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Central Bedfordshire Health and Wellbeing Board

Agenda

Meeting Title:	Central Bedfordshire Health and Wellbeing Board
Date:	Wednesday, 29 March 2017
Time:	2.00 p.m.
Location:	Council Chamber, Priory House, Monks Walk, Shefford

1. **Election of Chairman**

   To elect a Chairman of the Health and Wellbeing Board for the remainder of the Municipal Year 2016/17.

2. **Apologies for Absence**

   Apologies for absence and notification of substitute members.

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

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

4. **Minutes**

   To approve as a correct record the Minutes of the last meeting held on 25 January 2017 and note actions taken since that meeting.

5. **Members' Interests**

   To receive from Members any declarations of interest.

6. **Public Participation**

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

HEALTH AND WELLBEING STRATEGY

Item	Subject	Page Nos.	Lead
7.	**Health and Wellbeing Strategy Performance** To present the latest performance data in the priority areas of the Joint Health and Wellbeing Strategy.	13 - 24	MS

OTHER BUSINESS

Item	Subject	Page Nos.	Lead
8.	**Employment Support Allowance** To provide detail about the Employment Support Allowance and what Central Bedfordshire Council is doing to support claimants.	25 - 32	JO
9.	**Better Care Fund Plan 2017/18 - 2018/19** To advise the Board of the requirement to produce a two year Better Care Fund Plan for 2017/18 – 2018/19.	33 - 36	JO
10.	**Joint Local Government Association Peer Review: Reablement and Rehabilitation** To present the findings of the Joint Local Government Association Peer Review into Reablement and Rehabilitation, in October 2016 across Central Bedfordshire and Bedford Borough Councils.	37 - 92	JO
11.	**Sustainability and Transformation Plan 2016-2020** To receive an update on the Sustainability and Transformation Plan.	93 - 100	RC
12.	**Work Programme 2017/18** To consider and approve the work programme. 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.	101 - 106	RC

To: Members of the Central Bedfordshire Health and Wellbeing Board

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

please ask for	Sandra Hobbs
direct line	0300 300 5257
date published	16 March 2017

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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, 25 January 2017

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 M Scott	Director of Public Health

Apologies for Absence: Mr C Ford
Mrs J Ogