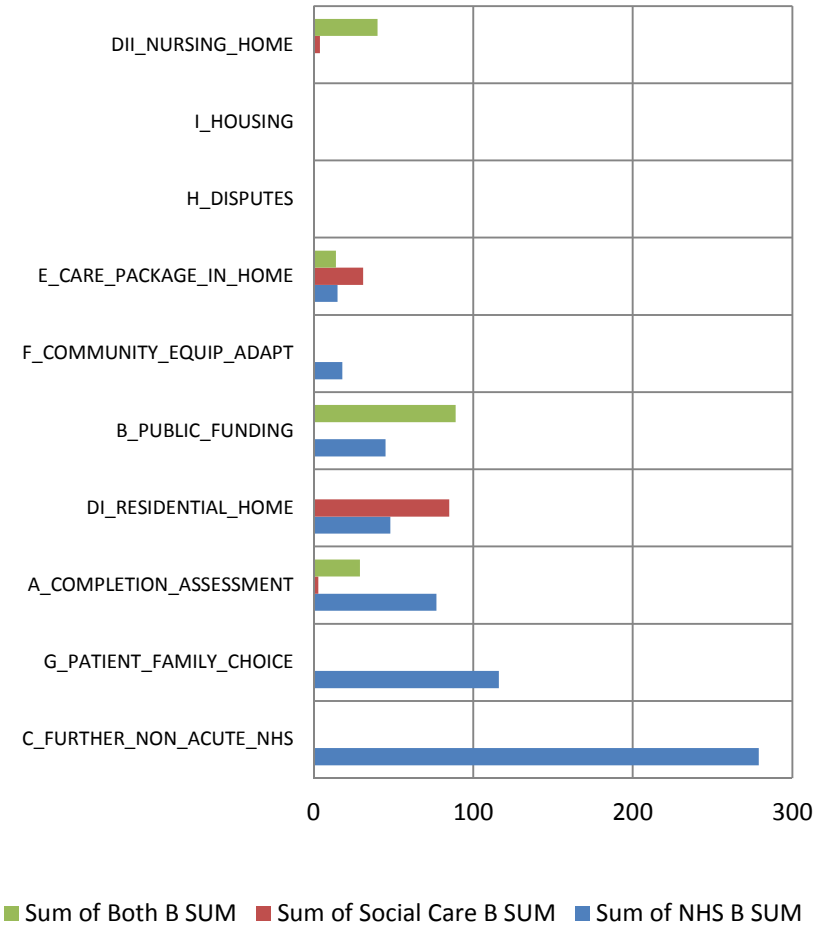
Average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month. A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:
(a)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

		Target	Current Performance	Current RAG rating and trend
Baseline rate (2013-14)	Apr – Jun 13	642.0		R ⇩
	Jul – Sep 13	522.7		
	Oct – Dec 13	680.0		
	Jan – Mar 14	571.7		
2014-15 target	Apr – Jun 14	598.0	242.1	
			285.0	
			181.7	
	Jul – Sep 14	483.7	119.3	
			242.1	
			198.3	
	Oct – Dec 14	635.0	251.3	
			257.2	
			220.2	
	Jan – Mar 15	534.2	233.3	
			196.3	
			228.5	
2015-16 target	Apr – Jun 15	559.4	110.1	
			141.7	
			150.0	
	Jul – Sep 15	448.9	170.0	
			205.6	
			120.3	
	Oct – Dec 15	595.4	173.4	
			139.8	
			158.3	
	Jan – Mar 16	496.5	200.6	
			244.0	
			162.7	
	Apr – Jun 16	372.6	87.5	
			142.8	
			181.0	
	Jul – Sep 16	432.5		
	Oct – Dec 16	437.1		
	Jan – Mar 17	423.2		

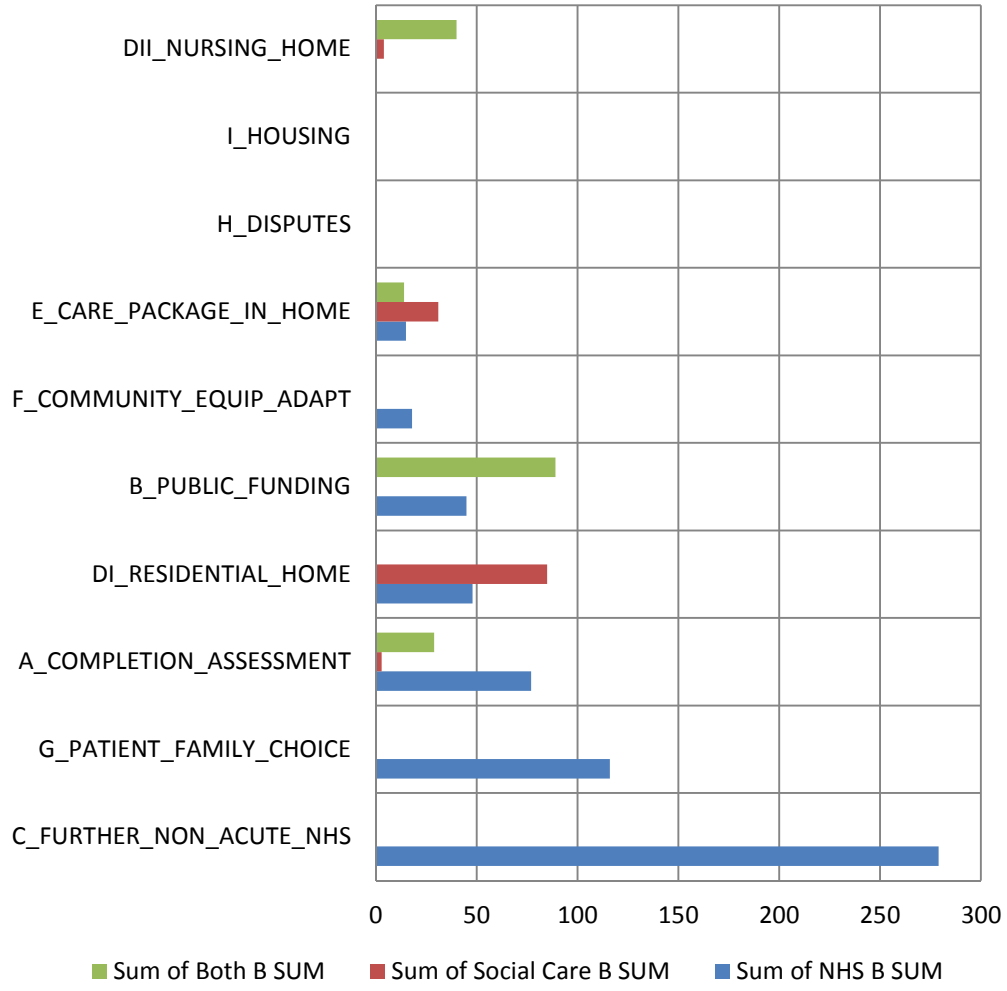


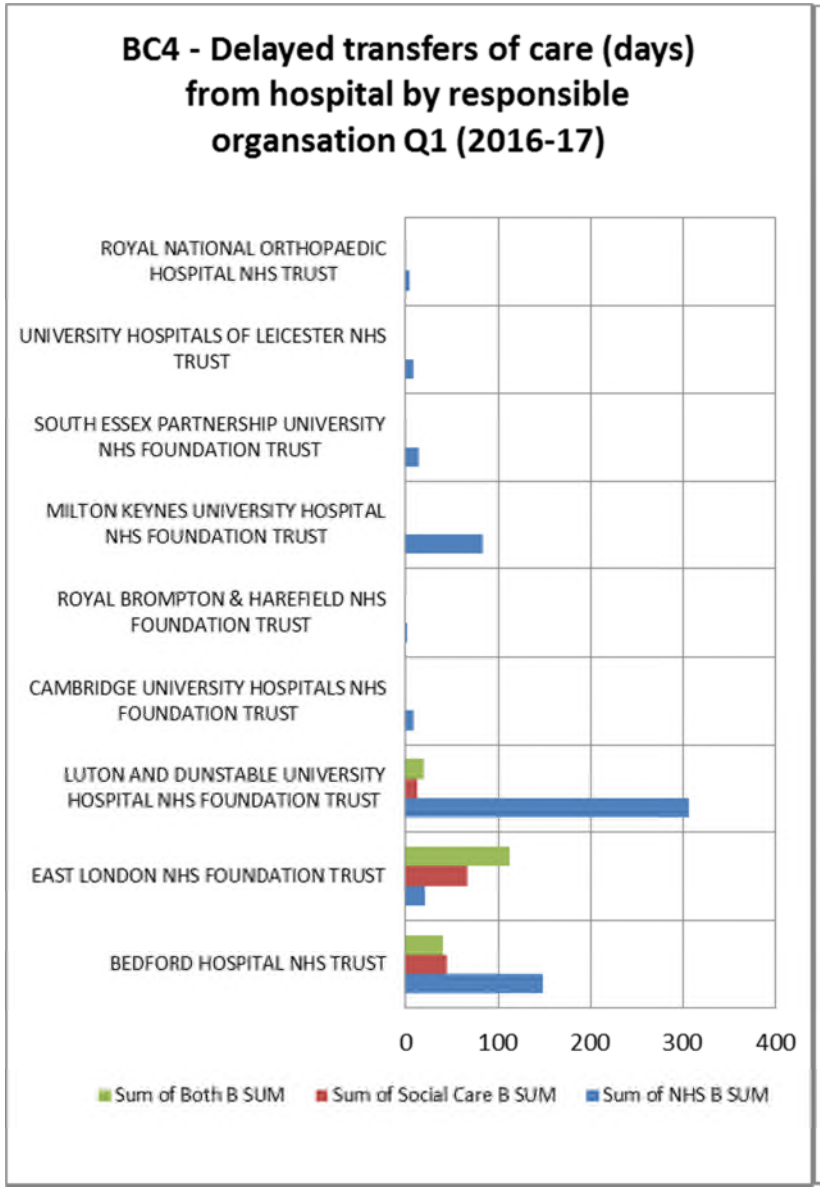
Source: Delayed Transfers of Care – NHS England

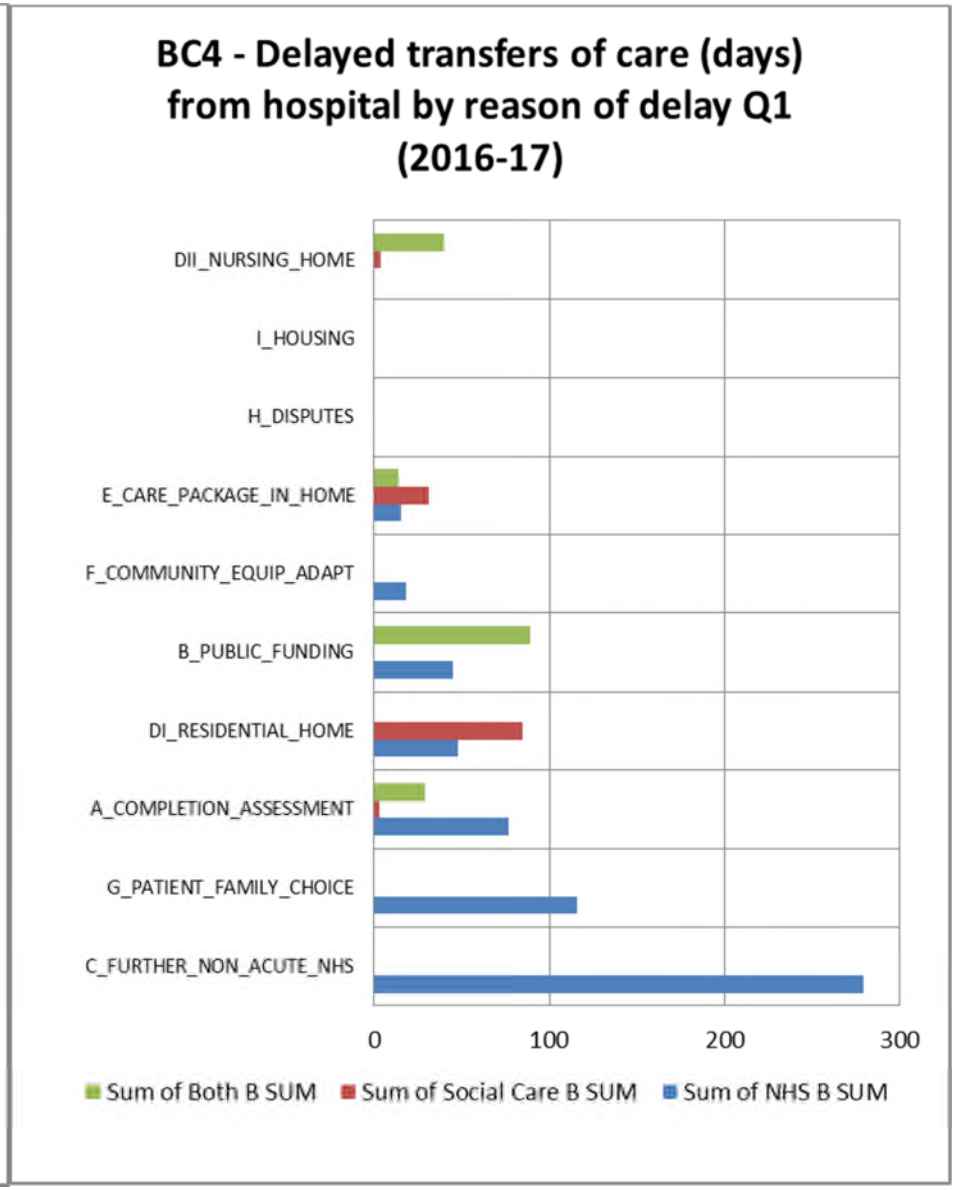
BC4 - Delayed transfers of care (days) from hospital by responsible organsation Q1 (2016-17)



BC4 - Delayed transfers of care (days) from hospital by responsible organsation Q1 (2016-17)



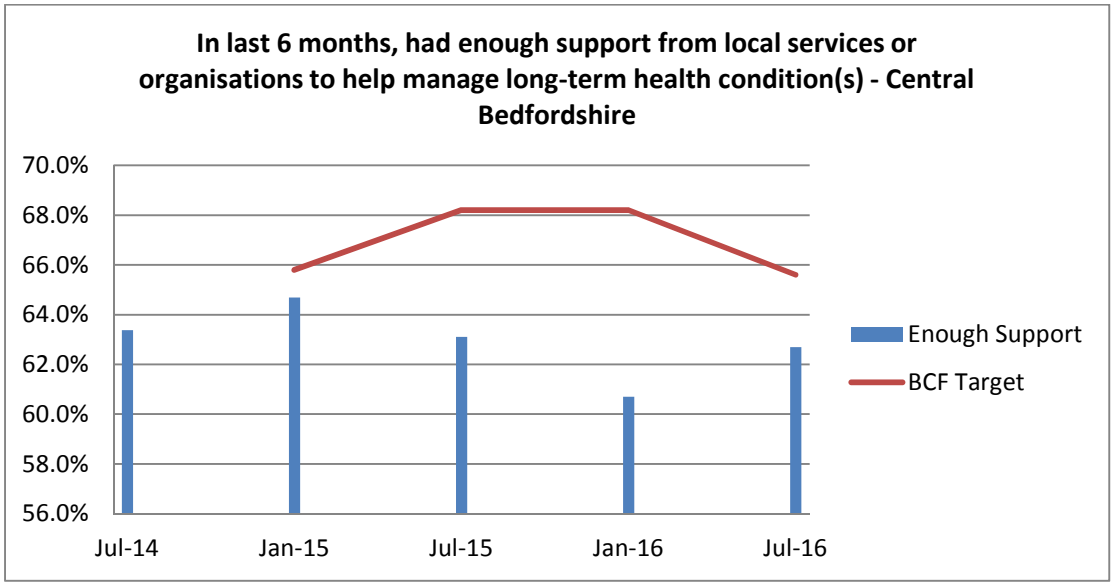

BC4 - Delayed transfers of care (days) from hospital by responsible organsation Q1 (2016-17)
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
EAST LONDON NHS FOUNDATION TRUST
BEDFORD HOSPITAL NHS TRUST
0
100
200
300
400
Sum of Both B SUM
Sum of Social Care B SUM
Sum of NHS B SUM


BC4 - Delayed transfers of care (days) from hospital by reason of delay Q1 (2016-17)
DII_NURSING_HOME
I_HOUSING
H_DISPUTES
E_CARE_PACKAGE_IN_HOME
F_COMMUNITY_EQUIP_ADAPT
B_PUBLIC_FUNDING
DI_RESIDENTIAL_HOME
A_COMPLETION_ASSESSMENT
G_PATIENT_FAMILY_CHOICE
C_FURTHER_NON_ACUTE_NHS
0
100
200
300
Sum of Both B SUM
Sum of Social Care B SUM
Sum of NHS B SUM

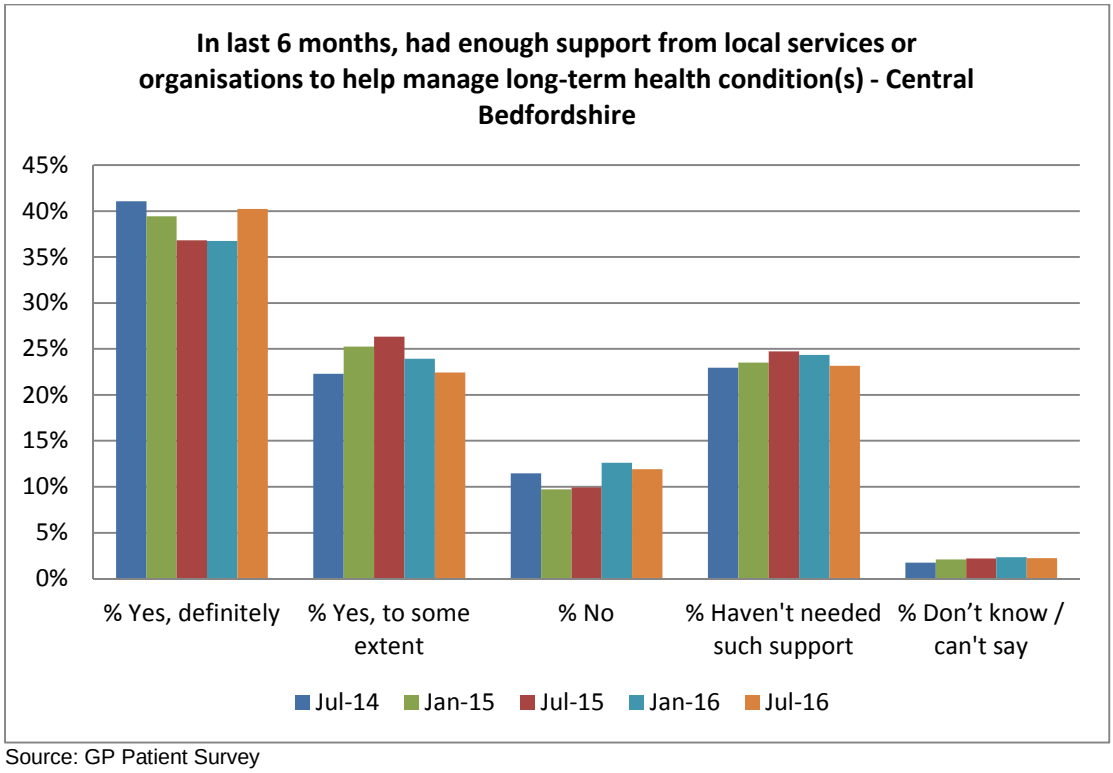
BCF5 - Patient / service user experience

In the last six months, have you had enough support from local services or organisations to help manage long-term health condition(s)
BCF Aim – to increase patient/customer satisfaction with services
Data is reported six monthly
High values are **good**
Data source – GP Patient Survey

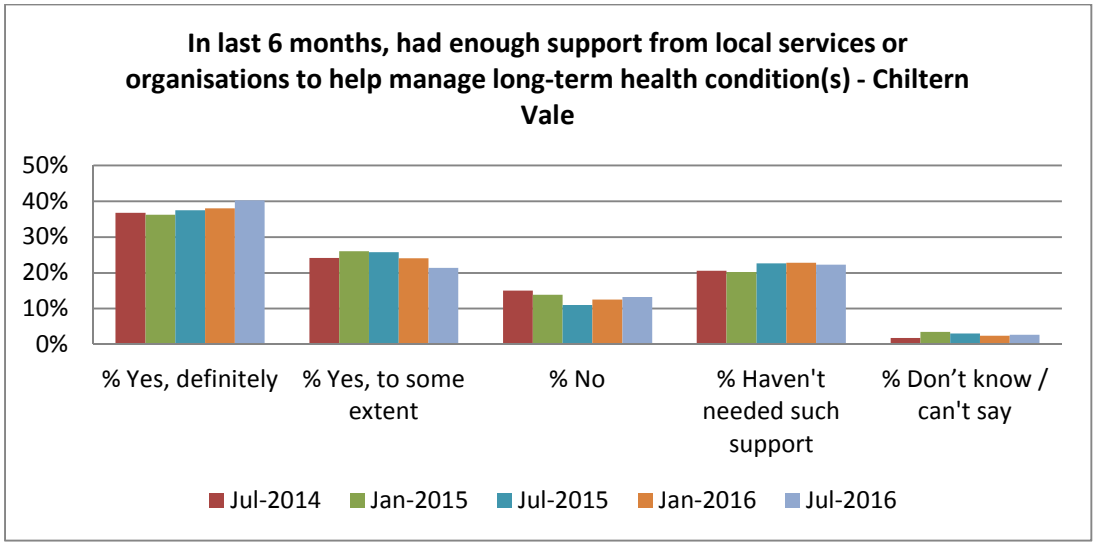
	Actual	BCF Target	**Current RAG rating**
Baseline Rate (13 –14)	63.4%		**R ⇩**
Jan-15	64.7%	65.80%	
Jul-15	63.1%	68.20%	
Jan-16	60.7%	68.20%	
Jul-16	62.70%	65.60%	



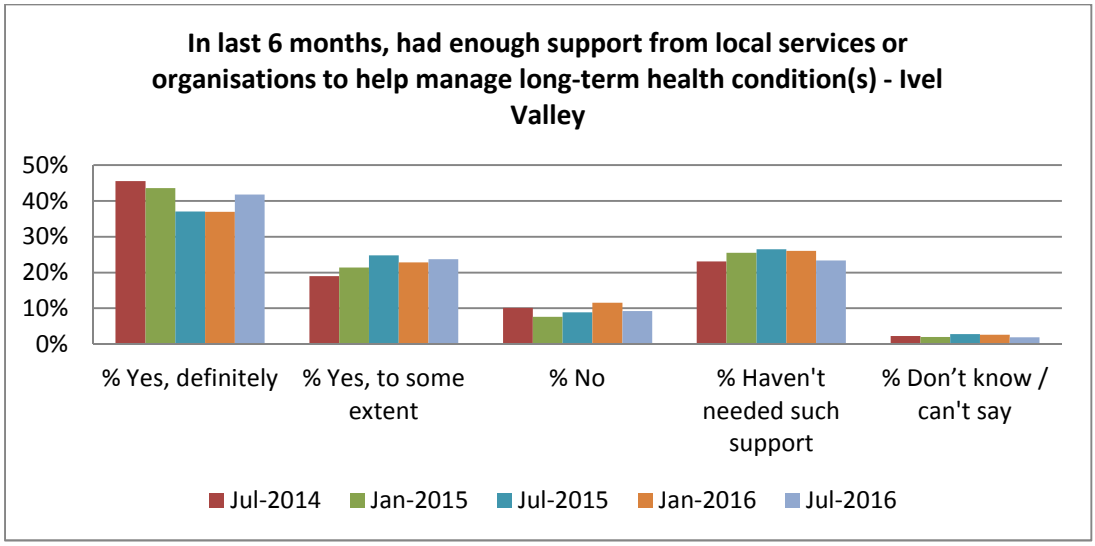
Source: GP Patient Survey



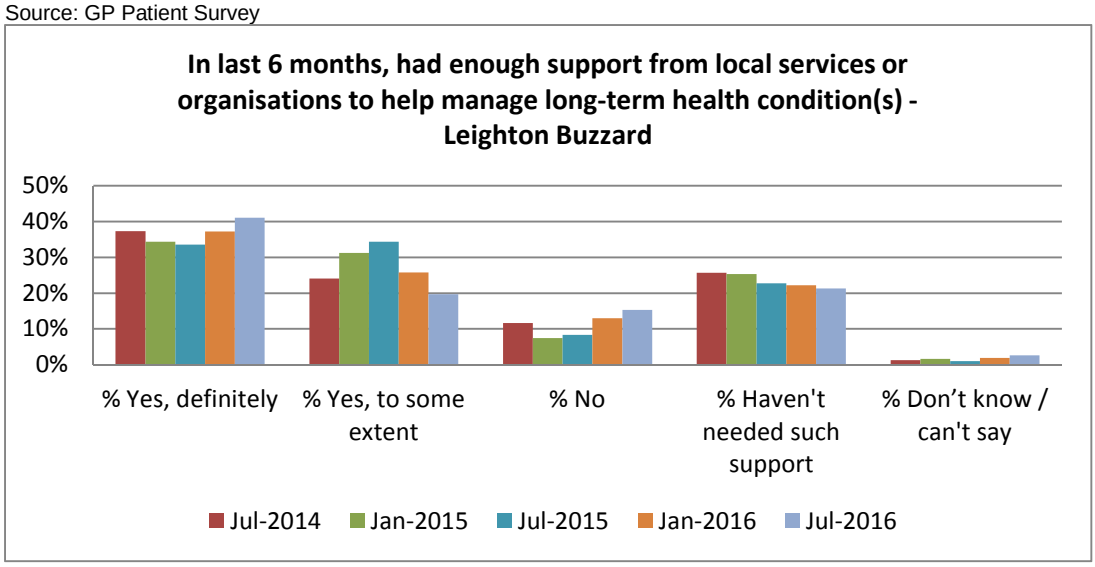
Source: GP Patient Survey



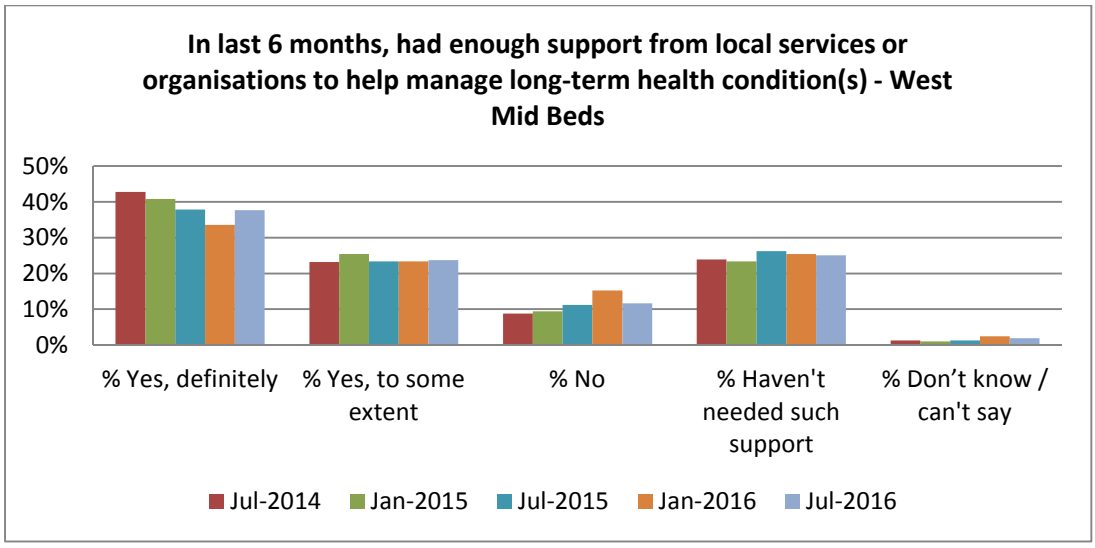
Source: GP Patient Survey



Source: GP Patient Survey



Source: GP Patient Survey



Source: GP Patient Survey

Supporting Patient and Customer Satisfaction metrics

Disabled Facilities Grant

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Customer satisfaction

Customer satisfaction is measured using a customer satisfaction questionnaire that is sent to each DFG customer upon completion of works. A number of questions ask for a rating out of 5 (5 being excellent, to 1 poor). The average of each questionnaire is captured into an average for each quarter for performance indicator review.

Historically

Average score 2015/16 – 4.43 (slightly below target of 4.5)
Average score 2014/15 – 4.68
At the end of Q1 – 4.64 (up from 2015/16 outturn)

Measures Completed DFG 2015/16

Type of adaptation	Total	CBC
Level access shower/wet room	115	11
Straight stair lift	29	4
Curved stair lift	28	
Toilet alterations	48	6
Access ramps	27	3
Dropped kerb and hard standing	7	
Wheelchair/step lift	3	1
Through floor lift	2	
Major extension	12	1
Kitchen alterations	11	2
Access alterations (doors etc)	54	3
Heating improvements	3	
Garage conversions/minor additions	5	1
Safety repairs/improvements	5	1
Other	23	3
Total	372	36

Measures Completed DFG Q1 2016/17

Type of adaptation	Total
Level access shower/wet room	44
Straight stair lift	8
Curved stair lift	7
Toilet alterations	12
Access ramps	8
Dropped kerb and hard standing	0
Wheelchair/step lift	1
Through floor lift	3
Major extension	4
Kitchen alterations	3
Access alterations (doors etc)	16
Heating improvements	2
Garage conversions/minor additions	2
Safety repairs/improvements	4
Other	8
Total	122

DFG Average time from referral to DFG approval

Q1 2016/17 – 8.46 weeks

2015/16 – 8.35 weeks (a great result and record)
2014/15 – 10.9 weeks

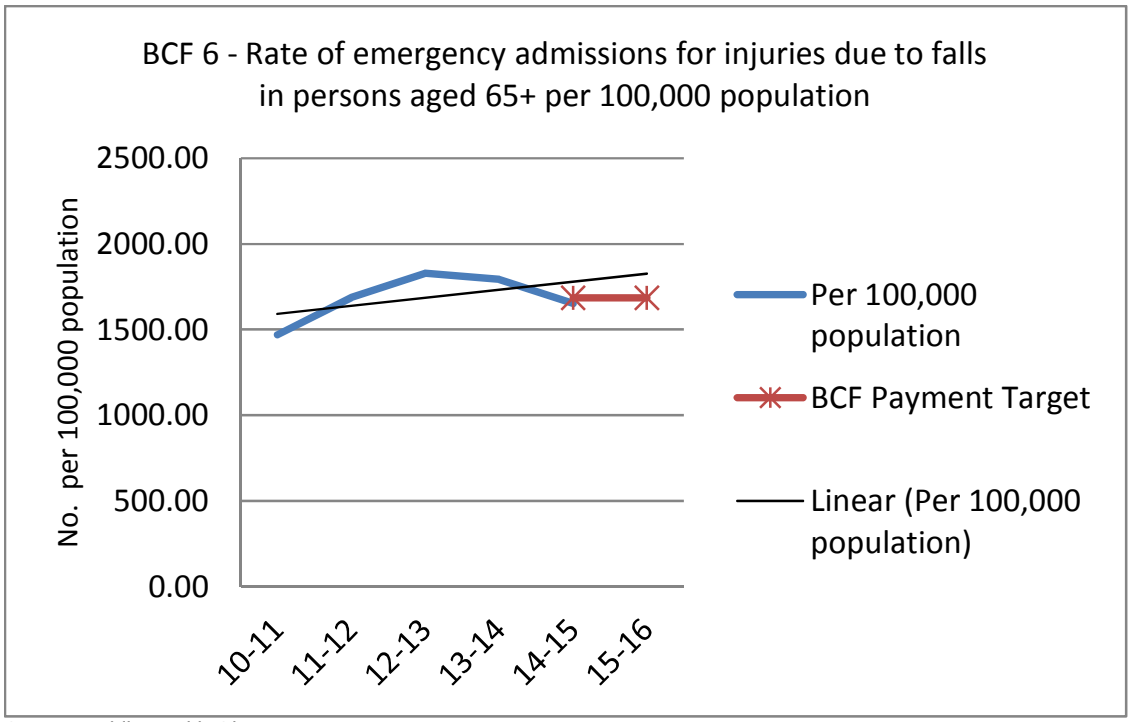
Social Care

ASCOF 3a Overall satisfaction of people who use services with their care and support Data is reported annually High values are **high** Data source – Adult Social Care Survey			
Baseline Rate (Apr 13 – Mar 14)	63.6%	**Current RAG rating and trend**	
2014-15 target	65.6%		
Current Performance			
2014-15	63.0%		
2015-16 target	67.7%		
2015-16	65%		
Comments	Ninety two percent of those who completed the Adult Social Care Survey reported that they were extremely or quite satisfied with the care and support services they received.		

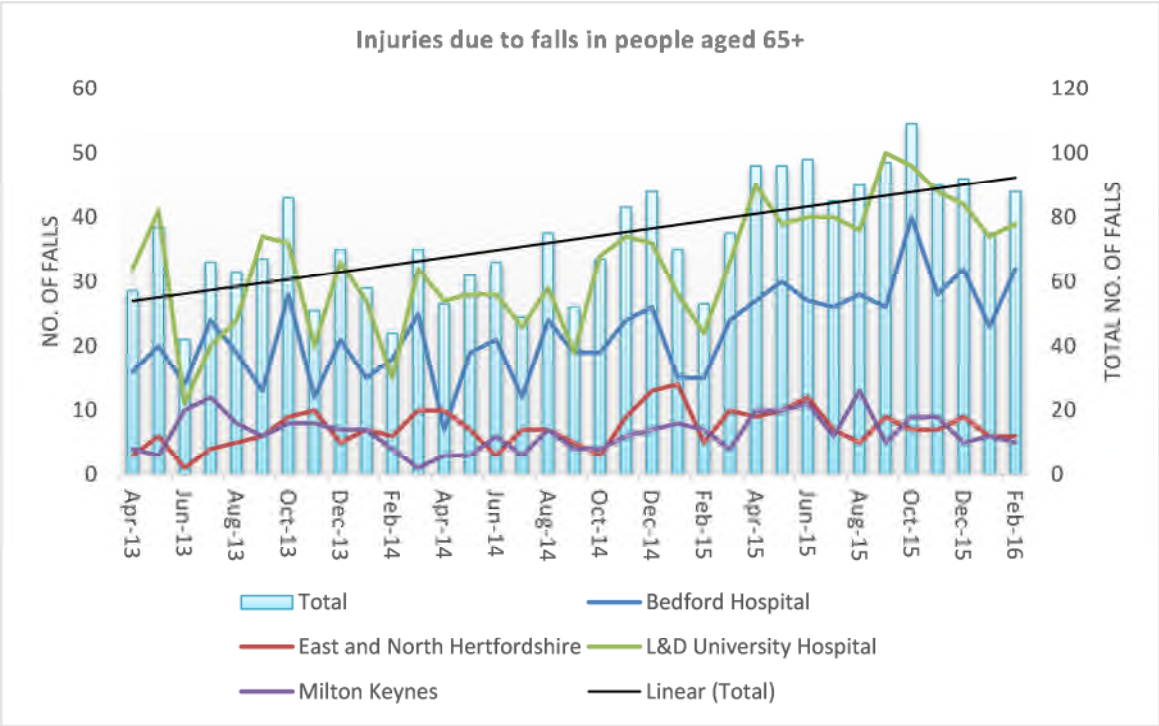
ASCOF 3d Proportion of people who use services who find it easy to find information about services Data is reported annually High values are **high** Data source – Adult Social Care Survey			
Baseline Rate (Apr 13 – Mar 14)	**73.0%**	**Current RAG rating and trend**	
2014-15 target	**75.3%**		
Current Performance			
2014-15	**74.3%**		
2015-16 target	**77.4%**		
2015-16	**74%**		
Comments	75% compared to a national average of 53%		

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

Emergency admissions to hospital for falls injuries. BCF Aim – to reduce the number of emergency admissions in older people due to falls Data is reported annually High values are **bad** Data source – Public Health Observatory				
Baseline Rate (Apr 12 – Mar 13)	1829.7		**Current RAG rating and trend**	
2014-15 target	1685.0			
2015-16 target	1686.4			
2016-17 target	1770.5			
Comments				
Key Issues				
Mitigating Actions				



Source: Public Health Observatory



Source: Bedfordshire CCG

Compared with benchmark: Better Similar Worse | Lower Similar Higher | Not Compared

Trends for: Central Bedfordshire
All in East of England region

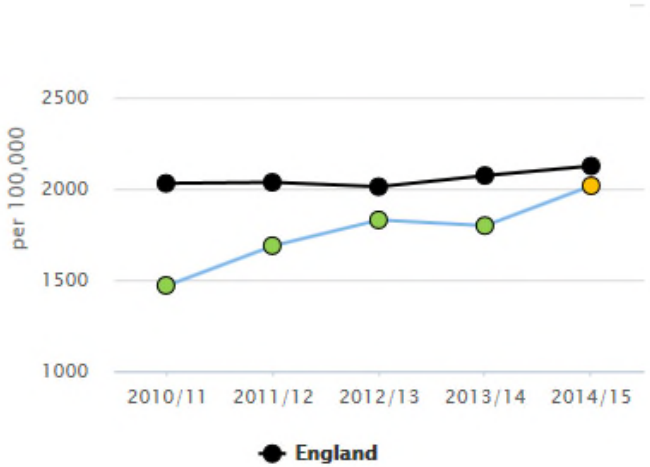
* a note is attached to the value, hover over to see more details

2.24i - Injuries due to falls in people aged 65 and over (Persons)

Central Bedfordshire

Directly standardised rate - per 100,000

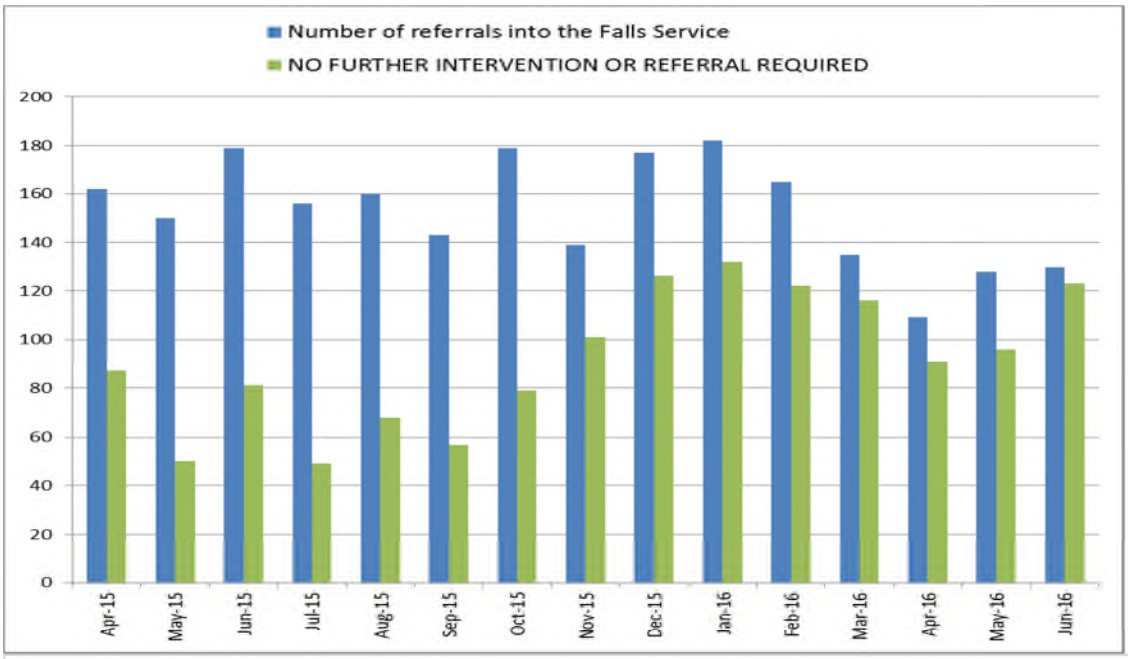
Export chart as image Show confidence intervals

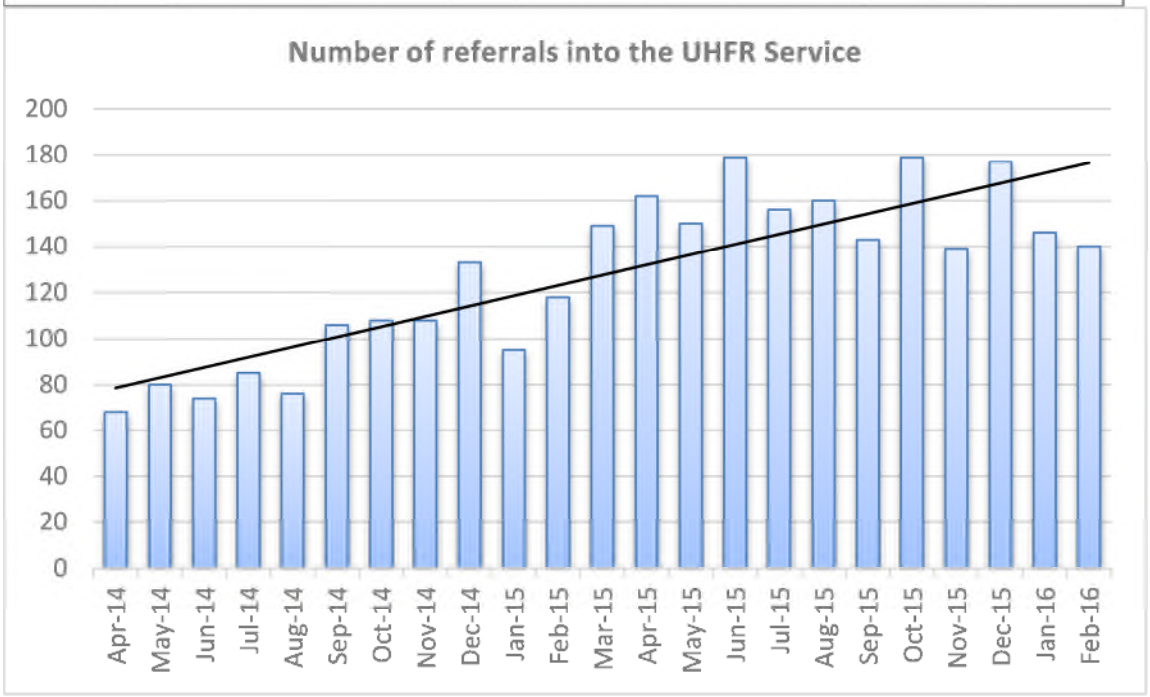


Period		Count	Value	Lower CI	Upper CI	East of England	England
2010/11		576	1,470	1,346	1,601	1,805	2,030
2011/12		658	1,688	1,554	1,829	1,841	2,035
2012/13		740	1,829	1,693	1,972	1,888	2,011
2013/14		754	1,797	1,667	1,935	1,950	2,072
2014/15		875	2,016	1,881	2,159	1,956	2,125

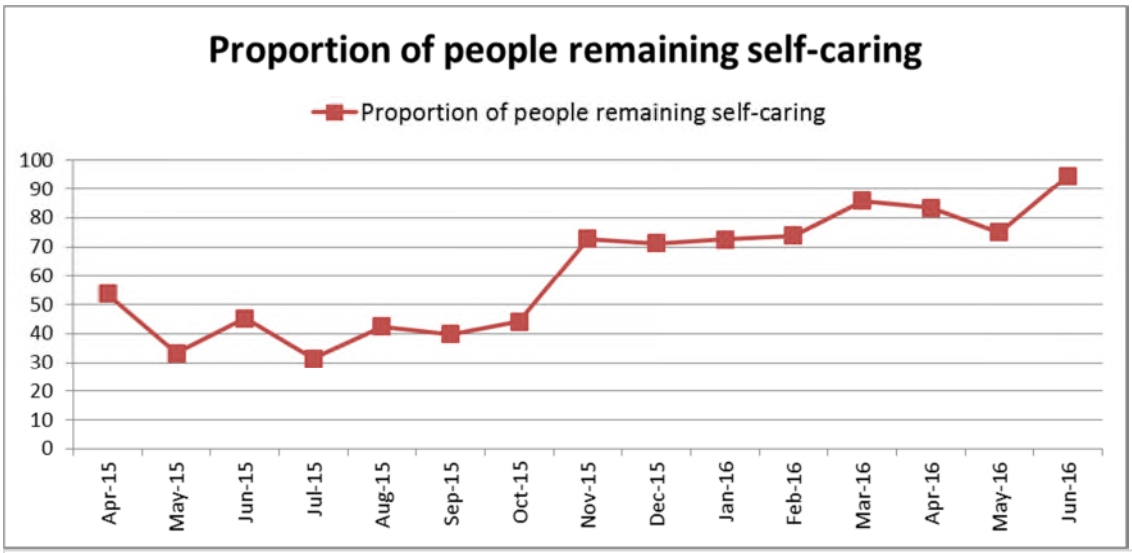
Source: Calculated by West Midlands Knowledge and Intelligence Team from data from the Information Centre for Health and Social Care - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates

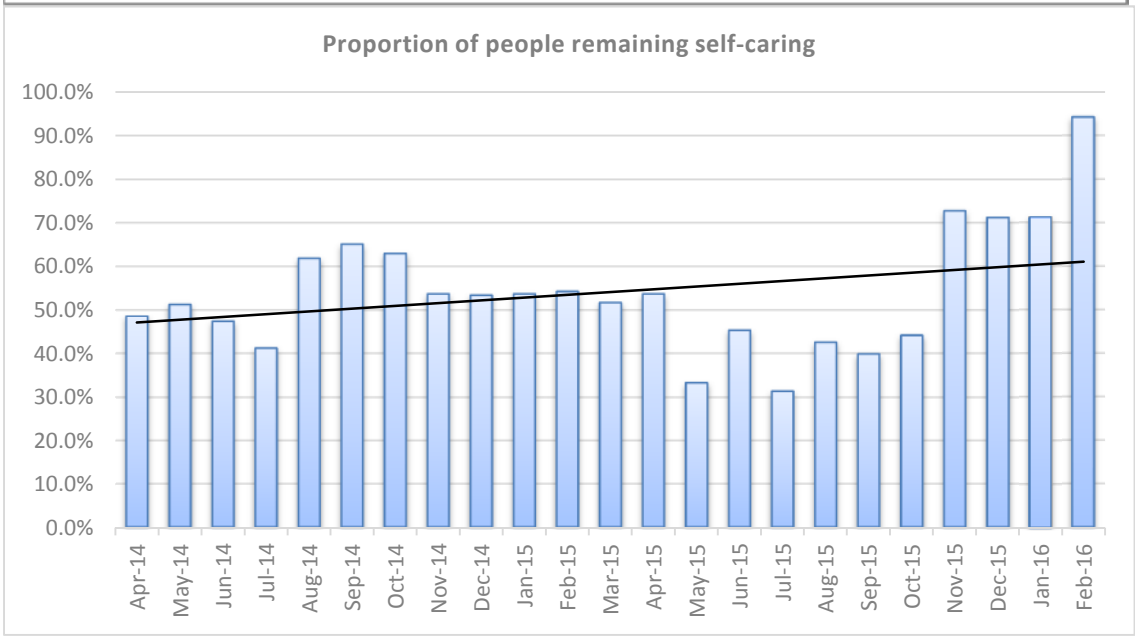
Source : Public Health Outcome Framework





Source: UHFRS, Central Bedfordshire Council





Source: UHFRS, Central Bedfordshire

Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Sustainability and Transformation Plan 2016-2020
Meeting Date:	19 October 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. **receive an update on the Sustainability and Transformation Plan;**
2. **note that the STP will take forward work on the appropriate configuration of acute services across Bedfordshire and Milton Keynes, building on the work of the Health Care Review; and**
3. **note the requirement for local involvement and engagement in shaping the plan.**

Purpose of Report	
1.	To update the Health and Wellbeing Board on the development of Sustainability and Transformation Plan for BLMK.
2.	To inform the Board of the requirement for local involvement and engagement to ensure local people are able to shape the future of their local services.

Background	
3.	Bedfordshire, Luton and Milton Keynes (BLMK) health and care communities have come together to formulate a Sustainability and Transformation Plan (STP), as part of a national drive to improve health and well-being, care quality, and affordability across the NHS.
4.	The BLMK STP is one of 44 health and care ‘footprints’ in England, bringing organisations together to develop plans to support the delivery of the NHS Five Year Forward View. The plans will show how local services will evolve, develop and become clinically and financially sustainable over the next five years (to 2020/21).

5.	The Health and Wellbeing Board received report in July outlining the national policy for Sustainability and Transformation Plans and steps taken in the Bedfordshire, Luton and Milton Keynes footprint to develop the plan.
6.	The BLMK STP is led by Pauline Philip, chief executive of Luton and Dunstable University Hospital NHS Foundation Trust and national lead for urgent and emergency care.
7.	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 is intended to foster greater collaboration between the NHS and local government, with patients and the public kept at the centre.
Content of STPS	
8.	All 44 STP Footprints were required to submit a draft plan on 30 June 2016. These draft plans explored ideas and possibilities for transformational change to support improved health and well-being, service quality and affordability. The BLMK draft plan sets out the STP's priorities in delivering the Five Year Forward View. These priorities are:
9.	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.
10.	An example of the plan on a page for prevention and health improvement, reflecting the key workstreams that are being developed and constituent priority actions is attached for information at Appendix one.

11.	These exploratory draft plans are being worked through with NHS England and NHS Improvement. Following feedback and further refinement, the Plans will shared for further involvement and engagement with local communities, staff and other stakeholders.
The Healthcare Review in Bedfordshire and Milton Keynes	
12.	The Bedfordshire, Luton and Milton Keynes STP June submission identified that the Healthcare Review should be incorporated within the Bedfordshire, Luton and Milton Keynes STP as appropriate acute services are an integral element of delivering a sustainable health system.
13.	Undertaking this transfer, ensures the options are checked against the wider opportunities offered through extended working with Luton.
14.	The detailed governance arrangements and the means by which the STP will be agreed and decisions made are still to be finalised but must ensure appropriate engagement of all local stakeholders.
	Engaging Local People – A Guide for Local Areas Developing Sustainability and Transformation Plans
15.	Following the recent national media interest in STPs, NHS England released the following statement in late August: *"We need an NHS ready for the future, with no one falling between the cracks. To do this, local service leaders in every part of England are working together for the first time on shared plans to transform health and care in the communities they serve, and to agree how to spend increasing investment as the NHS expands over the next few years.* *"This is a unique exercise in collaboration. It is hardly a secret that the NHS is looking to make major efficiencies and the best way of doing so is for local doctors, hospitals and councils to work together to decide the way forward in consultation with local communities. Proposals are at a draft stage but we expect all local leaders to be talking to the public and stakeholders regularly – it is vital that people are able to shape the future of their local services.* *"No changes to the services people currently receive will be made without local engagement and, where required, consultation. There are longstanding assurance processes in place to make sure this happens."* An NHS England Guide published in September expects that most areas will take a version of their STP to their organisation's public board meeting for discussion between late October and the end of the year.
16.	The BLMK STP development process involves engagement with key partners and builds on local priorities and strategic plans such as the Better Care Fund Plans. Further engagement is anticipated as the plans develop.

	Next Steps
17.	The plans will continue to be developed locally, with the involvement of local communities, staff and other stakeholders, towards the submission of a more detailed iteration to NHS England in Autumn 2016.
18.	The STP's nine current work streams remain in place to develop the next steps needed to deliver the five key priorities. The workstreams are: 1. Health promotion and illness prevention 2. Urgent and emergency care 3. Primary, community and social care 4. Workforce 5. Shared care records, digitisation and assistive technology 6. New models of care 7. Clinical support services 8. Back office services 9. Health and social care estate.

Reasons for the Action Proposed	
19.	Health and Wellbeing Boards 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.
20.	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
21.	Following submission on 30 June 2016, the draft plans from all 44 STPs across the country have been reviewed and considered by NHS England and NHS Improvement, amongst others. The BLMK plan has been assessed favourably as a result of this process.
22.	Work on the development of the five key priorities of the Plan is continuing locally.

Issues	
Governance & Delivery	
23.	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 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	
24.	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)	
25.	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.
26.	Are there any risks issues relating Public Sector Equality Duty **No**
27.	If yes – outline the risks and how these would be mitigated

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Presented by Richard Carr, CEO Central Bedfordshire Council

Appendix One – STP Plan

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Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan

Empowering communities and keeping people healthy

High quality, scaled and resilient primary, community and social care

Sustainable secondary care services

Designing and delivering a BLMK digital programme

Re-engineering demand management, commissioning and health and social care provision

Prevention is the golden thread that runs across Bedfordshire, Luton and Milton Keynes. We will work together to close the health and wellbeing gap by improving healthy life expectancy and reducing health inequalities.

Three key enablers

Prevention principles embedded across BLMK, with Board-level champions

Health and Wellbeing Boards lead local delivery of prevention priorities

Consistent, clear and strategic health messages across BLMK

Six priority areas for prevention

1. Giving every child the best start

a) Reduce smoking at time of delivery
b) Increase breastfeeding
c) Increase referrals to weight management services for children and pregnant women
d) Reduce hospital admissions for asthma
e) Support families where there are parental mental health, substance misuse or domestic violence issues

2. Improving immunisations & screening

a) Increase flu immunisation uptakein risk groups and frontline staff
b) Increase flu and pertussis immunisation uptakein pregnant women
c) Increase cervical screening coverage in younger women
d) Increase bowel screening coverage
e) Reduce late diagnosis of HIV
f) Increase detection and treatment of chlamydia

3. Tackling the four lifestyle behaviours that have the greatest impact

a) Reduce the harms caused by alcohol drinking
b) Increase the uptake of preventative programmes in vulnerable and deprived groups
c) Increase opportunities for healthy eating and physical activity
d) Support implementation of the Diabetes Prevention Programme

4. Promoting mental health & wellbeing

a) Strengthen perinatal mental health pathways
b) Improve the emotional wellbeing and resilience of vulnerable children and young people
c) Improve the awareness, diagnosis and treatment of dementia
d) Improve the physical health of people with mental health issues

5. Achieving healthy workforces

a) BLMK partners become exemplars for workplace wellbeing
b) All NHS Trusts develop and achieve workplace wellbeing CQUINs
c) BLMK partners implement smoke-free estates
d) Reduce the employment gap for people with mental illness, sensory, physical and learning disabilities

6. Empowering communities & self-management

a) Increase the contribution of self-managed care
b) Optimise detection and treatment for diabetes, cardiovascular disease and respiratory disease
c) Reduce injuries due to falls
d) Increase the uptake of volunteering opportunities
e) Strenthen the role of the ‘wider workforce’ in prevention, including pharmacists
f) Ensure the voice of the local community is listened to and acted upon

Prevention Targets: What will success look like for BLMK?

E1. Prevention principles embedded across Bedfordshire, Luton and Milton Keynes

i. A Board-level champion is appointed by each BLMK partner
ii. Health Impact Assessments are carried out for major policy decisions.
iii. BLMK partners deliver on their agreed prevention actions

E2. Health and Wellbeing Boards lead local delivery of prevention priorities

i. HWB boards receive regular updates on prevention achievements
ii. BLMK prevention priorities are reflected in Joint Health and Wellbeing Strategies

E3. Consistent, clear and strategic health messages across BLMK

i. All partners nominate a communications lead to participate in a BLMK-wide Communications Group
ii. An annual BLMK Prevention Communications Plan is approved by the BLMK Steering Group and Health and Wellbeing Boards

1. Giving every child the best start in life

1a. Reduce smoking at time of delivery
i. 0.5% annual reduction and a 2.5% reduction by 2020/21

1b. Increase breastfeeding
i. 1% annual increase and a 5% increase in breastfeeding at 6 to 8 weeks by 2020/21

1c. Increase referrals to weight management services for children and pregnant women
i. Target TBC

1d. Reduce hospital admissions for asthma
i. 15/100,000 annual reduction annual reduction in hospital admissions for asthma in under 19s, and a 75/100,000 reduction by 2020/21

1e. Support families where there are parental mental health, substance misuse or domestic violence issues
i. Target TBC

2. Improving screening & immunisation

2a. Improve flu immunisation uptake across BLMK
i. 100% of frontline health and care workers are offered a flu jab
ii. For over 65s, 75% uptake is achieved and maintained
iii. For risk groups including pregnant women, a 3% annual increase and a 15% increase by 2020/21

2b. Increase cervical screening coverage in women aged 25-49
i. Achieve and maintain 80% coverage for women aged 25-49

2c. Increase bowel screening coverage
i. Achieve and maintain 65% coverage

2d. Reduce late diagnosis of HIV
i. Achieve and maintain <50% late diagnosis of HIV

2e. Increase detection and treatment of chlamydia
i. Achieve and maintain a chlamydia detection rate of 2,300 per 100,000

3. Tackling the four lifestyle behaviours

3a. Reduce the harms caused by drinking
i. 50/100,000 annual reduction in alcohol-related admissions (broad definition), and a 250/100,000 reduction by 2020/21

3b. Increase the uptake of preventative programmes in vulnerable and deprived groups
i. Health checks target , weight management and smoking targets TBC
ii. Achieve and maintain 70% coverage for annual learning disability health checks

3c. Increase opportunities for physical activity
i. Target TBC

3d. Support implementation of the Diabetes Prevention Programme
i. Target TBC

4. Promoting mental health & wellbeing

4a. Strengthen perinatal mental health pathways
i. Target TBC – maternal mood assessment

4b. Improve the emotional wellbeing and resilience of vulnerable children and young people
i. Target TBC

4c. Improve awareness, diagnosis and treatment of dementia
i. Target TBC
ii. BLMK partners are recognised as dementia friendly organisations

4d. Improve the physical health of people with mental health issues
i. Target TBC

5. Achieving healthy workforces

5a. BLMK partners become exemplars for workplace wellbeing
i. All partners achieve Level 3 'Excellence' accreditation for the National Workplace Wellbeing Charter by 2020/21

5b. All NHS Trusts develop and achieve workplace wellbeing CQUINs
i. Workplace wellbeing CQUINs developed and approved
ii. Workplace wellbeing CQUINs achieved

5c. BLMK partners implement smoke-free estates
i. All partners' estates smoke free by 2020/21

5d. Reduce the employment gap for people with mental illness, sensory, physical and learning disabilities
i. Target TBC

6. Empowering communities & self-management

6a. Increase the contribution of self-managed care
I. **Target** TBC

6a. Optimise the detection and treatment of diabetes, cardiovascular disease and respiratory disease
i. 1% annual increase in the achievement of diabetes treatment targets and a 5% increase by 2020/21
ii. Other targets TBC

6b. Reduce injuries due to falls
i. 2% annual reduction in admissions for injuries due to falls and a 10% reduction by 2020/21

6c. Increase the availability and uptake of volunteering opportunities
i. Target TBC

6d. Strenthen the role of the 'wider workforce' in prevention, including pharmacists
i. 75% of pharmacies achieve Healthy Living Pharmacy accreditation

6e. Ensre the voice of the local community is listened to and acted on
i. Target TBC

Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information No.

Title of Report **Bedfordshire CCG Local Digital Roadmap**

Meeting Date: 19 October 2016

Responsible Officer(s)

Presented by: Ben Jay, Chief Finance Officer, BCCG

Recommendation(s)

1. **To note the requirements for Local Digital Roadmaps (LDR) to have engaged with local partners and how this has been achieved.**

2. **To note the key proposals contained within the BCCG LDR.**

Purpose of Report	
1.	This paper sets out key points on the content, context, and preparation of the Local Digital Roadmap (LDR) for Bedfordshire CCG (BCCG). It also sets out planned next steps to implement the LDR.

Background	
2.	Local Digital Roadmaps were required to be prepared by Clinical Commissioning Groups (CCGs) in the NHS in the first half of 2016. CCGs were tasked with clarifying the existing position for information technology in the local environment, and set out key developments to be followed up over the next 2-4 years. An important early deadline is ‘paperless’ treatments to be enabled for urgent and emergency care by 2018.

Reason(s) for the Action Proposed	
3.	The Health and Wellbeing Board should be aware of the process of compiling the LDR and also aware of the key contents of it.
4.	The main options considered were those where early progress could more easily be made, or where key objectives had already been defined at a national level.
5.	The LDR is focussed on better use of technology to support residents and patients more effectively – for example, through an expansion of 'self-care' for people living with long term conditions, or through data sharing (in a managed and controlled data environment) between social care, community care, primary and acute care settings.

Issues	
Governance & Delivery	
6.	Development towards the LDR objectives will be reported back to the BCCG governing body and to the STP leadership (digitisation workstream). Periodic reports and updates could also be brought back to the Health and Wellbeing board as required.
Financial	
7.	There are no financial implications arising from the report. Supporting delivery of the LDR will require additional NHS capital investment. This is currently being developed in the context of the Estates and Technology Transformation Fund (ETTF) bids made by the BCCG and also in the context of STP capital planning. Other funding sources may also become available.
Public Sector Equality Duty (PSED)	
8.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
	Are there any risks issues relating Public Sector Equality Duty ~~Yes/~~No
	If yes – outline the risks and how these would be mitigated

Ben Jay

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Presented by Ben Jay, Chief Finance Officer, BCCG

Appendix A

Bedfordshire CCG Local Digital Roadmap

This paper sets out key points on the content, context, and preparation of the Local Digital Roadmap (LDR) for Bedfordshire CCG (BCCG). It also sets out planned next steps to implement the LDR.

1. Context

LDR was announced in September 2015 as part of the Five Year Forward View, specifically targeting paperless emergency and urgent care by 2018 and paperless care in general by 2020. Detailed NHS guidance published April 2016: https://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2016/05/develp-ldrs-guid.pdf

2. Engagement

Section 7.1 of the guidance sets out requirements to 'engage with' local partners in the STP footprint. Engagement focussed on key areas of weakness that needed to be addressed in order to line up broader future progress.
Ideally, LDR plans should seek board level approval from partners by the end of June 2016, although there was a recognition that this may depend on the level of maturity of local partnerships.
Engagement by BCCG has included the following:

1. Contacted Chief Executives of Bedford Borough Council and Central Bedfordshire Council for details of appropriate contacts in Information Technology teams and social care teams.

2. Meetings with key partners and stakeholders as part of baselining the current position and undertaking the maturity assessment work. Included discussion with local authority contacts in IM&T and social care (CBC – Patricia Coker and Nick Murley).

3. May 4th - Workshop held by BCCG - 35 individuals across 11 organisations invited, 22 individuals across 8 organisations attended (including Bedfordshire CCG, Bedford Hospital, East London Foundation Trust (EFLT), South Essex Partnership Trust (SEPT), Luton and Dunstable Hospital, Milton Keynes CCG, Luton CCG, Central Beds Council).

4. STP digitisation workshop in June.

3. Maturity assessment

This shows that the development across the STP footprint is variable. The maturity assessment highlights three areas

- secondary care,
- information flows between areas such as secondary, primary and social care,
- promoting self-management and health promotion.

Secondary care data is not always recorded once and digitally, clinician alerts are not always used, and IT tools (eg computerised rostering, medicines optimisation) are not used consistently. Generally, Luton and Dunstable presents as having a higher level of digital 'maturity' than Bedford and Milton Keynes hospitals.
Paperless flows of information are also not yet 'normal'. Local use of electronic data is increasing, but information on transfer, referrals, bookings etc are less usual, and use of collaborative technology is not yet well developed.
Using technology to promote self-care was identified as weak across the whole footprint.
This was closely mirrored in other STP findings, particularly that the ability to share patient information in a consistent and coherent way, to support key aspects of care (referrals, discharges, transfers, appointments etc) was a key blockage.

4. LDR

The LDR document itself sets out a vision to maximise the use of information to secure best outcomes and the greatest efficiency. The document itself is available but is summarised below as it runs to 50 pages, with many further pages of appendices.
Key LDR priorities are identified as

- Enhancing the use of existing systems. For example, 'system one' is used by all GP practices in Bedfordshire (which is unusual) and is also used by SEPT. An early 'win' would be to secure use of the data both to support individual patient tranasctions in a more consistent and efficient way, but also to provide insight into the overall performance of the local health economy.
- Convergence between hospital campuses. Current hospital systems between L&D, Bedford and MK are a patchwork demonstrating different levels of maturity and integration both across sites and between sites. A clear goal is therefore to improve those systems consistent with paperless operation objectives, initially for urgent and emergency care.
- Health information exchange. This is a key requirement to provide greater 'interoperability' or sharing of patient data between different agencies.

Other priority areas for development include

- Greater use of risk stratification, including layering of different stratification analysis, and enhancing predictive analytics.
- Supporting greater self-care
- More proactive decision making around patient pathways
- Increased levels of system insight (areas of activity under pressure, and analysis of that)
- Developing the local evidence for 'what works' and prioritising investment accordingly
- Promoting citizen-based ownership of health and well-being

The LDR has been received by Governing Bodies/Executive Leadership Teams across the 3 CCGs. Next steps will include taking the document to Health and Wellbeing Boards.

5. Mobilisation

In implementing the LDR, the current intended next steps are set out below. However, this will be influenced by the extent of STP leadership and direction on this theme that emerges across the course of the summer.

- Governance - establishing a Digitisation Programme Board, including Terms of Reference and relationships with organisational interfaces (e.g. primary care, social care, secondary care etc)

- Programme definition - the more detailed development and mobilisation of the Digital Programme, building on the outline LDR / STP digital workstream.

- Strategic options appraisals and business case support for the major themes of the Digital Programme, including on integrated care records, PHRs and network infrastructure - these would need close development with the service-facing initiatives of the STP.

- Programme management and technical project management for the BLMK tech fund scheme: the 1st phase / early wins focus for records sharing and integration.

- Supporting development of patient consent models for information sharing, linked to patient & public engagement and communications and IG.

- Commercial / supplier engagement and market intelligence.

6. Conclusion

This note has summarised the context and content of the BCCG LDR document. It also sets out key next steps in adopting and progressing the areas for improvement identified within the LDR.

Further work will be undertaken, aligned to the STP, to secure delivery of the key objective of the LDR. Close working with all STP partners will be critical to the success of this programme.

Ben Jay
Chief Finance Officer
Bedfordshire CCG

Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Bedford Borough and Central Bedfordshire Safeguarding Adults Board Annual Report 2015-2016
Meeting Date:	19 October 2016
Responsible Officer(s)	Julie Ogley
Presented by:	Julie Ogley

Recommendation(s)

1. **For the Health and Wellbeing Board to receive the 2015-2016 Annual Report of the Safeguarding Adults Board.**

Purpose of Report	
1.	Under the Care Act 2014 the Safeguarding Adults Board (SAB) must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any safeguarding adults reviews and subsequent action. Every SAB must send a copy of its report to: • the Chief Executive and Leader of the Local Authority • the Police and Crime Commissioner and the Chief Constable • the local Healthwatch • the Chair of the Health and Wellbeing Board. It is expected that those organisations will fully consider the contents of the report and how they can improve their contributions to both safeguarding throughout their own organisation and to the joint work of the Board.

Background	
2.	The SAB is a statutory Board covering the areas of Bedford Borough and Central Bedfordshire. The core objective of the SAB is to seek assurance that local safeguarding arrangements and partners act to help and protect adults in its area who are unable to protect themselves form abuse or neglect due to their care and support needs.

	The SAB oversees and leads adult safeguarding across the locality and is interested in a range of matters that contribute to the prevention of abuse and neglect. These include the safety of patients in its local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services. The SAB has three core statutory duties: • Produce a strategic plan • Publish and annual report • Conduct any safeguarding adults review in accordance with Section 44 of the Care Act.
3.	The Health and Wellbeing Board has previously received the SAB Annual Report 2015-2016.
4.	During the past 12 months the Board focussed on: • Embedding the well being principles of the Care Act, including “making safeguarding personal” which ensures that we have a focus on the outcome that the person we are seeking to support is at the fore. • Increasing awareness of sexual exploitation, modern slavery and self neglect. • Improving our working arrangements with the Local Safeguarding Children Boards and Community Safety Partnerships. • Responding to and monitoring the ongoing impact of the Supreme Court ruling on Deprivation of Liberty Safeguards (known as “Cheshire West”). The Board also moved to recruit its first Independent Chair, who came into post in March 2016.
5.	The developing context for safeguarding adults in 2015-2016 was marked by four key themes: • The Care Act and implementing statutory changes to the focus of safeguarding. • Making Safeguarding Personal, meaning a renewed focus on safeguarding being less about substantiating an investigation and more about being person-led and outcome-focused. Safeguarding work engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It may not always reduce or remove the risk.

	• Exploitation and Modern Slavery; through work with the Local Safeguarding Children's Boards and the Community Safety Partnership, a more detailed understanding of these areas and how people with care and support needs might be affected is beginning to be understood. • Working with Vulnerability; increasing reports into safeguarding services about people in vulnerable or high risk situations, and the focus on "well being" of the Care Act, has prompted a focus on people whose care and support needs are not easily identifiable but who may need access to support and guidance.
6.	During the year, the Council's serious concerns process was initiated in respect of one nursing care home, following 19 safeguarding concerns reported to the Council; four in April, nine in May, and four in June. Following CQC enforcement action to remove the registration, this care home was closed on 7 August 2015. Following an appeal the home's registration has been reinstated by tribunal and the home has since reopened under a new name. The serious concerns process continues to monitor progress following the court order.
7.	The SAB commissioned two Safeguarding Adults Reviews (SARs) during the year. One related to a suspected case of domestic servitude in Bedford and the other related to the quality of care received by a Central Bedfordshire resident. Both of these SARs concluded after the end of the reporting year; both have an action plan which is being monitored by the SAB Safeguarding Adults Review sub group.
8.	In February 2016 the two local authorities commissioned an external case file audit of safeguarding work. The findings showed a high degree of understanding of the need to ensure immediate safety; a proportionate response to safeguarding concerns and subsequent enquiry; holistic and robust risk assessment; concern for quality of life issues in addition to the safeguarding concern; a personal approach, appreciation of well-being and appropriately reflected desired outcomes; and an understanding of Mental Capacity Act issues, advocacy provision and Deprivation of Liberty Safeguards (DoLS). Areas for development included accurate recording; consistency of approach to risk enablement and assessment; use of the safeguarding recording framework to evidence making safeguarding personal; ensuring close collaboration with Police; consistently recording reasons for delay; management oversight; managing complex meetings so minutes are taken accurately; and developing a feedback process.
9.	Each partner agency has reported on its progress with its safeguarding action plan, specific safeguarding risks and issues managed over the year, outcomes of audit, and priorities for the forthcoming year.

	The Council has identified the following priorities for 2016-2017: • Address the significant increase in volume of reports via the safeguarding team that are not of a safeguarding nature or relate to people with care and support needs. The number of safeguarding enquiries has increased by 39% but is a much smaller proportion of total reports compared to the previous year (11%). The total number of reports was 2,935, with 330 progressing to a safeguarding enquiry. • A review of the safeguarding training offer and the related competency frameworks. • Ongoing development work is required with care providers who undertake delegated safeguarding enquiries under the Care Act, to move the standard from “adequate” to “good”. The CCG has identified the following priorities for 2016-2017: • Development of a care home profile for each care home within Central Bedfordshire and Bedford Borough. This will enable improved oversight of issues and/or concerns so that appropriate action can be taken. • Development of an announced and un-announced visit schedule of all commissioned services, to incorporate care homes. • Part of the NHS England Midlands pilot scheme to use a standardised, electronic safeguarding data/ assurance tool. Roll out is anticipated for September 2016.
10.	The overall learning from the SAB annual report is as follows: • Increased volumes of reporting that identify risk but are not of a safeguarding nature and that could be managed through other routes. A priority for 2016-2017 will be to work closely with partners to ensure that safeguarding reports are proportionate and clearly identify whether a person is experiencing abuse or neglect, and to identify where there are opportunities for alternative referral routes. • Pressure on advocacy services resources to respond to the requirements of the Deprivation of Liberty Safeguards (DoLS). A priority for 2016-2017 will be consideration of alternative models of provision; ensuring DoLS data is included in contract reviews. • The Law Commission draft Bill on DoLS is expected December 2016. A priority for 2016-2017 will be to keep abreast of legislative changes for DoLS and planning for the response.

	• An ongoing focus on “making safeguarding personal” is required. A priority for 2016-2017 will be to review practice development and quality improvement opportunities that promote a more person centred approach in safeguarding. • An ongoing focus on agencies other than the local authorities undertaking S42 enquiries is required. A priority for 2016-2017 will be to continue to audit and review the outcomes and quality of all enquiries.
11.	During the coming year the Board will be focusing its activities around four broad themes: • Improving Board resilience – ensuring all Board members understand and deliver their roles and responsibilities as Board members; • System Assurance – ensuring the Board is confident that arrangements for safeguarding are effective, well managed and performing well and staff have the skills and knowledge required; • Challenge – the Board identifies areas where agencies need to improve their service or performance and is assured that action is taking place; • Awareness – the Board is confident that partners are aware of the strengths and challenges within the local community and that agencies are effectively identifying and responding to emerging risks. The SAB has a Business Plan for the year 2016-2017 that reflects the findings of the annual report.

Reason(s) for the Action Proposed	
12.	This report is for the consideration of the HWB.

Issues	
Governance & Delivery	
13.	The Bedford Borough and Central Bedfordshire Safeguarding Adults Board is a joint partnership Board and is jointly accountable to the Chief Executives of the relevant Councils. Bedfordshire Clinical Commissioning Group and Bedfordshire Police are statutory partners of the Safeguarding Adults Board.
Financial	
14.	None

Public Sector Equality Duty (PSED)	
15.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Organisations safeguarding functions play a very positive role in terms of promoting equality by working with vulnerable groups and being proactive in tackling issues such as domestic abuse, hate crime, modern day slavery and hate crime. The low level of reporting from ethnic groups referenced in the annual report will be considered further by safeguarding board partners in the work around awareness raising
	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 Julie Ogley

Annual Report of the
Bedford Borough and Central Bedfordshire Adult Safeguarding Board

April 2015- March 2016

Abuse is Everybody's Business
Safeguarding is our Responsibility

Contents **Page**

Introduction

This annual report covers the work of the Bedford and Central Bedfordshire Safeguarding Adults Board during the year April 2015 to March 2016.

It aims to inform residents of the two unitary council areas, including those who use social care and health services, their families and carers, elected members of each Council, those who work in social and health care across all partner agencies, about the work of the Board and safeguarding activity across the area. Over the year all partner agencies who are part of the Board continued to work closely together with the aim of ensuring effective safeguarding. Partners have openly shared information on how they have performed, about the issues and challenges that they have faced over the course of the year and have sought to identify areas where closer joint working and co-operation will lead to improved outcomes for people.

During the past 12 months the Board focussed on

1. Embedding the well being principles of the Care Act, including "making safeguarding personal" which ensures that we have a focus on the outcome that the person we are seeking to support is at the fore.
2. Increasing our awareness of sexual exploitation, modern slavery and self neglect.
3. Improving our working arrangements with the Local Safeguarding Children Boards and Community Safety Partnerships
4. Responding to and monitoring the ongoing impact of the Supreme Court ruling on Deprivation of Liberty Safeguards (known as "Cheshire West")

The Board also moved to recruit its first Independent Chair and I came into post in March of this year.

During the coming year the Board will be focusing its activities around four broad themes:

1. Improving Board resilience – ensuring all Board members understand and deliver their roles and responsibilities as Board members;
2. System Assurance – ensuring the Board is confident that arrangements for safeguarding are effective, well managed and performing well and staff have the skills and knowledge required;
3. Challenge – the Board identifies areas where agencies need to improve their service or performance and is assured that action is taking place;
4. Awareness – the Board is confident that partners are aware of the strengths and challenges within the local community and that agencies are effectively identifying and responding to emerging risks.

A business plan with specific actions will build on those themes and will guide the work of the Board in the year to come.

Safeguarding is everybody's responsibility – the Board will do all that it can to support the work of our professional teams across health, local authority, voluntary sector and care providers. We will build on the strengths that currently exist and aim to learn from instances where things may not have been entirely successful. We will keep the Making Safeguarding Personal tenets of well-being and that outcomes people with care needs wish for are at the heart of our work.

Terry Rich
Independent Chair

1. The Developing Context for Safeguarding

1.1 The Care Act 2014

From April 2015 the Care Act 2014 put the Safeguarding Adults Board on a statutory footing. Revised statutory guidance was introduced in March 2016. Some of the more substantial changes reflected learning and feedback through the first period of implementation, including:

- Clarification that ordinarily, an enquiry under Section 42 of the Act is not appropriate where people are failing to care for themselves. Section 42 is primarily aimed at those suffering abuse or neglect from a third party.
- Updated definition of domestic violence to reflect new legislation.
- Additional information in relation to financial abuse to reflect significant increases in internet, postal and doorstop scams and crime.
- Amendments to reporting and responding to abuse to highlight the need for practitioners to consider the need for criminal investigations and take advice if necessary.
- Reporting and responding to abuse and neglect amended to remind local authorities that they have powers even where they do not have duties - adult safeguarding is one area where this may be significant.
- Reinforcement of the principle of prevention (better to prevent abuse than act after the event) and a reminder to practitioners of the importance of identifying and managing risk of abuse and neglect, even where those concerns are not the presenting issue.
- New guidance on allegations about people in positions of trust - emphasising that this is a responsibility of all partner agencies as well as the large and diverse independent provider sector.
- Local authorities encouraged to use existing tried and tested surveys to understand the experience of carers and service users who have been involved in a safeguarding process.
- The removal of the requirement to appoint a Designated Adult Safeguarding Manager (DASM). This was seen to have been confusing and contradictory and distracted from improving practice.
- The role of professional and practice leadership in adult safeguarding strengthened, to recognise the need to have expertise within an organisation where practitioners and their managers can go for advice and guidance. Emphasises the potential role of the Principal Social Worker in this area of practice.
- Section on strategic leadership reworked to articulate clearly the need for a strategic and accountable lead for safeguarding at a senior level in an organisation to ensure action to implement the SAB Strategic Plan.

1.2 Making Safeguarding Personal

The Care Act (2014) defines safeguarding adults as protecting an adult's right to live in safety, free from abuse and neglect. Making Safeguarding Personal (MSP) aims to make safeguarding person-centred and outcomes focussed, and moves away from process driven approaches to safeguarding. The approach started in 2009, and has been led by councils. Since then it has grown in scale and momentum, culminating in inclusion in the Care Act (2014).

Rethinking key elements of safeguarding are important to making safeguarding personal, such as:

- Working to individuals' stated outcomes, rather than imposing outcomes. For example, in cases of domestic abuse, safety planning rather than encouraging people to leave the relationship straight away may be a positive outcome
- Agreeing 'desired' and 'negotiated' outcomes with people and spending time at the beginning of an intervention to get this right. This can be helpful to agree on outcomes that are realistic and take account of the broader context (e.g. law, human resources law and public interest).
- Ensuring that adequate time is spent preparing people for meetings, and not making assumptions about people's ability to express their outcomes, involving advocates where needed.
- Gathering feedback as the enquiry is progressing where possible, to avoid 'opening old wounds' by seeking feedback after the enquiry is closed.

In addition it is important to review our processes and ways of working including:

- where meetings are held
- who attends
- what can and cannot be discussed
- who needs to know what
- how data, discussions and decisions are documented
- how and by whom meetings are chaired
- and what skills, training and support people need to participate

While making safeguarding personal has started to become embedded, Recording of outcomes is an area that still needs significant work, despite much time and effort already having been spent on it. Data relating to outcomes is patchy and inconsistent and recording systems are often not set up to support this way of working.

1.3 Exploitation and Modern Slavery

Modern Slavery can include victims that have been brought from overseas, and vulnerable people in the UK, being forced to illegally work against their will in many different sectors, including brothels, cannabis farms, nail bars and agriculture. Sexual exploitation is included within the definition of modern slavery. In Bedford and Central Bedfordshire we have experience of homeless and alcohol dependent people in forced labour on traveller's sites, and domestic servitude experienced by a person with mental health needs.

From 1 November 2015, specific public authorities have a duty to notify Home Office of any person identified in England and Wales as a suspected victim of slavery or human trafficking. If the person consents, the national referral mechanism (NRM) should be used. The NRM is a victim identification and support process designed to make it easier for all the different agencies that could be involved in a trafficking case, for example, police, UK Visas and Immigration, local authorities, and non-governmental organisations to co-operate; to share information about potential victims and facilitate their access to advice, accommodation and support.

From 31 October 2015 there is a requirement for regulated health and social care professionals and teachers in England and Wales to report 'known' cases of female genital mutilation in under 18s which they identify in the course of their professional work to the police.

1.4 Working with Vulnerability

The implementation of the Care Act and its focus on well being has led to an increased focus on issues such as self neglect, hoarding, domestic abuse, and exploitation, as well as on people who may not have accessed adult social care historically but present as being vulnerable. This means there is an increased responsibility for Safeguarding Adults Boards to work in partnership, think creatively about how to respond, and balance the challenges of working with risk. For example, in cases of self neglect using multi agency risk enablement panels or conferences to establish which agency is best placed to support individuals on a longer term basis; ensuring domestic abuse cases are escalated and heard at MARAC; using existing resources in areas such as anti social behaviour and utilising partners skills, knowledge and expertise in challenging situations.

2. The work of the Safeguarding Adults Board in Bedford Borough and Central Bedfordshire

Name Of Organisation:	Bedford Borough Council

1. Progress on agency action plan for safeguarding

- The safeguarding team meets with the council Local Authority Designated Officer to share information and improve links with children's services.
- Meetings with representatives from Housing sector, Community and Voluntary sector and care providers to support issues pertinent to the sector
- Joint work within PAN Bedfordshire Group to produce a common template for providers undertaking S42 Enquires including guidance.
- Focus on Dignity in Care Day with displays and publicity to raise awareness.
- MCA awareness exercise relating to unwise decision making to promote greater awareness of the principals of the Mental Capacity Act held on Mental Capacity Awareness day (15/03/16).
- Partnership working by representation at Safer Community meetings, Anti-social behaviour meeting, Hate Crime Partnership, info sharing meeting with Care Quality Commission (CQC)
- 6 weekly meeting with the council Care Standards Team to share information about providers of concern and agree actions
- Attendance at the Pan Bedfordshire meeting to review training at Bedford Borough Council, Central Bedfordshire Council and Luton Borough Council with Workforce development managers as well as sharing case studies and implementing joint pieces of work
- Worked towards implementing the ADASS guidance and paperwork re Deprivation of Liberty Safeguards (DoLS) in relation to senior management sign off of DoLS
- Risk Enablement Panel met on a regular basis to consider complex cases where service users were making unwise decisions
- Work has continued following the investigation into criminal abuse at Winterbourne View Hospital in 2012 which 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 behaviors that are described as challenging. In 2015 a 'Joint Transformation Plan' for Bedfordshire, Luton and Milton Keynes was drafted in response to the required actions led by the government. The plan been developed in partnership with the organisations identified within a new footprint area (Specified by NHS England), this includes three Clinical Commissioning Groups (CCG) and four Local Authorities, including Bedford Borough Council. A Transformation Board now meets on a monthly basis to oversee progress, this is led by Luton Clinical Commissioning Group and attended by core members of the Safeguarding Board.
- Bedford Borough Council has set up a Board concerning Child Sexual Exploitation and other vulnerabilities. This extends to the PREVENT agenda as well as modern slavery and other known vulnerabilities to enable concerns and intelligence to be shared amongst professional agencies.
- Regular meeting with East London Foundation Trust (ELFT) in relation to mental health services
- Meeting with team managers and advanced practitioners to share good practice and address safeguarding and DoLS issues
- Meeting with managers at an immigration detention centre to discuss safeguarding issues, regular meetings have been set up, which includes a representative from the council's children service
- Ongoing liaison and meetings with Bedford Hospital, the Bedfordshire Clinical Commission Group (CCG) and ELFT in relation to complex cases
- Individual work with providers where practice issues or concerns are identified for safeguarding, mental capacity and DoLS

2. Safeguarding risks and issues related to your agency and action taken

The Care Act 2014 came into effect on 1st April 2015 and enabled local authorities to request that another agency undertakes a formal safeguarding enquiry under section 42 of the Care Act. Bedford Borough Council took the decision not to ask other agencies to undertake a Section 42 Enquiry until training had been offered to ensure agencies and providers had the appropriate skills to undertake such an enquiry. Due to capacity issues for trainers, it was not possible to commission dates until after April 2016. A programme of training has now been implemented with a view to providers and agencies undertaking Section 42 Enquires.

An ongoing risk resulting from the Care Act is the requirement to provide an advocacy support for any individual part of a safeguarding enquiry that has 'substantial difficulty' in understanding and being involved in the process. Because of the pressures upon the local advocacy service, discussions have taken place between the service and the Bedford Borough Commissioning Team around the contract and what services can be provided, but it is likely that there will be a reduction in funding and this may impact on the level of community advocacy services offered for 16/17. Further pressure is resulting from the DoLS Supreme Court Ruling and the involvement of advocates to support this process.

The Bedford Borough Safeguarding Team continues to receive a high volume of safeguarding concerns/contacts and requests for DoLS, which results in the team being stretched at points. Consequently there has been a reduction in the amount of awareness sessions and developmental work that the team has been able to undertake. Team processes are reviewed to ensure the team is working effectively and changes in paperwork have been introduced to speed up processes.

DoLS has had a 29% increase over the year and throughout the year the number of DoLS authorisations that have exceeded time scales had increased. Reasons for exceeding time scales included increase in volume of requests resulting in administrative and process delays and backlogs, and delays in completion of assessments. Additional administrative staff have been employed to support this process and options for more effective and timely sign off of authorisations by senior council staff have been considered. An increased number of Section 12 Doctors and independent Best Interest Assessors have been commissioned by the Safeguarding Team and the team has also employed 2 permanent Best Interest Assessors to deal with the increasing levels of requests. Compared with other local authorities, the team has managed the volume of alerts well and there was no waiting list for assessments during this period.

Bedford Borough Adult services have been involved with a Serious Case Review initiated by children's services which involved the death of a young adult of 17 with a learning disability whose care would have been part of the transitions process. Recommendations have been made which include a holistic approach to Carers assessments and challenges and taking action when families refuse care and support for a vulnerable person.

Bedford Borough Council initiated a Safeguarding Adult Review for a case of suspected modern slavery. An independent reviewer with expertise in modern slavery and safeguarding was appointed to undertake the review and produce a report identifying learning across the agencies involved.

There has been ongoing collaboration with the Bedford Borough Care Standards Team to monitor a residential care home that had previously been under serious concerns. The home was unstable due to lack of management and the company placed a voluntary suspension of admissions whilst it reviewed its management position and put in place an interim manager.

As a result of ongoing concerns about practice issues in an independent hospital, ongoing monitoring and liaison between commissioners, CQC, BBC and CCG has been in place. CQC undertook an announced visit in August which resulted in an inadequate rating. Ongoing monitoring is still in place.

Following covert filming at a care home by family members which highlighted issues of poor care, 6 staff were suspended, and a S 42 Enquiry instigated which up held the concerns. The case was reported to the media and local press. The provider took disciplinary action which resulted in some staff being dismissed. The individual with family involvement was moved to a new care home.

Close working with ELFT and the CCG in relation to levels of safeguarding concerns within inpatient settings.

Following on from the independent audit undertaken, a recommendation was for the Safeguarding Board to consider the case of an individual who was admitted to hospital and concerns raised regarding the treatment, care and decision making that occurred in relation to his mental health needs and proposed use of ECT when the hospital were not licence to give ECT. This was discussed with the chair of the SAB and the case was to be referred to the SAB SAR Subgroup that was to be set up.

Due to capacity issues caused by staff vacancies, the Bedford safeguarding team has faced challenges in responding to all safeguarding concerns within timescales. Particular difficulties have been experienced with the high level of concerns and contacts either of a low level risk, where no abuse has occurred or where support needs where identified. The team has recruited to vacancies and will be fully staffed by September.

Issues in recording outcomes of completed S 42 Enquires have been identified. Regular meetings with the Corporate Performance Team have been set up and information reports are to be sent to the team monthly so any recording issues can be identified at an early stage.

An Easy Read leaflet explaining the safeguarding process to people with care and support needs involved in a safeguarding enquiry has been started, but due to capacity issues within the team issues has not been completed.

3. Outcomes of audit

- Programme of audits of Mental Capacity Assessments implemented, with feedback given to individual practitioner. Themes show that assessments were not evidenced based, not enough steps had been taken to support the person to help them make a decision, and it was unclear in some assessments how the decision as to whether a person had capacity or not was reached.
- Each completed S42 Enquiry is audited by the team manager or advanced practitioner for that team. There is a need to update the internal audit tool to incorporate checks that practitioner are appropriately recording outcomes on the council data base.
- Independent audit undertaken of both completed S 42 Enquires and safeguarding concerns that were screened out by the safeguarding team
- An internal audit planned for Oct with team managers and advanced practitioners. The audit did not take place due to unprecedented levels of sickness and low capacity within teams.

4. Risks and issues related to safeguarding training and policy

- Care providers training to undertake S 42 Enquires have been introduced so that providers have the relevant skills to undertake S 42 Enquires. Courses are well subscribed to and additional courses may have to be considered.

- It has been identified that the basic Mental Capacity training is not run frequently enough to ensure new employees receive the training within a reasonable timescale of starting. The metal Capacity Lead Practitioner is undertaking training to be able to deliver a monthly programme of basic mental capacity training. This training can also be adapted to meet the requirements of a specific team if needed.
- The Eastern Regions Safeguarding Leads Group has identified areas to develop and is working on modern slavery, Safeguarding Adult Reviews guidance, Making Safeguarding Personal and PREVENT
- The Safeguarding Competencies have been reviewed. Implementation of Safeguarding Competencies with teams needs to be undertaken
- Completion and implementation of MCA competencies
- Regular meetings with the Corporate performance team to identify an issues with recording and consideration if training for teams is required
- Review of safeguarding and Mental Capacity Assessment training and meetings set up with trainers for to discuss next year's training needs
- Regular Best Interest Assessors (BIA's) supervision groups including independent BIA's. Programme of training to for appropriately qualified workers to undertake their BIA training.
- Sessions to be set up with team managers and advanced practitioners on how to audit mental capacity assessment's and best interest decisions to ensure quality assessments and decisions.
- Review of the Multi Agency Policy and Procedure

5. Safeguarding risks and issues to prioritise in 2016-2017

- Introduction of safeguarding documentation that is based on Making Safeguarding Personal principals
- Implementation of a tracker and quality monitoring system for S 42 Enquires allocated to providers and other agencies
- Review of ongoing safeguarding training for practitioners undertaking S42 Enquires and review and commissioning of generic training for others
- Partnership working with agencies to identify alternative routes into services for people with care and support needs other than via the safeguarding team
- Ongoing work with providers in relation to appropriate reporting of concerns
- Strengthen links with LSCB and children's services with a focus on
- Review of S42 training for providers
- Training for safeguarding conference meetings minute takers to improve quality of mins
- Eastern Regions Safeguarding Group to focus on areas of modern slavery, Making Safeguarding personal, Safeguarding Adult Review and PREVENT.
- The Mental Capacity training has been reviewed with new trainers commissioned and additional training set up for practitioners managing complex cases which could result in Court of Protection proceedings.

Name Of Organisation:	Central Bedfordshire Council

1. Progress on agency action plan for safeguarding

- Corporate project established to respond to DoLS across the Council including the Coroner and Childrens services
- Revision of the safeguarding recording framework to include a review of person centred outcome and evaluation forms
- Review of risk enablement approach including policy and practice guidance

- Joint Board meetings across the LSCB and CSP are taking place; the chairs of these Boards have met and the Boards leads have been tasked to meet to plan a shared approach to common agenda. Leads for the Central Bedfordshire LSCB, CSP, SAB and HWB produced a paper for the chairs focusing on domestic abuse, mental health, prevent and radicalisation, female genital mutilation, hate crime, modern slavery, substance misuse and child sexual exploitation to support prioritisation of common issues
- Contribution to the Central Bedfordshire Domestic Abuse Strategy following a review by Safe Lives, the CSE strategy and the annual CSP strategic assessment
- Modern slavery and self neglect have been highlighted at the eastern region safeguarding leads meeting. Focus on improving the skills of the safeguarding team - attendance at modern slavery train the trainer event; attendance at self neglect briefing from Making Research Count.
- Safeguarding team awareness raising with a day centre, a housing tenants forum and the full of life older people's festival, carers rights day and day centre. Targeted work has begun with care homes and care agencies where safeguarding reporting patterns are noted
- Central Bedfordshire and Bedford Borough safeguarding teams met to review their approach to responding to safeguarding concerns post Care Act
- Representation at regular partnership group meetings - Police pan Bedfordshire steering group, L&D adult safeguarding board and CQC information sharing group

2. Safeguarding risks and issues related to your agency and action taken

During May a focused piece of work to review the recording of risk in safeguarding was undertaken. This revealed that that there continues to be variability in recording throughout the safeguarding process and throughout teams. A further monthly review of open safeguarding cases is carried out in order to proactively identify where gaps in recording and practice may be occurring.

The safeguarding team audited all cases undertaken by external agencies under S42 of the Care Act. Those with outcome of poor were due to the limited information within the report, and further information was requested from the agency to satisfy the team that a robust response had been initiated. Other results were as follows:

- Good and excellent reports did not require any further additions from the safeguarding team
- Adequate reports were varied in their quality, content and format
- Most adequate reports failed to clearly record involvement of, and feedback to, the individual and or their advocates
- Some adequate reports had outcomes but no real details in relation to how these would be met and within what timescales
- Some adequate reports did not report immediate actions or include comprehensive assessments of risk

Proposed actions:

- The safeguarding team need to be available to people undertaking S42 enquiries to discuss as cases progress, to provide a consistent approach.
- A template or form will be considered to assist and promote consistency
- Awareness of Duty of candour and its relationship to safeguarding needs to be strengthened.

The serious concerns process was initiated in respect of one nursing care home, following 19 safeguarding concerns reported to the Council during the quarter four in April, 9 in May, and four in June. Following CQC enforcement action to remove the registration, this care home was closed on 7th August 2015. Following an appeal the home's registration has been reinstated by tribunal and the home has since reopened under a new name. The serious concerns process continues to monitor progress following the court order.

A safeguarding adults review was initiated in respect of a resident formerly living at Greenacres care home. Abuse or neglect did not contribute to this person's death, however the safeguarding enquiry identified concerns relating to multi agency information sharing and response. A Serious Incident Learning Process was used to review the circumstances.

Two serious case reviews in respect of children were initiated by the Council. In both cases parents were identified as having a learning need and had been known to adult services.

The Council took a case to the Court of Protection following serious safeguarding concerns which resulted in social workers seeking an urgent order to remove an older man from his home to a local care home.

The Council had its first appeal against Deprivation of Liberty taken to the Court of Protection. An order was granted without a hearing due to all parties agreeing that the placement was in the person's best interests.

Mr X was reported to have died in a fire at his own home on 29th Feb 2015. The incident was reported to Bedfordshire police by Bedfordshire fire and rescue service. It has been logged by Bedfordshire police as non suspicious, related to cooking. His death has been confirmed and no further police or fire investigation action is being taken. The Chair of the SAB was briefed on the incident and a decision reached that: while the case raises issues around the role of agencies in safeguarding individuals who are resistant to services and are prone to self-neglect, there are not sufficient issues to warrant an SAR. The Council will initiate an internal management review with a view to presenting a case study to assist the board in considering the general issue of self-neglect and service resistance and the role of statutory and voluntary sector agencies in safeguarding their well-being.

3. Outcomes of audit

Rating	Number of files	Themes
Excellent	2	Well managed with clear documentation and planning. Risks clearly identified. Protection plan robust in its analysis of risks. Good multiagency working. Information recorded relevant to outcomes. Creative, person centred, outcomes focused and holistic with good managerial oversight.
Good	4	Very clear recording of the process and interventions used- Excellent communication with family throughout Good initial assessment and assessment of risk and protection plan. Good person centred working and involvement of person causing harm as appropriate. Could have identified strengths more clearly, would be helpful to pull all risks across to protection plan, Lacked good evidence of planning at strategy and may have discussed risks more clearly at case conference as documented.

Adequate	3	No evidence that family were contacted at the initial visit. May have considered supportive approach with the view to engaging family. Did provide appropriate responses to the concern in regard to protection planning but the risk assessment was limited in terms of its focus. Further ongoing work on domestic abuse support would have been good practice. Risk assessment holistic but fails to identify main risk concerns adequately. Outcomes not recorded
Poor	1	No good analysis of risk or liaison with other professionals, no consideration of strategy discussion to identify risks and close the case.

During October and November 2015 30 open safeguarding cases were reviewed. These have been reviewed through a combination of peer review with the practitioner and desk top review with feedback provided to the practitioner afterwards. Common themes show that the safeguarding recording framework is not being used as live documentation to show actions undertaken, evidence based decision making and protective measures in place. In undertaking these reviews the safeguarding team has been able to have discussions with practitioners about the advantages of recording a case in real time in terms of efficiency and effectiveness. This piece of work will continue in January, with the safeguarding team continuing to review open cases, and undertaking some shadowing of a safeguarding case using real time recording to test the barriers to working in this way.

4. Risks and issues related to safeguarding training and policy

- The pan Bedfordshire sub group has identified modern slavery and self neglect as potential areas where there are training needs. Both of these areas have been highlighted at the Eastern Region
- There is a need to maintain and develop the focus on person-centred safeguarding responses within the adult social care workforce and with those undertaking S42 safeguarding enquiries.
- The multi agency safeguarding policies and procedures are unwieldy as a consequence of covering many areas pertinent to safeguarding adults and the number of cross cutting issues. Consideration needs to be given to an electronic web based version that partners can easily access.
- Low numbers have attended the financial abuse and making safeguarding personal training during 2015. A review of the training offer for safeguarding was undertaken in April 2015
- The MCA DoLS training offer is being reviewed in light of the requirements for social work/ nursing staff to have a sufficient level of competency in relation to DoLS and court of protection.
- The competency frameworks for safeguarding have been updated post Care Act but the MCA competencies require review and updating post Cheshire West.

5. Safeguarding risks and issues to prioritise in 2016-2017

- The disproportionate increase in volume of reports via the safeguarding team that are not of a safeguarding nature or relate to people with care and support needs.
- A review of the training offer and the MCA competency framework

- Ongoing work required with providers who undertake S42 enquiries

6.Bedford Borough and Central Bedfordshire Joint Case File Audit

The annual independent case file audit of safeguarding work in the two Councils was undertaken in February 2016. The auditor undertook audits across both Bedford and Central Bedfordshire Councils. In summary, the audit found that:

- 75% of the Individual case audit was rated “Good”, 25% rated “Adequate”
- 82% of the Threshold decisions audit was rated “Good”, 18% rated “Adequate”
- Case recording demonstrated a high degree of understanding of the need to ensure immediate service user safety
- Response to safeguarding concerns and subsequent enquiry was proportionate in all cases
- All cases demonstrated holistic and robust risk assessment
- All cases demonstrated concern for quality of life issues in addition to the safeguarding concern
- All cases demonstrated a personal approach, concerns regarding well-being and appropriately reflected desired outcomes
- All cases demonstrated an understanding of Mental Capacity Act issues, advocacy provision and Deprivation of Liberty Safeguards (DoLS)

The headline areas of focus for development are:

- Accurate recording. The SWIFT Data base does not support practitioners to achieve excellent due to lack of appropriate tabs which reflect both the Care Act (2014) and the Multi Agency Policy. The updating of data systems can ensure actions and decisions are accurately recorded
- Risk enablement and assessment
- Use of the safeguarding recording framework to evidence making safeguarding personal
- Ensuring close collaboration with Police
- Consistently recording reasons for delay
- Management oversight
- Managing complex meetings so minutes are taken accurately
- The Service User feedback process
- Consistent approach to recording when a decision tool for an alert is not required
- Mental health services and access to SWIFT

The full report has been disseminated to all teams within the two Councils within adult social care. The safeguarding team lead officers will run practice surgeries with all teams to ensure full understanding of the learning within the report.

Name Of Organisation:	Bedfordshire Clinical Commissioning Group

1. Progress on agency action plan for safeguarding

The following actions were identified on the BCCG Safeguarding Adults 2015/2016 work plan;

- The development of an audit tool to understand the training needs for safeguarding adults in primary care. This action was met and enabled a targeted programme to be developed.
- The development of a primary care adult safeguarding training programme. An adult safeguarding training schedule, jointly delivered by BCCG and Luton CCG, is now place incorporating MCA, DoLS and WRAP. 131 delegates have attended to date, 57% of which were from Bedford Borough and Central Bedfordshire.
- The development of a training programme for BCCG staff in relation to Prevent basic awareness and WRAP dependant on role. A training programme is now in place.

2. Safeguarding risks and issues related to your agency and action taken

In acknowledgement of the Supreme court ruling, the BCCG MCA and DoLS lead has been working with the CHC team to identify intensive community care packages that may reach the threshold for DoLS. For those cases identified, capacity assessments are being undertaken to ascertain if the individual can consent to the care package/ regime that is in place. Where appropriate, applications to the Court of Protection will be sought to ensure CHC funded care packages in the community are lawful.

There are currently two Safeguarding Adult reviews, one approaching conclusion and the other awaiting publication. BCCG are working with providers to support and oversee delivery of the single agency recommendations identified. These will be monitored through contractual arrangements to ensure they are being embedded into practice. BCCG will facilitate wider learning across the health economy by sharing lessons learnt with neighbouring CCG's.

3. Outcomes of Audit

A safeguarding audit was undertaken within primary care to establish learning needs. A training programme has subsequently been developed to incorporate the identified gaps in knowledge, namely, MCA, DoLS and PREVENT.

4. Risks and issues related to safeguarding training and policy

- During 2015/2016 a combined, Care Act compliant, Safeguarding Adults and Children's policy was developed. Further policies relating to MCA and DoLS have been developed and are currently awaiting ratification.
- The Safeguarding Adults: roles and competencies Intercollegiate Document, due to be published imminently, will have significant implications in relation to the training that is delivered to health care professionals. Following publication, BCCG will review its current Adult Safeguarding training package to ensure adherence to this document.
- Adult safeguarding training for BCCG staff is provided via an e- learning module and face to face as part of the corporate induction. As of March 31st 2016, compliance for the e- learning module was recorded as 91.86%.
- Additionally, BCCG oversee provider safeguarding arrangements which includes compliance with training and assurance that appropriate policies are in place.

5. Safeguarding risks and issues to prioritise in 2016-2017

- Development of a care home profile for each care home within Central Bedfordshire and Bedford Borough. This will enable improved oversight of issues and/or concerns so that appropriate action can be taken.
- Development of an announced and un-announced visit schedule of all commissioned services, to incorporate care homes.
- BCCG are to be part of the NHSE Midlands pilot scheme to use a standardised, electronic safeguarding data/ assurance tool. Roll out is anticipated for September 2016.
- To work with and support providers, to ensure that the recommendations from the Safeguarding Adult Reviews, commissioned in 2015/2016, are addressed and embedded into practice.

Name Of Organisation:	Bedfordshire Police

1. Progress on agency action plan for safeguarding

- Domestic Violence Protection Notices and Orders (DVPN/Os) continue to be successfully issued in Bedfordshire. The number of DVPOs served and obtained by the force has increased significantly.
- A new offence came into force on 29 December 2015 which sees coercive and controlling behaviour in abusive relationships carry a sentence of up to five years. Over the last six months we saw an upward trend in the conviction rate towards the national average of 75%, with the rolling rate sitting at 73%, up from 70% last year.
- The force has commenced a domestic violence perpetrator panel alongside the Integrated Offender Management that seeks to reduce repeat victimisation.
- Work on Hate Crime has led to the recruitment of the first 3rd party reporting centres for hate crime, there are now 5 spread across the County. Members of these organisations have received specific hate crime training.
- Following a hate crime action week involving the Police and partner agencies over 90 people attended from 50 different organisations, 7 of these have signed up to become 3rd party reporting centres with a further 10 expressing an interest.
- Reports of hate crime have steadily increased year on year, this year has averaged 68 reports per month compared to 64 last year. Conviction rates currently stand at 88% in Bedfordshire compared to the national average of 82%.
- During the last year the safeguarding team have undertaken serious and complex crime investigations including ones of theft committed by carers on the

elderly service users. In March 2016, the force were committed on a county wide operation where officers attended a Bedfordshire travellers site as part of a multi-agency task force looking for victims of modern day slavery. This is the 2nd Operation of a similar nature within the year.

2. Safeguarding risks and issues related to your agency and action taken

- Domestic abuse continues to be under constant review both internally and externally, with HMIC revisiting the Force throughout the year after the HMIC Vulnerability Inspection Report was published in December 2015 and the Force was graded inadequate.
- The Rape Investigation Unit has an improvement plan in place which seeks to improve standards of investigation and evidence gathering, raise awareness and increase knowledge and understanding of sexual abuse, ensure consistent identification and assessment of risk, support and safeguarding and lastly to ensure sufficient training of frontline responders and investigators. The improvement plan includes actions generated from the HMIC inspections and as such the number of Initial Contact Officers across the county has increased to meet demand.

3. Outcomes of audit

- Bedfordshire Police has introduced a feedback process to review and advise frontline officers on the quality of investigations and case handovers to ensure wider improvement across the organisation.

4. Risks and issues related to safeguarding training and policy

- The force is currently providing hate crime training both internally and externally, a hate crime safe-guarding tool kit has been developed for operational Police Officers. Hate crime stalls have been run in Bedford and Luton Town Centres raising awareness and encouraging the reporting of hate crime. Service users from mental health and learning disabilities have also been given hate crime awareness training.
- The Child Sexual Exploitation (CSE) team have attended meetings with Central Beds Local Authority to support training for Hotels and B & B's. The CSE team have attended a training day at the Luton and Dunstable Hospital, with the CSE SPOC for Luton where over 300 health professionals attended three sessions and Chelsea's Choice was performed.

5. Safeguarding risks and issues to prioritise in 2016-2017

- The Force was recognised in the work that has been done to improve the assessment of risk in domestic abuse cases and working closely with partners to safeguard the vulnerable in our society. We are constantly reviewing the way we work and exploring new opportunities to better protect people and we hope our commitment will be reflected in the next HMIC inspection on this priority area for the force in the autumn of 2016.
- The force has committed to funding the training of a critical mass of "first responders" and DA Matters is the training that is recognised to be capable of changing the mind-set of a workforce, endorsed by the College of Policing. It has been agreed that the best option is to train the critical mass as quickly as possible to maximise the cultural change and therefore the training shall take place over an 8 week period commencing January 2017.
- Bedfordshire Police are due to 'go live' with the roll out of Technical SoS (TecSoS) mobile phones which are another tool available to support high risk victims of Domestic Abuse. The aim of the TecSOS project is to introduce a mobile handset that provides high-risk vulnerable people with enhanced access to the police in an emergency.
- A Countywide Sexual Abuse Strategic Group is being considered
- Bedfordshire Police have worked with Mind, Samaritans, ELFT and EAST to introduce Mental Health Street Triage (MHST). This is an all ages, county-wide service which delivers an emergency response to people experiencing a mental health crisis.

Name Of Organisation:	POhWER

1. Progress on agency action plan for safeguarding

- POhWER has remodelled its Safeguarding training to reflect the requirements of the Care Act. New staff must complete POhWER safeguarding training as part of their induction – this must be signed off before staff complete their probation. The Community Manager delivers regular safeguarding briefings and updates during team meetings.
- During this year the Community Manager gave presentations to local social work teams and to the local mental health social work teams with a focus on the Care Act and advocacy. POhWER is a co-opted member of the Safeguarding Adults Board – the Community Manager provides regular updates from the Board to the POhWER Senior Management team.

2. Safeguarding risks and issues related to your agency and action taken

- As the year progressed it became apparent that there may be risks to timely allocation of IMCAs due to the increased rate of referrals (see below). POhWER has managed to continue to meet its internal service standards and is in ongoing discussions with the commissioners regarding the way forward in the future.

3. Outcomes of audit

Bedford Borough Council MCA/DoLS referrals 2015-16

	Q1	Q2	Q3	Q4	Total
39a	8	10	10	15	43
39c	3	2	3	4	12
39d	23	16	4	9	52
ppr	**18**	**34**	**39**	**29**	**120**
safeguarding	3	4	3	2	12
					239

Central Bedfordshire Council MCA/DoLS referrals 2015-16

	Q1	Q2	Q3	Q4	Total
39a	14	8	8	16	46
39d	9	5	8	5	27

ppr	**7**	**28**	**19**	**18**	**72**
safeguarding	6	2	3	4	15
					160

The increase in paid person's representative referrals in both local authorities is evident from the above tables (192 referrals in total).

There have continued to be few referrals for community advocacy support for an individual who is subject to a safeguarding enquiry (27 in total in the year 2015-26), with only 3 referrals coming from local safeguarding teams. However, as the Care Act begins to have an impact, a further 9 referrals have been received under this legislation.

POhWER advocacy staff have raised 5 safeguarding alerts during this period:

Emotional abuse	2
Institutional abuse	1
Physical abuse	1
Self neglect	1

4. Risks and issues related to safeguarding training and policy

As well as ensuring the staff have regular safeguarding updates, the Community manager uses published Safeguarding Adult Reviews to deliver further training to staff and to consider where advocacy could have had an impact.

The Community Manager has acted as independent chair in respect of a Safeguarding Adults Review for Bedford Borough Council relating to Modern Day Slavery and will, when the time is right, conduct an internal learning event in respect of this type of safeguarding concern.

5. Safeguarding risks and issues to prioritise in 2016-2017

The pressure on the MCA/DoLS service continues in two particular respects:

Relevant Paid Representative Service (RPR) – this statutory service supports people who are subject to DoLS long-term, by offering a regular visit to check on the appropriateness of the DoLS authorisation. This service applies to people who have had an authorisation for up to a year and whose condition is unlikely to improve, with a restriction likely to continue to be in place. Authorisations are renewed annually unless the client is deceased. Therefore clients accumulate on an advocate's dashboard, increasing pressure on the advocate's workload. Discussions are on-going with Bedford Borough Council to identify alternative models of delivery, where this work can be undertaken by trained community advocates rather than IMCAs.

Litigation Friend support – requests are coming in now for POhWER to provide a litigation friend service where a DoLS authorisation is being challenged at the Court of Protection. These pieces of work are very time consuming and apply significant pressure on the service. A piece of litigation friend work can typically take up as

much as 50 hours of an advocate's time.

Additionally, there is a need for further awareness raising in local health and social care professional teams with the aim of improving the referral rate for supporting individuals through the safeguarding process (making safeguarding personal), either through the IMCA service or through the Care Act advocacy service.

Name Of Organisation:	Healthwatch Bedford Borough

1. Progress on agency action plan for safeguarding

Healthwatch Bedford Borough (HBB) has seen its contribution in focusing on aspects of the SAB Action Plan as follows:

- By involving people who access services and carers in continual service improvements and the management and development of Safeguarding arrangements across Bedford Borough and Central Bedfordshire

Examples of this work are:

Enter and View visits to local Care Homes – where issues such as recommending the use of Makaton – which is a language programme using signs and symbols to help people to communicate. This was seen as a way of ensuring that by its use, that care home residents are better able to understand matters that may affect their wellbeing/safety. We also recommended safety improvements to fixture/fittings in the Care Home, which although not immediately apparent to staff, will reduce/avoid such incidences as trips/falls by residents.

Signposting service – HBB became aware people that people/patients/carers who are D/deaf can be at a serious disadvantage/exclusion from receiving the service which is appropriate to their needs. HBB has worked jointly with organisations such as Access Bedford to use electronic (emails/etc) communications to enable local service providers to engage with members of the D/deaf community as necessary. The pioneering work that HBB has been engaged on in this work has now been replicated in other parts of the Country.

Complaints - HBB has now installed the Contact Relationship Management (CRM) system – this system is managed by Healthwatch England (HWE) on behalf of the local Healthwatch (LHW) network. This enables HWE to correlate items of concern which emerge across the network of 152 LHW`s in England. Whilst HBB does not deal with individual complaints, the trends which emerge from recording data received, can be used to assist commissioners/service providers in preventing/minimising similar occurrences in the future.

HBB also includes the use of the Browsealoud sound system on its website www.healthwatchbedfordborough.co.uk to ensure that "everyone" is included (it has 35 other languages which can also be accessed) – the website also translates into over 70 different languages.

2. Safeguarding risks and issues related to your agency and action taken

HBB seeks to ensure that staff and volunteers are provided with appropriate training in safeguarding matters. All staff and volunteers are required to undertake a Disclosure and Barring Service (DBS) check.

3. Outcomes of audit
As an added precaution - the copy of the outcome of an individual DBS check – HBB requires to be provided with a copy of the outcome report.
4. Risks and issues related to safeguarding training and policy
None identified.
5. Safeguarding risks and issues to prioritise in 2016-2017
HBB will be mindful of the SAB Action Plan and will use that to guide its safeguarding activities during 2016-2017.

Name Of Organisation:	Healthwatch Central Bedfordshire

1. Progress on agency action plan for safeguarding

Healthwatch Central Bedfordshire is a full member of and is represented at the joint Adults Safeguarding Board. HWCB prepare quarterly reports for the Safeguarding Board which detail current issues and concerns.

Safeguarding Alerts

- As part of our signposting service we have referred service users, who contacted us with particular concerns, to the relevant organisations and officers to assist with their anxieties and distress. This has highlighted areas of general concern in relation to safeguarding issues which was reported to the relevant safeguarding officers during 2015/16. Key issues arising during 2015/16 included suspected abuse at an Inpatient Unit; concerns about a disabled resident and the uncaring attitude of staff at a sheltered housing resource.
- HWCB will continue to refer service users and carers, who contact us with general concerns in relation to safeguarding issues, to the relevant organisations and officers to assist with their concerns, into 2016/17.

Prevention

- Prevention is at the forefront of the Healthwatch agenda. In addition to gathering the views and understanding the experiences of patients and the public, one of HWCB's key roles and priorities is to signpost people to local health and social care services and to support people who may need to raise a safeguarding issue.
- It is important that local residents have access to the information they need at the time they need it. There are many occasions when people are unaware of help and support services available to them and HWCB are here to help.

- In addition to enquiries received via telephone, email, our Feedback Centre and face to face, HWCB also provide information and signposting for people who use health and care services via our outreach project, 'Just Ask' and engagement events held throughout 2015/16. HWCB are able to signpost to the Safeguarding team at CBC or other support agencies or organisations that can help.
- An Enter and View visit was conducted by HWCB following the re-opening of a care home after its closure by CQC in the summer of 2015. .

2. Safeguarding risks and issues related to your agency and action taken

- None

3. Outcomes of audit

Enter & View Visits

- Part of the local Healthwatch programme is to carry out 'Enter and View' visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being managed and to make recommendations where there are areas for improvement.
- The Health and Social Care Act 2012 allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families, patients and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies.
- Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.
- All our Enter & View representatives are fully trained to visit a range of NHS and social care premises to talk to staff, patients, Carers and other service users about their experience.
- During 2015/16 Healthwatch Central Bedfordshire carried out 28 Enter & View visits on services in our area which includes Residential and Nursing Care Homes (for a full list, including a report of each visit, please go to www.healthwatch-centralbedfordshire.org.uk). This year we launched HWCB's 'Enter & View' programme of visits to GP Practices in Central Bedfordshire.
- Each Enter & View report, which includes our recommendations, is shared with the local authority, Central Bedfordshire Council, the Bedfordshire Clinical Commissioning Group, the Care Quality Commission and Healthwatch England. The final reports, of which many include the Provider response, are then published on our website.
- Since the beginning of 2016 we are working even more closely with the Care Quality Commission as we are now sharing a national organisation structure. We hope to continue to be at the forefront of improvements in service provision.

4. Risks and issues related to safeguarding training and policy

Volunteers

- HWCB authorised volunteers who are part of our 'Enter & View' task and finish group completed a series of five pre-requisite training courses during 2015/16, including Safeguarding, Equality & Diversity, Data Protection and Confidentiality and 'Enter & View' in-house training sessions. Further training sessions will be organised as additional volunteers join the team during 2016/17.
- This training is designed to give them a greater understanding and awareness and to be able to identify safeguarding issues if they become apparent during the Enter & View visit. They will also be aware of who to report to with any areas of concern when conducting a visit.

Workforce Development

- Healthwatch Central Bedfordshire staff have all successfully undertaken the Safeguarding Adults Awareness one day course and refresher course. Safeguarding remains an important issue for all HWCB Board members

5. Safeguarding risks and issues to prioritise in 2016-2017

Healthwatch Central Bedfordshire will continue to report issues and concerns to the Safeguarding Board and to Safeguarding Officers at the Council into 2016/17.

Name Of Organisation:	SEPT Community Health Services

1. Progress on agency action plan for safeguarding

- The Trust continues to be active members of the Bedfordshire Safeguarding Board and Operational Group. The Locality Manager of Bedfordshire Community Health Services represents SEPT at the Operational group. This provides clinical knowledge and experience of issues pertaining to a wide range of Community Services and information is cascaded to teams as appropriate.
- The Locality Manager also attends the Trust Safeguarding meeting and provides updates from the Operational Group. The minutes of all Bedfordshire Board meetings are standard agenda items at the Safeguarding group.
- The Trust Safeguarding team continue to work in partnership with the CCG, other NHS organisations, police, advocates and voluntary sector.
- The Trust continues to use a Safeguarding Questionnaire for those subject to investigation. Feedback is reported regularly and influences the process of engaging service users, their families and advocates. The Trust are exploring how this can be adapted for use with CHS service users.

2. Safeguarding risks and issues related to your agency and action taken

- The Safeguarding team have worked with BBC and CBC to implement the changes since the introduction of the Care Act 2014 and Sec 47 enquiries. The Trust are in regular contact with Local Authority teams to discuss the progress of cases and to provide evidence to support enquiries.
- The Safeguarding team have continued to support staff, advising on robust risk assessments and the least restrictive and intrusive options when supporting service users.

3. Outcomes of audit

- The Trust Learning Lessons Oversight group meets monthly and regularly features a safeguarding case in order to learn lessons and cascade learning
- The Trust received excellent feedback from the Trust wide CQC inspection with regard safeguarding service.
- The Trust has responded to the initial recommendations from NHS England from the Goddard Inquiry which included a checklist for NHS organisations which provides assurance that SEPT have effective arrangements in place for safeguarding.

4. Risks and issues related to safeguarding training and policy

- A series of preventative and awareness raising initiatives continue to be implemented within SEPT. This includes training programmes and the introduction of reflective practice forums where clinical staff meet with the Trust Safeguarding Lead to discuss open safeguarding cases, potential cases and to explore emerging themes.

- The Trust compliance with safeguarding training has been above 90% for 2015/16. Training has been delivered via E-Learning and face to face programmes.
- The Trust Training strategy has been updated and includes Face to Face Prevent training programme where there is an 89% compliance of Bedford CHS clinicians. Prevent training is also incorporated into Level 1-3 safeguarding programmes.
- MCA DoLS training has been introduced this is both E-Learning and Face to Face dependant on staff role.

5. Safeguarding risks and issues to prioritise in 2016-2017

- Good ownership of the safeguarding agenda within Community Health Services staff
- Compliance with staff knowledge and skills continues to improve
- Good partnership working
- Opportunities to discuss, reflect and share lessons learned
- Continue to develop the reflective practice sessions
- Arrange a combined safeguarding child and adult conference
- Continue to improve skills of staff working in Community Health Services

Name Of Organisation:	Bedford Hospital NHS Trust

1. Progress on agency action plan for safeguarding

- The substantive Adult Safeguarding Specialist Nurse commenced her role in August 2015 to support the Adult Safeguarding Lead Nurse.
- Bedford Hospital Safeguarding Board continues to meet monthly, this is a monthly meeting chaired by the Director of Nursing with key stakeholders in attendance including CCG representation.
- The Joint Adult and Children Safeguarding Board commenced meeting quarterly in Q4 of 2015/16. This Board allows both the Children services and Adult services in the hospital to share information and develop joint policies and procedures.
- The Adult Safeguarding Specialist Nurse or Adult Safeguarding Lead Nurse attends the daily operational quality meeting – this includes discussion of emerging safeguarding issues and possible referrals, providing guidance, direction and practical help.
- Matrons and Ward Managers continue with daily quality checks and Site Practitioners have a schedule for conducting quality audits at night with feedback in real time to staff in charge of the area.
- The Adult Safeguarding Lead Nurse meets fortnightly with the Local Authority and Bedfordshire CCG to discuss and follow up on actions that are required in terms of open Safeguarding Investigations to expedite the process. This includes review and monitoring of all open cases/safeguarding Investigations. There are formal terms of reference for this meeting.
- 265 alerts were raised in 2015/16; a decrease of 4 alerts on 2014/15, with 9 alerts upheld against the Trust, a decrease of 11 in the previous year.
- In Quarter 1 of 2015/16 a high majority of alerts related to 'Harm by Family' and there have continued to be a high number of alerts in relation to this throughout the year.
- There has also been an increase in regards to alerts raised regarding harm in care-residential/nursing.
- In regards to allegations raised about harm in hospital, the number of alerts has remained consistent throughout the year.

- The number of alerts raised in regards to discharge issues has remained low, and during quarter 4 at the point of winter pressures this number is very small (3).
- The number of alerts raised in regards to pressure ulcers which have occurred both in the community and in the acute hospital; due to self harm or negligence has decreased in 2015-16 comparison with the previous year 2014-15 (28 vs 36 respectively).
- Increasingly we are seeing more alerts where harm has occurred outside of the trust particularly when the patient is in the care of their family or residential/nursing care. This increase may be associated with patients making allegations when they feel that they are 'safe' within the hospital environment and because staff are more skilled at identifying signs of abuse and are raising appropriate alerts.
- An extensive Registered Nurse recruitment drive has taken place in 2015/16 which has included both the recruitment of overseas nurses as well as the recruitment of local nurses from recruitment initiatives.
- The role of a 'Patient Champion' has been developed; this incorporates Safeguarding Adults, Dementia and Dignity Champions. This was launched in September 2015. There are currently 64 patient champions within the hospital from 39 of the 47 wards and departments. The 'Patient Champions' meet monthly for the opportunity to share good practice and learn lessons from previous Safeguarding concerns.
- 12 nursing staff successfully completed a Safeguarding Adults Champions Course with the University of Bedfordshire.
- The hospital has achieved a 50% reduction in the number of avoidable pressures ulcers reported in 2015/16.
- There is now a link tissue viability nurse on each ward. Quarterly, tissue viability link nurse meetings are held to share root cause analysis and learning and increase their knowledge base. This allows the link nurse to return to their ward bases to share this information.
- Alzheimer's Society have commenced weekly clinics in Quarter 1 of 2015/16 on Elizabeth and Harpur Ward for patients with Alzheimer's dementia and/or their carers for advice, support and signposting to other services.

2. Safeguarding risks and issues related to your agency and action taken

Deprivation of Liberty- Throughout the year and increasingly so, we have had patients who have not received a standard authorisation prior to their urgent authorisation expiring. This is due to a delay in obtaining a Standard authorisation from the local authority due to the processes they are required to follow and is particularly heightened during bank holiday periods. In each of these cases family members were consulted with and they were happy for care and treatment to be provided in the patient's best interests. In each case an Internal Incident Form has been completed. This risk has now been added to the risk register as detailed above and escalated to the Multi agency Safeguarding Adult Board. This was noted by the CQC during their inspection on the 16th December 2015.

Safeguarding Adults- It is recognised that there may be a delay in some Safeguarding Adults Investigations reaching conclusion particularly when there is police involvement and investigations of a criminal nature which Bedford Hospital NHS Trust has no control over, this may attract adverse media attention and complaints from members of the public. Therefore we have added this to the Bedford Hospital Trust Risk Register and maintain open dialogue with both local authorities to help mitigate the risk.

3. Outcomes of audit

At the beginning of Quarter 4 an audit was completed to monitor the use of DNA CPR with 10 patients who have Learning Disability patients in relation to recent changes in guidance on the implementation of DNACPR.

Main Points for Audit:
Was the patient part of the decision making process?

a) If not was Mental Capacity Act used to identify Best Interest and family/friends or Independent Mental Capacity Advocate (IMCA) involved.
b) How long was it from the instigation of a DNACPR form to consultation with Patient or representatives under Mental Capacity Act?
c) What rational was presented for the need for DNACPR, and did this include diagnosis of Learning Disability as a reason for DNACPR.

Findings included:

- No case had Learning Disability documented as the reason for the need or rational for a Do Not Attempt Cardio Pulmonary Resuscitation Decision; this is seen as best practice.
- Family or Independent Mental Capacity Advocate were used, or planned for, on all occasions. There were examples of excellent communication recorded with family.
- The Mental Capacity Assessments and Best Interest Decision practices used were appropriate.
- Quality of written records was often good but not consistently so. This adversely effected data acquisition and identification in records, on occasion, where handwriting or content was difficult to understand.
- Filing of records that may be required to demonstrate the good practice, were not in an order that made this reliable in all cases

Recommendations:

- For this report to support the review of the DNA CPR Paperwork being currently undertaken.
- Continue use of the categories of reason for use of DNA CPR
- Develop clear identification on the form of the need for Mental Capacity Assessment and Best Interest decisions.
- Continue delivery of Mental Capacity Act Training

Additional Action:
To contribute these findings to the revised DNACPR policy in order to reflect best practice in Mental Capacity Assessments. This is due for revision in Quarter 1 2016 / 17.

4. Risks and issues related to safeguarding training and policy

Table ONE: Attendance at Safeguarding Training over a Rolling Three Year Period at the end of Q4 (2015/16)
(Compliance for Adult Safeguarding Training is 90%)

Staff Group	% against target

Add Prof Scientific and Technic	93.28
Additional Clinical Services	93.26
Administrative and Clerical	87.83
Allied Health Professionals	96.59
Estates and Ancillary	93.61
Health Care Scientists	100.00
Medical and Dental	73.96
Nursing and Midwifery Registered	95.04
Total	**90.95**

Adult Safeguarding Training incorporates Mental Capacity Act Training and Deprivation of Liberty Training, alongside Basic PREVENT awareness.

In both Quarter 3 and Quarter 4 of 2015/16 additional Mental Capacity Act Training and Deprivation of Liberty Training was provided for all Consultants, Specialist Registrars and senior nursing staff from Mills and Reeves Health Care Solicitors. This course continues to be very well evaluated by participants.

5. Safeguarding risks and issues to prioritise in 2016-2017

- To continue to recruit and develop the role of the patient champion within the hospital
- Publish Bedford Hospital Dementia Strategy 2016-2019.
- Host a Primary Care and Acute Care Discharge Summit to improve partnership working with community health care providers and improve patient experience of discharge
- It is planned that during 2016/17 a service quality improvement project will be launched involving each of the tissue viability link nurses in their practice areas.
- Strong Partnership working with the Local Authority and CCG to continue.
- The Bedford Hospital Safeguarding Adults Board will continue to monitor and review key publications and national / local directives throughout the year, taking action where appropriate and reporting these through to the Executive Management Committee for assurance purposes.
- Further courses continue to be provided and commissioned in respect to Safeguarding Adults, Mental Capacity and Deprivation of Liberty.

Name Of Organisation:	Luton and Dunstable Hospital

1. Progress on agency action plan for safeguarding

- Full implementation of the Care Act 2014 has taken place. This continues to be discussed at every training session provided by the Adult Safeguarding Lead with specific attention given to the three new forms of abuse introduced by the Care Act 2014 including the abuse indicators.
- Both the Adult Safeguarding Policy and the Mental Capacity and Deprivation of Liberty Safeguards Policy have been updated and fully comply with the new Care Act 2014.

- The Adult Safeguarding Lead continues to represent the Trust at the Channel Panel with support from the Clinical Commissioning Group, as part of the Prevent programme and Governments counter-terrorism strategy. In addition, staff have been advised to raise concerns via the internal safeguarding processes as requested.
- No audits were completed in 2015/16. However 4 audits are planned for 2016/17.
- The Care Quality Commission visited the Trust in January 2016 to assess its compliance against the standards required. During the visit there was a strong focus on Adult Safeguarding as well as compliance with Mental Capacity (MCA) and Deprivation of Liberty safeguards (DoLS). The final report has been released and the trust was given an overall rating of good with some areas of practice deemed outstanding.
- Monthly meetings have been arranged between the MCA/DoLS lead and the Trusts Adult Safeguarding Lead which gives opportunities to discuss new legislation/guidance alongside gaining advice on complex cases where needed.
- The Adult and Paediatric Safeguarding teams continue to work more closely together and foster greater working relationships. As well as working on joint work streams such as Domestic violence and Prevent both teams now attend joint meetings and both Trust safeguarding boards. In addition to this IT access has been given to the adult safeguarding team to retrieve safeguarding information on children when required.
- Furthermore, the Adult and Children's Safeguarding Team have liaised with Luton Food Bank to become referrers. To raise awareness, both teams have arranged a Food Bank Drive within the Trust which will commence on the 18/07/2016 for five days. All donations will be given to Luton Food Bank in time for the school holidays. They have stated this will help support them during a time that increased activity is noted due to school holidays.
- The Safeguarding lead continues to attend the multi-agency Safeguarding Leads meeting which is chaired by the Head of Adult Safeguarding from the LCCG and the Operation sub-group meetings for Central Bedfordshire Council. The meeting is held quarterly with all the appropriate safeguarding leads from providers, managers and social workers from LBC and NHS England. This meeting is to discuss any issues and concerns and to support each other. This has been extremely useful and interesting with a robust action plan in place with good input from all the MDT.

2. Safeguarding risks and issues related to your agency and action taken

On review of the statistics it is noted out of the alerts raised against the Trust approximately 50% (34/66) had an issues or concerns relating to discharge. When assessed in further detail most of the concerns relating to discharge showed themes such as lack of communication, medications, pressure damage, restarting of care and discharge paperwork. This is an area that is being reviewed regularly with a view of improvement which includes the following:

- Currently an Audit is taking place looking at all discharge paperwork but in particular the Discharge Checklist.

- All training sessions incorporate learning around previous safeguarding alerts with a discharge theme and staff are informed of the importance of completing a safe and effective discharge. This includes learning from the recent SILP (Serious Learning Incident Process).

- Discharge planning highlight any delays from their PTL (Patient Transfer List) relating to Safeguarding to ensure a safe but effective discharge. This allows for both the Adult Safeguarding Team and the Discharge Planning Team to voice any concerns and share information which will aid in a safe discharge from hospital.

- Regular discussions take place with staff on Ward 19b to discuss any current or new safeguarding concerns on the unit. This ward is currently being used as a delayed discharge unit within the trust and therefore is responsible for discharging some of the trusts most vulnerable patients.
- Presentation completed at the sisters meeting looking specifically at discharges.
- Chief and Deputy Nurse arranging a meeting with one of the departments highlighted in relation to discharges.
- The Safeguarding lead will continue to meet with the CCG lead for Safeguarding as well as the Trusts Integrated Discharge manager to review all Discharge related alerts. These meetings continue to be successful with a resultant action plan that is also shared with the CCG.

3. Outcomes of audit

- From April 2015 to March 2016 the Trust has raised 312 safeguarding alerts and received a total of 66 alerts against the Trust. There is a slight increase in the number of alerts from 2014/15 (299 to 312) and a marked decrease in alerts raised against the Trust (80 to 66). The alerts discussed cover various areas such as LBC (Luton Borough Council), CBC (Central Bedfordshire Council) and HCC (Hertfordshire County Council).
- DoLS (Deprivation of Liberty Safeguards) applications have also increased significantly from 4 applications in 2014/15 to 107 applications in 2015/16.
- In relation to alerts raised by the Trust, the main theme identified was neglect/Acts of omission, shortly followed by alerts raised for self-neglect. This particular abuse domain has seen an increase each quarter which could be in conjunction with the new care act and an increased awareness. Other themes identified were Domestic Violence, Modern Day Slavery, Financial, psychological and physical abuse.
- In addition to this, themes identified within the alerts raised against the trust consisted mainly of neglect/Acts of omission. This was followed by alerts raised for Physical and sexual abuse.
- 4 alerts have been substantiated between April 2015 and March 2016. 2 of which were discharge related.
- The Trust has been involved in 2 SARs throughout the year 2015/16.One of which is near completion and the actions and recommendations are currently being put into place.
- Training compliance for Adult Safeguarding is currently at 86% for the Trust.

4. Risks and issues related to safeguarding training and policy

- Due the increased safeguarding activity and with the introduction of the intercollegiate document for Adult Safeguarding training, a business case for additional support was developed and funding has been agreed for a 1 year fixed term administrator and a Band 7 Vulnerable Adults Nurse Specialist. Job

descriptions have been completed and this is currently being advertised.

- Although there are still areas that require work to ensure Making Safeguarding Personal (MSP) is embedded in practice, there has already been some changes made to ensure compliance which includes the changing of our internal database to capture this information and the teaching of MSP within all training sessions and the commencement of the new provider led section 42 enquiry forms.

- An increased responsibility has been given to the Trusts Safeguarding Champions with a detailed job description written within the Adult Safeguarding policy. In addition to this a link email has been set up alongside a quarterly meeting to disseminate new and relevant information to each ward and department. These meetings also include teaching from internal and external groups and organisations.

5. Safeguarding risks and issues to prioritise in 2016-2017

- The Adult Safeguarding Lead is currently working in partnership with the Community Safeguarding Lead and the CCGs Designated Nurse for Adult Safeguarding in relation to the future introduction and implementation of the NHS England's Intercollegiate Document for Adult Safeguarding Training. This will ensure compliance within all training sessions provided within the Trust alongside ensuring training sessions are parallel to that of other health organisations. This work will also incorporate the Local Authority's framework as well as the core skills for heath document.

- The Trust will also continue to incorporate emerging themes into all training sessions such as Forced Marriage, Female Genital Mutilation, Honour Based Violence and internet/social bullying.

- In introducing Making Safeguarding Personal (MSP), we aim to develop an outcome focus to adult safeguarding work which should result in safeguarding being done with, and not to people and also aim to shift the emphasis from processes to a commitment of improving outcomes for people at risk of harm. This could prove difficult within a trust setting as the supervisory body would be in most cases leading with the enquiry. However, the Adult Safeguarding Lead has adjusted and added to the current safeguarding database to allow for this data to be collected where appropriate. The Adult Safeguarding Lead is also reviewing the DATIX AP1 forms with the aim of MSP compliance commencing with the initial referral. In addition, the introduction of the Provider Led Section 42 Enquiry forms will also ensure safeguarding enquiries are MSP compliant and person centred.

- The introduction of a full time administrator and a Vulnerable Adults Specialist Nurse will help support the Adult Safeguarding Team within the next year. This added support will concentrate on supporting wards and departments but also help with training staff within the Trust on Mental Capacity and Deprivation of Liberty Safeguards.

Name Of Organisation:	ELFT

1. Progress on agency action plan for safeguarding

- ELFT Adult Safeguarding Practitioners continue to support operational teams in giving support and guidance around adult safeguarding concerns.
- The ELFT Adult Safeguarding Team continues to record and monitor adult safeguarding activity within ELFT and report such both internally and externally.
- ELFT Adult Safeguarding Practitioners carry out audits of adult safeguarding enquiries to ensure quality and a person centred response. Action plans are developed where improvement is required.
- Meetings have been held with teams since the implementation of the Care Act 2014 to explain the changes impacting upon adult safeguarding and the importance of 'making safeguarding personal'.
- The ELFT Adult Safeguarding Practitioners have continued to provide adult safeguarding training to all levels of staff. Where possible this has included lessons learnt from practice.
- The ELFT Adult Safeguarding Practitioners meet with their respective local authority adult safeguarding managers to discuss/monitor/quality assure practice.
- ELFT Safeguarding Practitioners attend the Safeguarding Adult Operational Board and the Pan Bedfordshire Group.
- ELFT have set up a Safeguarding Assurance Group internally to review strategic safeguarding matters and operational issues.
- The ELFT Safeguarding Team continues to work with our commissioners and practitioners meet with the CCG Adult Safeguarding Lead.

2. Safeguarding risks and issues related to your agency and action taken

Local Safeguarding Management

- The Associate Director for Safeguarding Adults in ELFT was based in London and was also overseeing Safeguarding Adults in London Borough's which meant that she had limited time to manage safeguarding in Bedfordshire and Luton. ELFT have agreed a short term post for Associate Director for safeguarding Adults locally but have been unable to recruit to this position. The Associate Director in London finished in her position at the end of June 2016.
- Knowledge and compliance with multi-agency policy and procedures:
- The safeguarding thresholds for adult safeguarding differs greatly from London and the way ELFT respond to safeguarding adults in London is very different to how local arrangements are made. It took some time for managers and staff that moved from London to Bedfordshire to understand the differences in policies and procedures and action was taken to write a policy that will be able to amalgamate London, Bedfordshire and Luton.
- The local risks identified were where London staff were transferred to Bedfordshire without being aware of the differences in how adult safeguarding was being managed. This resulted in some safeguarding alerts not being done and concerns managed internally through Trust procedures. This was picked up quickly and we rolled out a training program for staff around local procedures. One-to-one training was offered and the safeguarding team attended team meetings and away days for wards to update staff on local procedures.

Incident Reporting

- The Trust safeguarding team will now be screening more incidents to ensure that safeguarding alerts are done appropriately and to ensure that training is targeted to the right audience.

Safeguarding Cover

- Owing to unforeseen circumstances (road traffic accident) two of the three ELFT Safeguarding Children Practitioners were absent/on phased return for three

months during the period. Cover was provided by the remaining Practitioner across all ELFT services in Bedfordshire and Luton.

Safeguarding Champions Meetings

- The re-introduction of Safeguarding Champions meetings on a quarterly basis was undertaken during the period. This involves a nominated lead from each ELFT service representing their team as a lead in the field of safeguarding.

3. Outcomes of audit

- In Central Bedfordshire and Bedford Borough, the Trust took part in an external audit commissioned by the local authorities. The outcome for all the cases was good.
- Joint audits have been undertaken within Central Bedfordshire for ELFT cases within the period. Of the four cases chosen two were rated 'good' one rated as 'adequate/good' and the remaining case was rated as 'poor'. The issues identified have been addressed and shared for learning.

4. Risks and issues related to safeguarding training and policy

Safeguarding Policy

- The ELFT safeguarding policy that was in place prior to ELFT acquiring services in Bedfordshire and Luton was not suitable as it was not compliant to the multi-agency safeguarding policy for the Safeguarding Adults Board. A new policy was written to integrate local processes and procedures, but this was a difficult task and it was clear that Bedfordshire and Luton will need their own procedures. The policy has been ratified and the procedures are in the process of being ratified.

Safeguarding Training

- As with the safeguarding policy, ELFT had different levels of training and a different relationship with London local authorities. The initial risk was that all internal training was stopped as the expectation was that local authorities would provide this training. The levels of training also did not match what was agreed locally in the past.
- ELFT safeguarding team have now resumed internal training and training compliance is now at 92%.
- ELFT has also agreed to return to the levels of training as recommended in the intercollegiate document for 2016. We are also in the process of developing a new safeguarding adults training strategy to ensure that we are able to deliver effective training but also that we are able to measure outcomes from the training effectively.

5. Safeguarding risks and issues to prioritise in 2016-2017

- Ensure all ELFT staff have safeguarding training at the level appropriate for the role that they are in and measure outcomes through the safeguarding competency framework.
- Ensure that staff relocating from the London Boroughs have local safeguarding adults procedures training as part of their induction.
- Continue to monitor the progress and quality of safeguarding enquiries through internal audits.
- Improve joint working process with serious incidents investigations and complaints investigations where it overlaps with safeguarding adults.
- Ensure robust management structures for safeguarding adults in the Trust.

3.1 Data Analysis

For the 2015/16 reporting year, the Bedford Borough safeguarding team received 2,193 contacts, which includes all safeguarding concerns, information sharing reports, referrals for social care or care management involvement and general incidents. Of these 1,115 received a safeguarding response with 152 proceeding to a Section 42 Enquiry. Overall the level of contacts to the team has increased from 2,038 in 2014/15 and from 1,829 in 2013/14.

The amount of contacts to the team compared to last year , which resulted in a safeguarding response has decreased from 1,303 to 1,115 with a lower level of 152 safeguarding initial enquires compared to 241 going to a S 42 Enquiry. There has been an ongoing increase in the levels of contacts to the team not requiring a safeguarding response which has increased from 735 to 926.

The Central Bedfordshire safeguarding team received 2,935 contacts during 2016- 2016. Of these 817 received an initial safeguarding response with 330 proceeding to a Section 42 enquiry. This is compared to the previous year when Central Bedfordshire Council received 1,100 alerts during the year, which was a decrease of 251 from 2013-2014. 238 alerts progressed to investigation in 2014-2015. The number of safeguarding enquiries has increased by 39% but is a much smaller proportion of total reports compared to the previous year (11%). This reduction is in response to the significant increase in incident reporting and the result of the teams taking a proportionate approach and considering other options such as care management involvement, reviewing of care packages and providers taking action such as dealing with complaints, taking HR action or reviewing care plans.

The difference between the numbers of initial safeguarding response and enquires is due to the ways the teams process and record information. The same initial screening and risk assessment tool is used in both teams. The recording differences have been addressed which should result in more comparative data next reporting year.

Of the safeguarding concerns that did not progress to a section 42 Enquiry there is a similar pattern to the previous year with information sharing and advice being the most common outcome.

Within the ethnicity category the “Not known” category has increased which is likely to be as a result of the number of concerns involving people not previously known to the council, where at point of contact, this information is not provided. Again this is reflected the category “Primary support reason” in the high number of people that concerns are received for where there is no identified support as they have not been previously known to the council and may not have any apparent care and support need. There continues to be a low level of reporting from ethnic groups which highlights that additional awareness raising may improve this position.

Reporting patterns for other areas show a similar patter to the previous year with Social Care Support (which includes providers and any agency providing social care support), being the main source of reporting concerns leading to a S42 Enquiry, and the main source of persons causing harm. In types of abuse, Neglect/Acts of Omission remains the largest category, followed by Physical Abuse. Location of abuse has a similar pattern to the previous year with ‘Own Home’ and ‘Care Home’ being the two main categories of where abuse has been reported, with a low level of the concerns reported leading to a S42 Enquiry. This is reflective of the high number of concerns that are received that are the reporting of an incident or the risk is very low or the incident is not of a safeguarding nature.

Graphs on p40 – 43 show a high level of enquires where the source of risk is unknown to the individual, this is because the category is based on the Department of Health reporting criteria for the Safeguarding Adult Collection (SAC) and includes health care staff, social care assessment staff, police, regulator and other, where not known to the person. The data for Central Bedfordshire shows a higher proportion of 'source of risk known to individual' because there are a higher number of incidents in peoples 'own home'. Bedford Borough has a higher number of social care providers which means greater numbers where 'source of risk is social care support'.

Reporting on mental capacity and outcomes continues to be a concern due poor recording of these outcomes. Audits show that this work is completed and that the issue is with the updates to the IT systems following the implementation of the Care Act.

3.2 Data – focus on incident reporting

In the year 2015-2016, Bedford Borough Council and Central Bedfordshire Council safeguarding teams received 3961 reports that were not considered to be of a safeguarding nature. This means that they were treated as one of the following:

- complaint
- referral for assessment/unscheduled review
- quality assurance information for contracts management
- care planning/ risk management/disciplinary process for provider
- information sharing about a vulnerable person
- inappropriate contact

This number represents a significant increase form the previous year and in both Councils the trend over the year is upwards.

Data analysis of these contacts to the teams shows that the majority of concerns related to younger adults (under 65) whose care and support needs are not known. By far the greater response (between 50 to 75%) to these concerns is to log them as "information sharing".

The police (Bedford 49%, Central Bedfordshire 34%) and ambulance service (Bedford 42% and Central Bedfordshire 16%are responsible for making the majority of these reports. On the whole reports from the ambulance service relating to people who live in their own home are reporting concerns about people who may not be coping, as opposed to concerns about abuse or neglect. In Central Bedfordshire the East of England Ambulance Service reports are sent via the Council's contact centre, which accounts for the lower proportion compared to Bedford Borough. Despite this, the reporting trend is upwards.

The upward trend of "Information sharing" that results in minimal outcomes is having a significant impact on the ability to focus on safeguarding reports of high risk, and on other partners who are also contacted as part of the information gathering stage. 77-81% of reports by the police are recorded as "information sharing". Consent is not sought from individuals before sending through to the local authority. This means that in the majority of cases an adult social care record is created and people are contacted directly. In 44-58% of cases referred by the police the person did not have identifiable care and support needs. Where the person does

have care and support needs, a significant proportion of these have mental health needs which may require assessment. 43% result in reports being shared with ELFT.

The two Councils continue to receive a significant proportion of reports from care homes where risk is identified but is not of a safeguarding nature. This frequently results in advice and information or the provider is requested to review care planning/ risk management/disciplinary process or documentation.

A priority for 2016-2017 will be to work closely with parters to ensure that safeguarding reports are proportionate and clearly identifiy whether a person is experiencing abuse or neglect, and to identify where there are opprtunities for alternative referral routes.

4. Mental Capacity Act (2005) and Deprivation of Liberty Safeguards

The impact of the Supreme Court judgement *P v Cheshire West and Chester Council (& Ors) and P and Q v Surrey County Council* (Cheshire West) has continued to challenge and evolve causing an ongoing increase in the number of people requiring statutory assessments and subsequently being considered as deprived of their liberty.

The previous reporting year of 2014-2015 data showed a 10% increase in the number of DoLS applications for Central Bedfordshire Council (CBC) received (when compared with before the Supreme Court judgment, March 2014) and 15% increase in Bedford Borough Council (BBC). This year's data reveals yet again a further increase.

Impact and Numbers BBC and CBC have processed the following requests in accordance with MCA DoLS:

	CBC 2015-2016	BBC 2015-2016
Number of Applications received in reporting year	954 (compared with 605 in 2014-2015)	1123 (compared with 872 in 2014-2015)
Number of Applications completed in reporting year	821 (compared with 449 in 2014-2015)	1072 (compared with 870 in 2014-2015)
Number of Authorisations granted	565	848

Number of Pohwer IMCAs/PPR referrals made (including 39a,39c,39d and PPR)	145 (compared with 49 in 2014-2015)	227 (compared with 208 in 2014-2015)

Update on significant changes cited in last year's annual report:

- ADASS priority tool - Neither Central Bedfordshire nor Bedford Borough are currently using the ADASS prioritisation tool however it is available if needed.
- Revised ADASS DoLS forms - Both Central Bedfordshire and Bedford Borough are using the revised ADASS DoLS forms. They have proved overall a positive move assisting Best interest Assessors (BIA's) and supervisory bodies.
- Law Society Practical Guide to Deprivation of Liberty Safeguards (2015) - The Law Society guidance produced in 2015 has shown to be helpful assistance in giving guidance to case law and application in practice. An example of this is around 'respite' placements and Intensive Care Units (ICU).
- Re X procedure – Both Central Bedfordshire Council and Bedford Borough have started taking community cases to the Court of Protection for consideration and subsequent authorisation where needed. In both Supervisory Bodies this is being lead by care management with support by legal departments.

Government updates

Law Commission review of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards:
The original Law Commission proposals – put out for consultation on 7 July 2015 have been revised following significant response to the consultation.

- a 'more straightforward, streamlined and flexible scheme' focused solely on authorising deprivation of liberty
- the responsibility of establishing the case for a DoL to be shifted from the provider of the care to commissioner (i.e. usually the local authority or CCG), using where possible the same assessments already in place for care planning
- there will still be rights to reviews, legal proceedings and advocacy
- there may be 'a defined group of people who should receive additional independent oversight of the DoL' by an Approved Mental Capacity Act Practitioner
- The proposed amendment to the Mental Health Act will not go ahead

Judicial review

Nottinghamshire, Richmond, Shropshire and Liverpool councils have lodged a judicial review against health secretary Jeremy Hunt, arguing he has created "an unacceptable risk of illegality" by leaving councils without adequate funds to meet their statutory duties to vulnerable service users. The local authorities say government funding for DoLS has been maintained at around £34m a year. The Local Government Association has argued at least an additional £172m a year is needed to meet the costs of the Cheshire West judgment in relation to DoLS. The Law Commission has estimated between £405m and £651m is needed annually to fully comply with the ruling. This estimate includes both DoLS cases and the applications to the Court of Protection required to authorise deprivation of liberty in community settings, such as supported living.

http://www.communitycare.co.uk/2016/06/07/government-face-legal-challenge-deprivation-liberty-safeguards-funding/

Potential Risks

- Increase in appeals and challenges under s21a – There is an increase in the number of cases going to court as S12a appeals and challenges. This involves the cost of taking cases to court as well as potential damages. In an example case in Essex http://www.bailii.org/ew/cases/EWCOP/2015/1.html the district Judge approved awards of between £3,000 and £4,000 per month in damages for the unlawful deprivation of liberty of incapacitated person.
- A continued increase in applications received is likely - This year has shown further increases for both Central Bedfordshire and Bedfordshire Borough. It is anticipated that there remains care homes that have not yet started sending new requests and or renewals. CQC appear to be taking a more assertive approach in their inspections around MCA and DoLS which will hopefully address this. Example of CQC reporting that a care home was illegally depriving residents of their liberty for failing to request further authorisations when they expired: http://www.mancunianmatters.co.uk/content/260575925-stockport-care-home-found-guilty-depriving-people-their-liberty-illegally-damning#.V1KK6JIBH_s.twitter
- Legal ramifications of not meeting timescales – It is evident from the data that both Supervisory Bodies have a number of applications that failed to meet the required legal timescales resulting in a period of unauthorised deprivation of liberty. If these were challenged than it is possible that the Supervisory Bodies would incur substantial penalties for breaches in article 5 rights.
- Quality of assessments – There is an identified risk around the ongoing substandard quality of some assessments and that it may continue to prove difficult to improve due to the volume and output of assessment undertaken by assessors. In both Supervisory bodies this has resulted in a number of concerns raised and remedial action has been necessary.
- There is a local and national lack of IMCA support / PPR - Pohwer is the provider for both Bedford Borough and Central Bedfordshire. Pohwer report a significant increase in the volume of IMCA and PPR requests in the last year which is reflected in our data. The consequence of this appears to be less frequent visits, by nominated IMCA/PPR, and delays in the initial visits. In addition to the difficulties with Pohwer, there is a national shortage of IMCA and PPR's which is resulting in problems accessing IMCA / PPR in other areas. Both authorities have experienced out of county IMCA services refusing to provide IMCA services citing a need to prioritise the residents commissioned by their host Local Authority.

5. Learning from Safeguarding Activity

Learning Outcomes	***Action To Ensure Learning***
Increased volumes of reporting that identify risk but are not of a safeguarding nature and that could be managed trough other routes	A priority for 2016-2017 will be to work closely with parters to ensure that safeguarding reports are proportionate and clearly identifiy whether a person is experiencing abuse or neglect, and to identify where there are opprtunities for alternative referral routes
Pressure on advocacy services resources to respond to the requirements for IMCA and PPR	Consideration of alternative models for the PPR role; ensuring DoLS data is included in contract reviews
Law Commission draft Bill on DoLS expected December 2016	Keep abreast of legislative changes for DoLS and planning for response.
An ongoing focus on making safeguarding personal is required.	Review practice development and quality improvement opportunities that promote a more person centred approach in safeguarding
An ongoing focus on agencies other than the local authorities undertaking S42 enquiries is required.	Continue to audit and review the outcomes and quality of enquiries

Appendix 1 Strategic Objectives for 2015-2016

Strategic aims:

1. Prevention and Raising Awareness
2. Workforce development and Accountability
3. Partnership Working
4. Quality Assurance and Protection
5. Involving People and Empowerment
6. Outcomes and Proportionality

Members of the Board must be able to:

- Influence and direct their organisations in ensuring adults are and feel safe and are supported to challenge and change abusive situations.
- Lead and support the development and implementation of safeguarding practice and procedures within their own organisations.
- Take forward any agreed action plans which prevent and minimise abuse, protect individuals and support the delivery of justice and fairness to all.
- Support the development of wider public protection and prevention initiatives as part of embedding the quality and safety agenda.
- Ensure safeguarding activities are monitored and audited.

1 Prevention and Raising Awareness

- Information to be made available identifying the steps individuals and communities can take to keep themselves safe, what abuse means and what everyone should do if they believe abuse may be happening.
- Hate crime, discrimination and harassment of people with disabilities.
- Information will be located in places that the public can access it.
- Access to support for ‘excluded’ people.
- Tackling the causes of abuse.
- Support for families, carers and perpetrators.
- Increasing the understanding of safeguarding in NHS resources.
- Promote awareness and actions to combat hate crime

2 Workforce Development and Accountability

- Staff should be able to recognise and manage risks in supporting and caring for adults at risk of harm or abuse.
- Staff should treat people with dignity.
- Staff should understand how to empower people and enable positive risk taking.
- There should be a focus on achieving outcomes for individuals and evidencing that these have been achieved, rather than processes.
- There should be competency based training to ensure that practice meets good quality standards and targeted training.
- Mental Capacity Assessments and Deprivation of Liberty Safeguards including the use of Independent Mental Capacity Advocates to raise awareness and improve practice within these areas

3 Partnership Working

- Secure electronic information sharing arrangement - receive reports and monitor progress and management of information.
- Tissue viability issues addressed through the Harm Free Care group and actions to be put arrangements and NHS bodies to monitor.
- Mental capacity and unwise decision making – put mechanisms, guidance, training in place.
- Ensuring safeguarding remains a priority and that lack of continuity does not cause risk to vulnerable person through organisational change.
- Ensure links are maintained to the Health and Wellbeing Boards, Community Safety Partnerships, Children's Safeguarding Boards and other strategic partnerships.
- Improvements to out of hours responses.
- Improve multi agency collaboration in respect of people not accessing services.
- Respond to national focus on care quality by continuing to work in partnership with key agencies and commissioners to improve quality in health services, learning disability services and with adult social care providers

4 Quality Assurance and Protection

- Develop more than one means of quality assurance to be able to triangulate information from different sources and evaluate effectiveness.
- Learn from serious case reviews and serious incidents, both locally and nationally.
- Take information from a wide group of partnership members and learn from those experiences to identify local issues.
- Learn from case file audits and what they tell us about the quality of practice improvement and service quality of different agencies.
- Commissioning by the NHS and local authorities in health and social care services builds in assurance that a quality framework is in place and is tested.

5 Involving People and Empowerment

- Ensure the views of people who have used services and their representatives or advocates, who have experienced harm or safeguarding processes, are taken into account.
- Gain feedback following incidents.
- Develop peer support and organisational support for people who have experienced abuse in the way that works for person.
- Develop a range of support and response options to empower people in safeguarding situations.
- Provide case studies to assist with developing services.

6 Outcomes and Proportionality

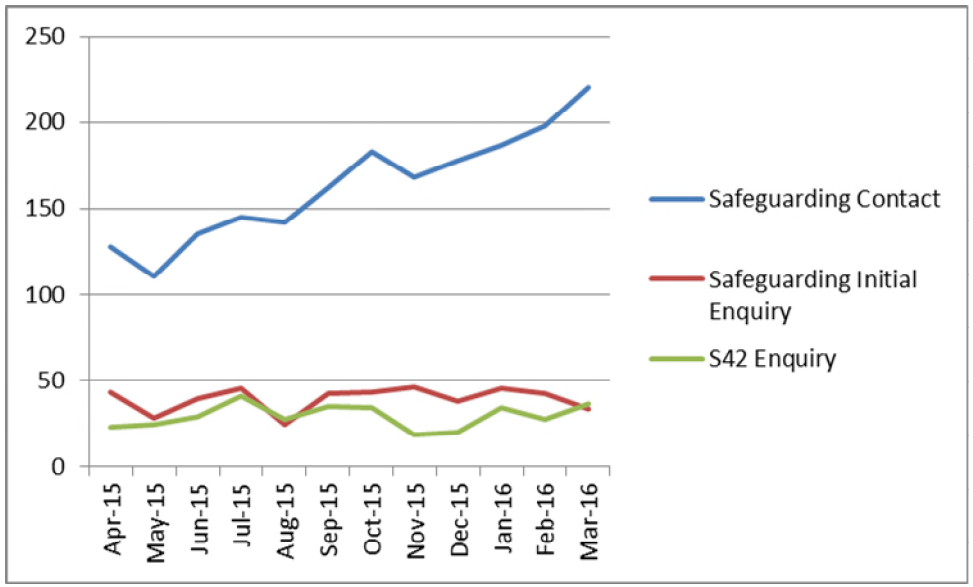
- Ensure people are empowered to drive safeguarding processes and find effective personal resolutions to harmful or abusive circumstances. The safeguarding team will work with victims of abuse through the personal use of the feedback forms as one means of improving the victim's experience during the safeguarding process.
- Ensure advocacy services are available for people who are unable to challenge or change circumstances that they experience as abusive or harmful.
- Involve service users during the investigation process.
- Continue to promote communication literature to the public via information leaflets about 'what is abuse' in different format and languages.
- Build confidence in the process of investigating concerns by making people feel comfortable at the start of a safeguarding process.

Appendix 2 Data

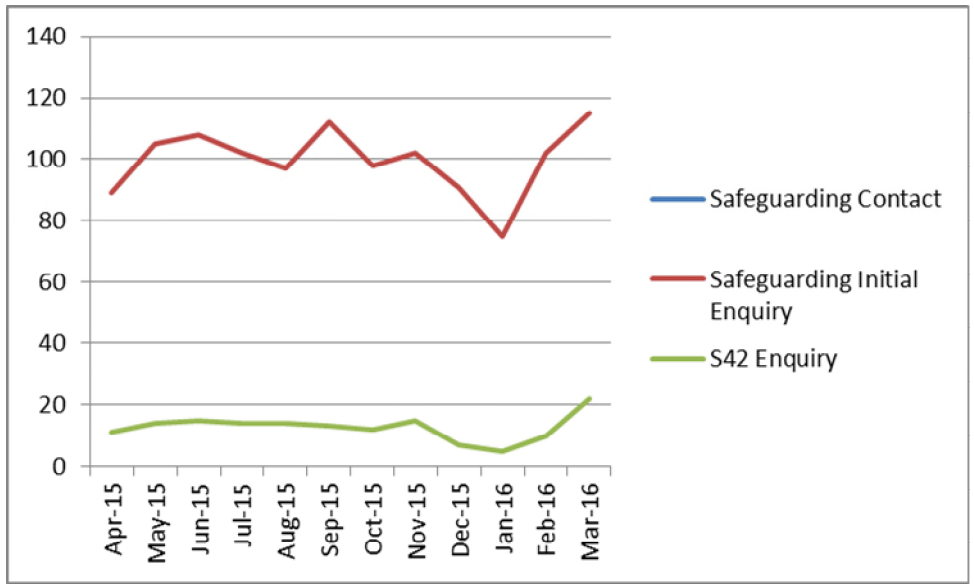
Safeguarding Activity April 2015 – March 2016 Based on the Safeguarding Adults Collection National Data return 2016 – 2017

Activity Data over time

Central Bedfordshire

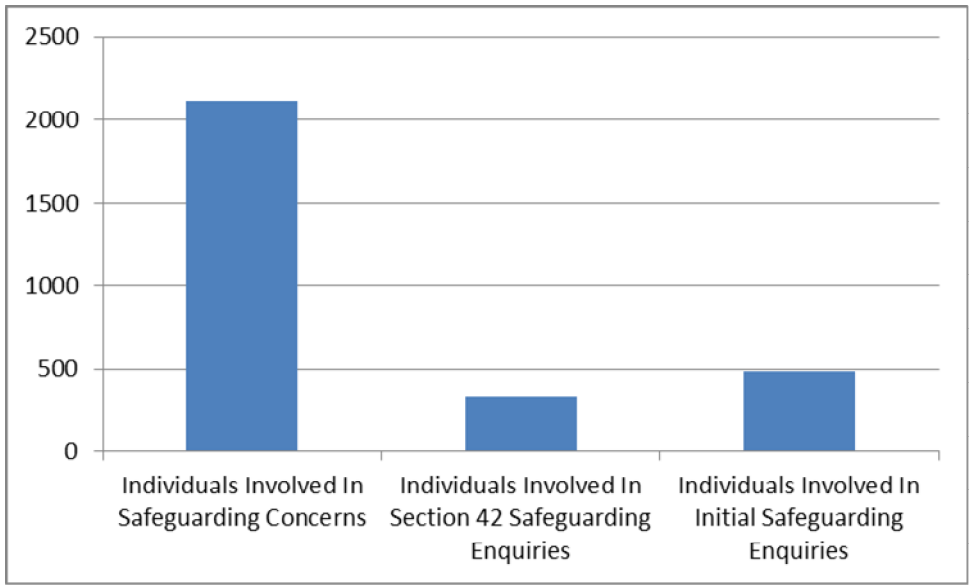


Bedford Borough

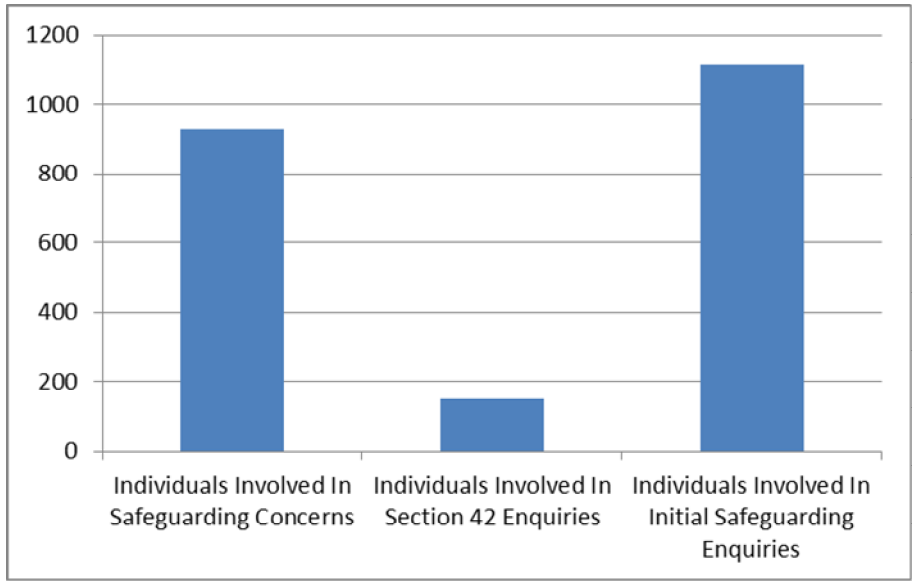


Individuals Involved in Safeguarding Concerns and Enquiries

Central Bedfordshire

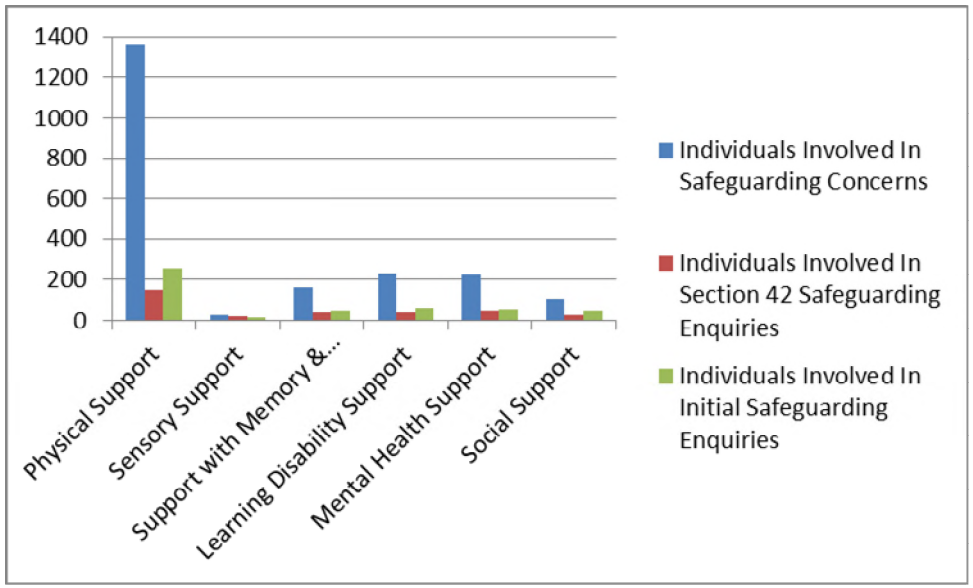


Bedford Borough

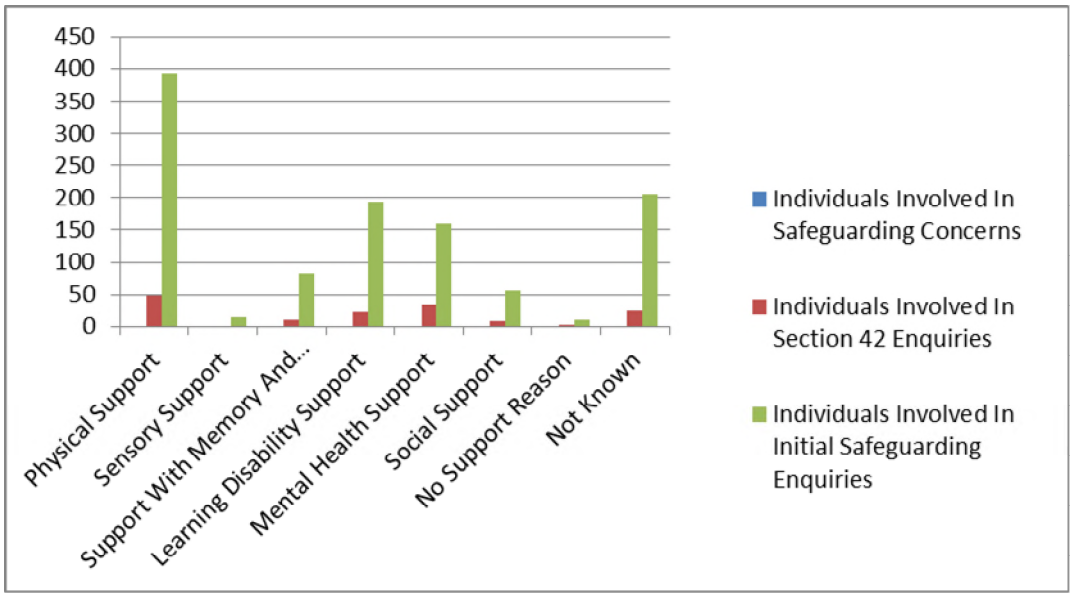


Safeguarding Enquiries by Type of Support Need

Central Bedfordshire

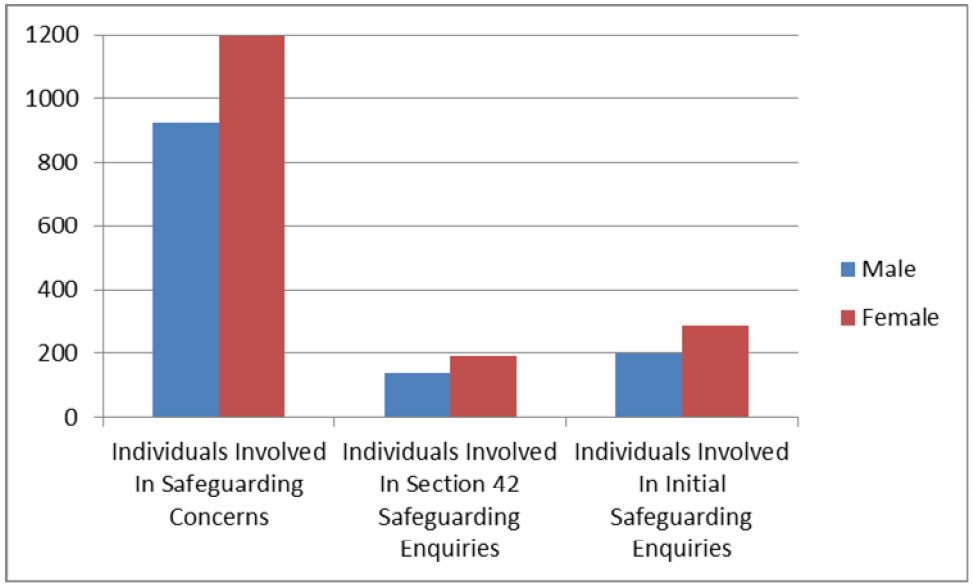


Bedford Borough

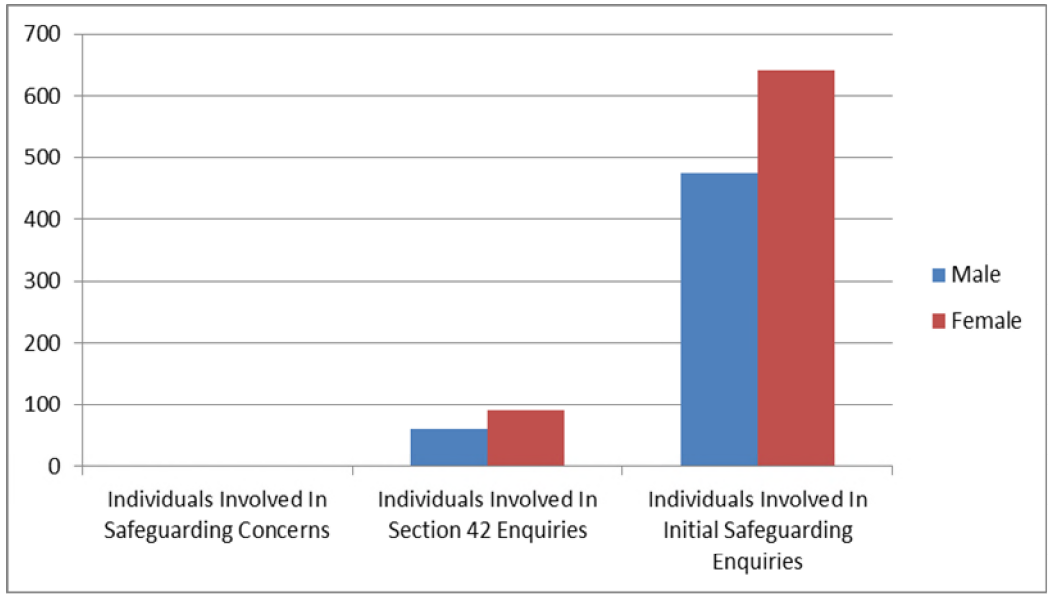


Safeguarding Enquiries by Gender

Central Bedfordshire

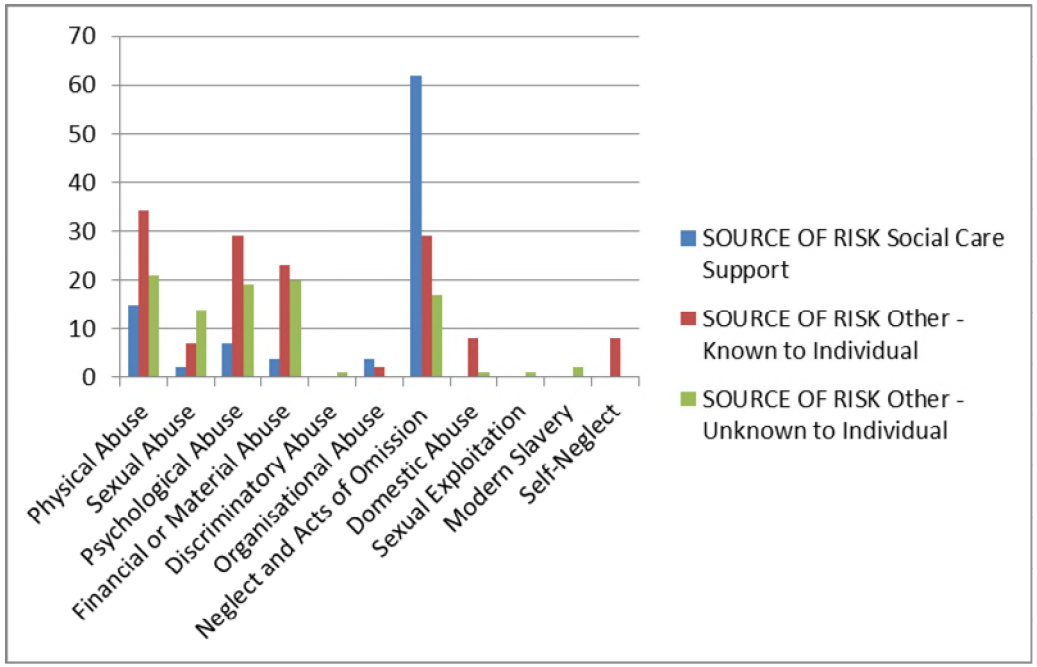


Bedford Borough



Safeguarding Enquiries by Type of Abuse

Central Bedfordshire



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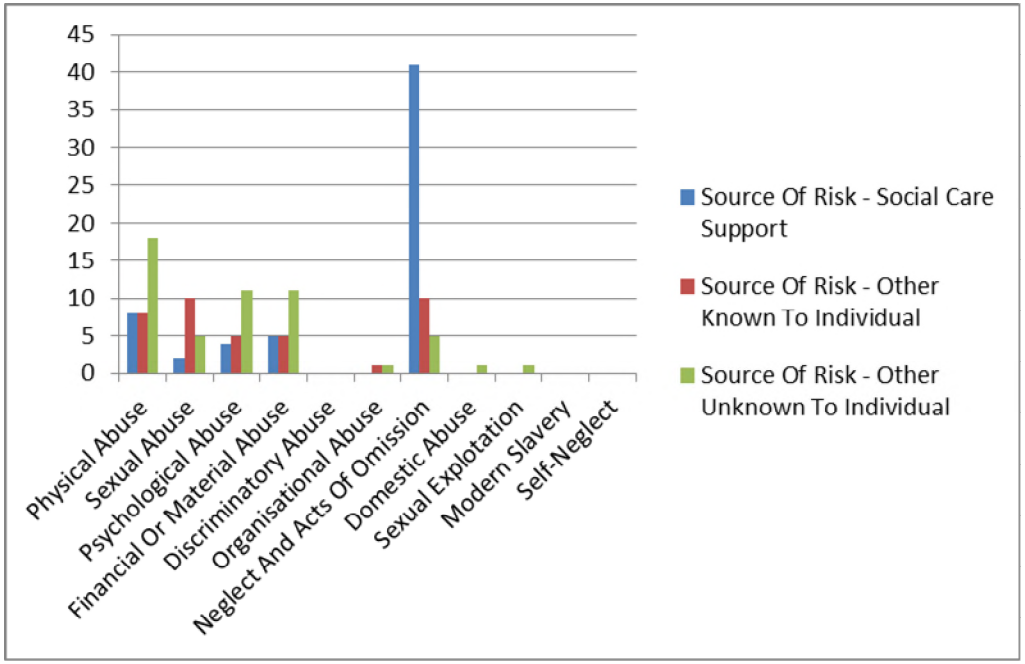
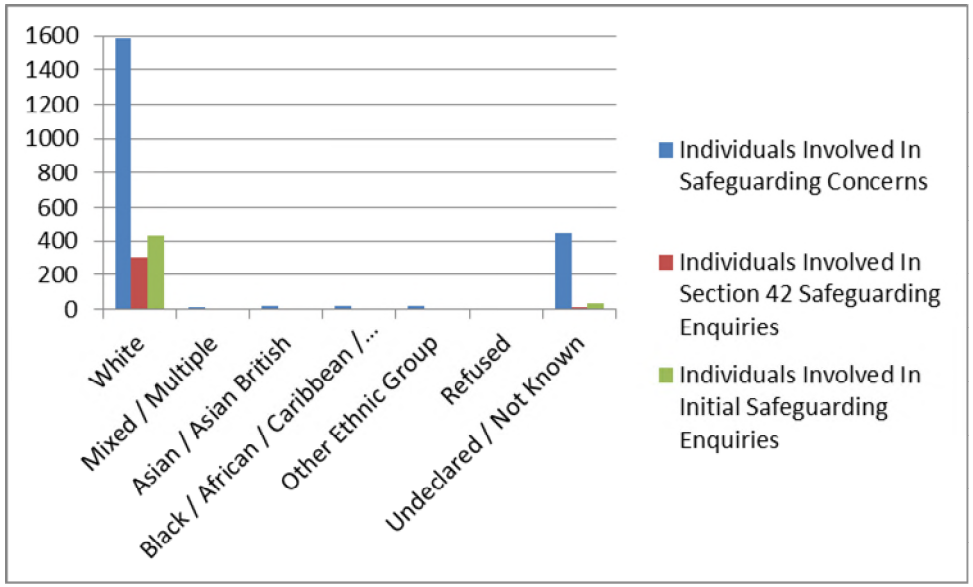


Safeguarding Enquiries by Ethnicity

Central Bedfordshire



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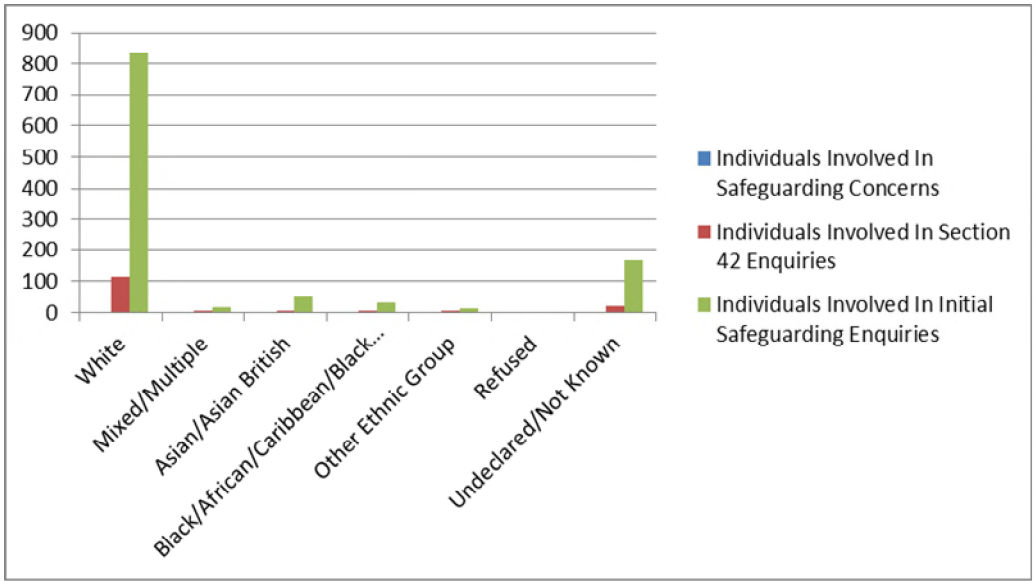
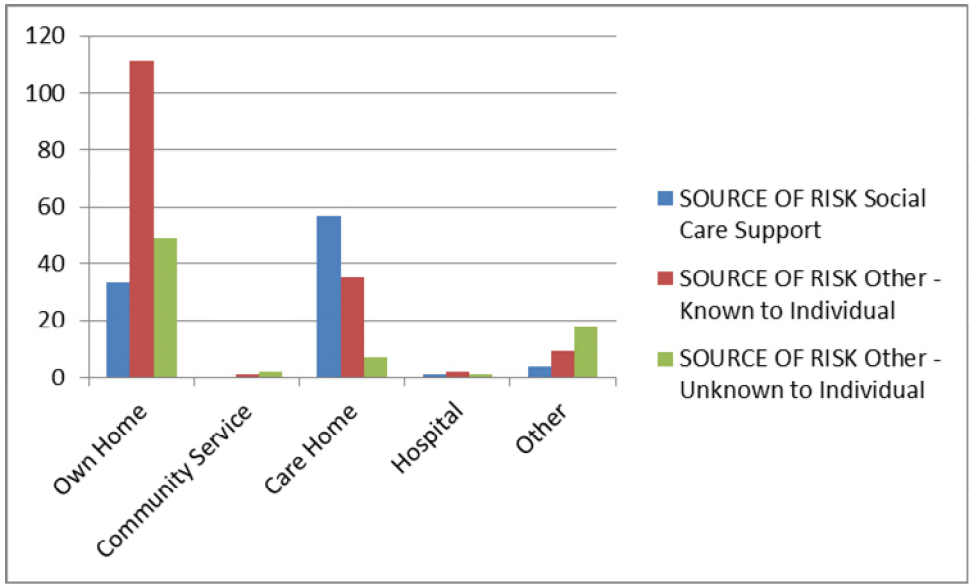


Safeguarding Enquiries by Location

Central Bedfordshire



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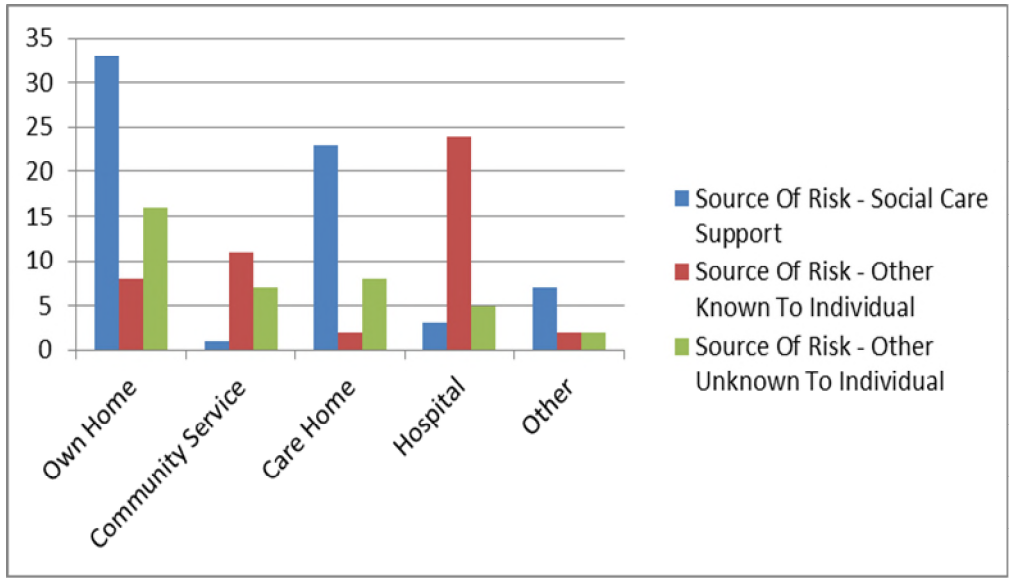
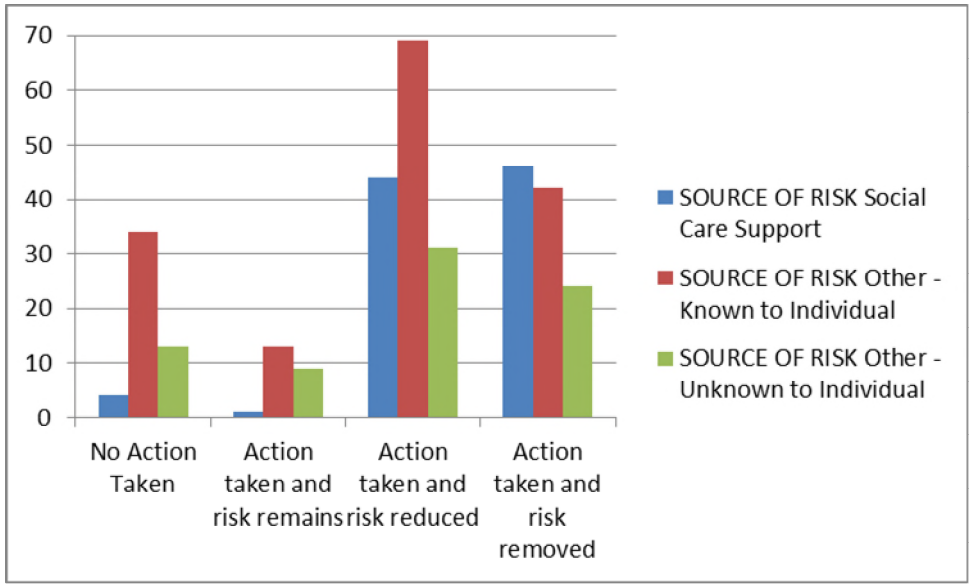
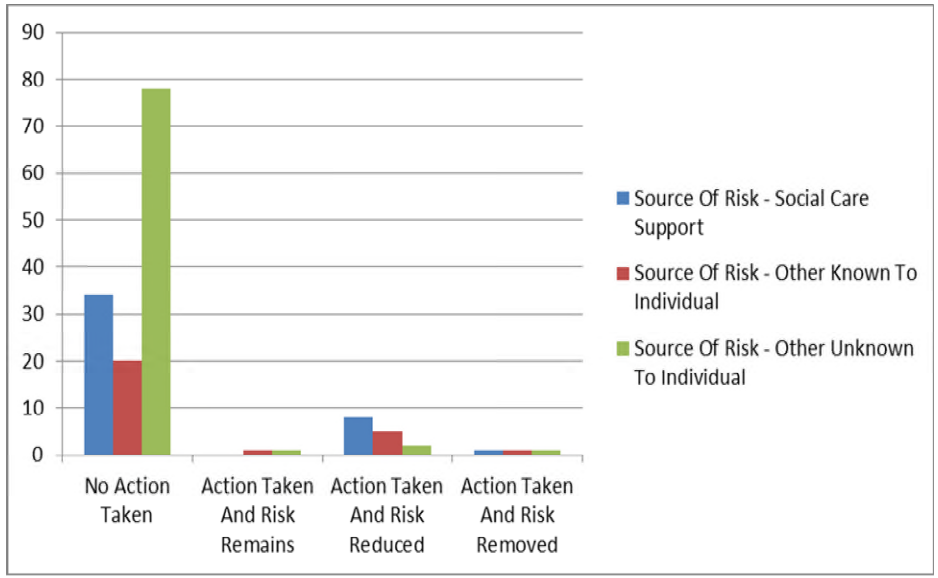


Safeguarding Enquiries by Action Taken

Central Bedfordshire

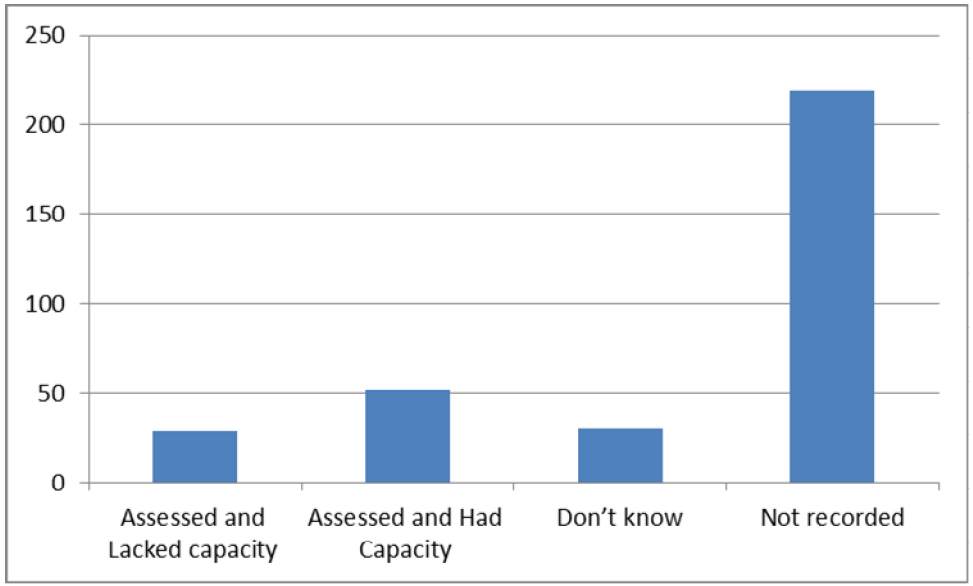


Bedford Borough



Safeguarding Enquiries by Mental Capacity

Central Bedfordshire



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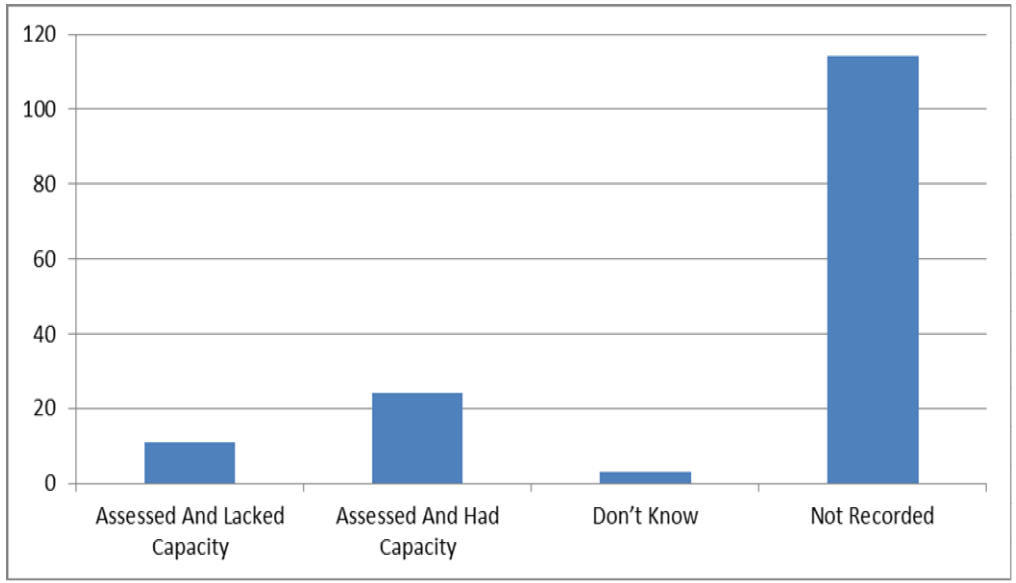
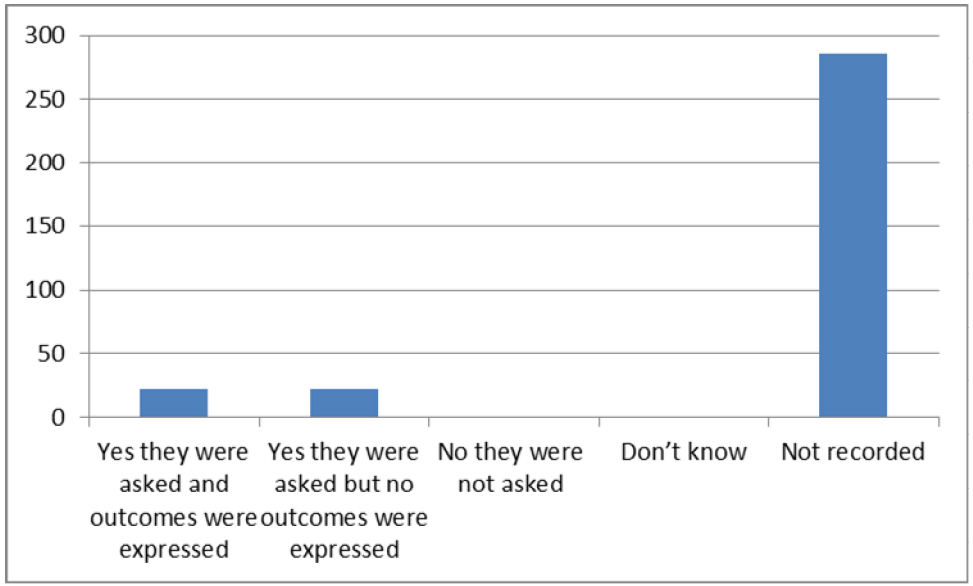


Safeguarding Enquiries by Outcomes

Central Bedfordshire



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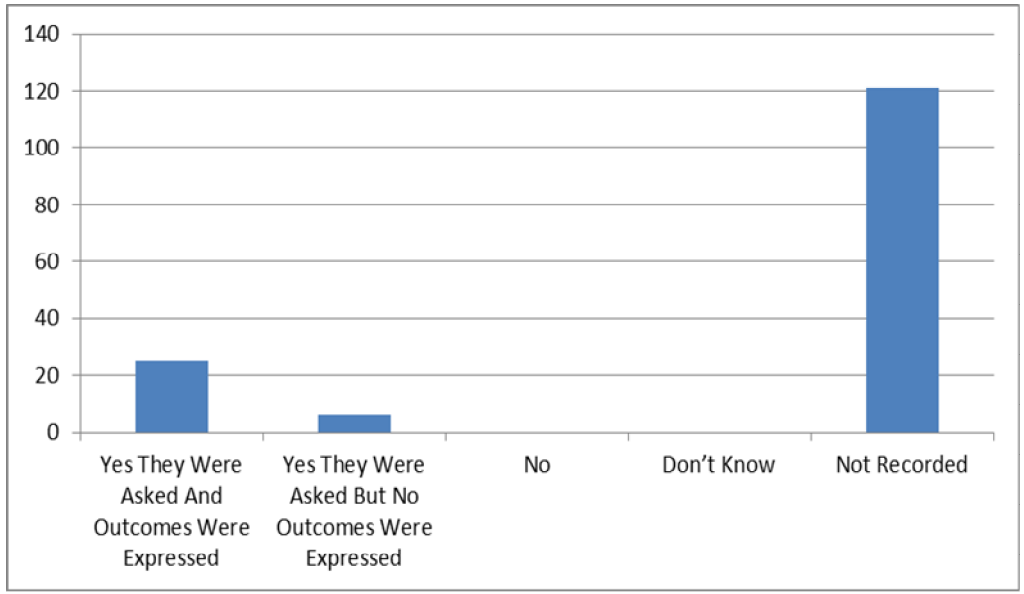

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	**Board Development and Work Plan 2016 -2017**
Meeting Date:	19 October 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.	Director of Public Health's Annual Report	To receive the annual report of the Director of Public Health.	25 January 2017		Muriel Scott, Director of Public Health, CBC Contact officer: Celia Shohet, AD Public Health, CBC
2.	East of England Ambulance Service	To receive an update on the discussions between the Bedfordshire Clinical Commission Group and the EEAST.	25 January 2017		Matthew Tait, Chief Accountable Officer, BCCG
3.	Giving Every Child the Best Start in Life: School Readiness	To receive an update on school readiness.	25 January 2017		Sue Harrison, Director of Children's Services, CBC Contact officer: Sue Tyler, Head of Early Intervention/Prevention, CBC
4.	Health and Wellbeing Scorecard	To receive the latest performance monitoring of the progress in delivering the priorities Health and Wellbeing Strategy.	25 January 2017		Muriel Scott, Director of Public Health, CBC Contact officer: Celia Shohet, AD Public Health, CBC

5.	Welfare Reform/Employment and Support Allowance Claimants	To make the Board aware of residents who are in receipt of the Employment and Support Allowance benefit in order that it may consider what steps should be taken to help such individuals into the workplace.	25 January 2017		Julie Ogley, Director of Adult Social Care, Health and Housing and Charles Warboys, Chief Finance Officer, CBC Contact officer: Peter Fraser, Head of Partnerships, Community Engagement and Youth Support and Christine Knox, Employment and Skills Service Manager, CBC
6.	CAMHS Transformation Plan Update	To receive an update on the CAMHS Transformation Plan.	25 January 2017		Matthew Tait, Chief Accountable Officer, BCCG Contact officer: Karlene Allen, BCCG
7.	Local Safeguarding Children Board (LSCB) Annual Report	The Chairman of the LSCB to present the annual report from the LSCB.	25 January 2017		Sue Harrison, Director of Children's Services, CBC Contact officer: Phillipa Scott, Strategic Safeguarding Partnership Manager, CBC

8.	Transforming Care – Transformation Plan	To receive an update on the Transforming Care – Transformation Plan following phase 1.	29 March 2017		Richard Carr, Chief Executive, CBC & Matthew Tait, Chief Accountable Officer, BCCG Contact officer: Kaysie Conroy, Acting Head of Mental Health and Learning Disabilities, BCCG
9.	Health and Wellbeing Scorecard	To receive the latest performance monitoring of the progress in delivering the priorities Health and Wellbeing Strategy.	29 March 2017		Muriel Scott, Director of Public Health, CBC Contact officer: Celia Shohet, AD Public Health, CBC
10.	Better Care Fund Plan 2016/17	To receive an update on the Better Care Fund Plan 2016/17.	29 March 2017		Julie Ogley, Director of Adult Social Care, Health and Housing, CBC Contact officer: Patricia Coker, Head of Partnership and Performance, CBC
11.	The Integration of Health and Social Care in Central Bedfordshire	To provide the Board with the Council's emerging vision for the integration of health and social care in Central Bedfordshire.	29 March 2017		Julie Ogley, Director of Adult Social Care, Health and Housing, CBC Contact officer: Patricia Coker, Head of Partnership and Performance, CBC

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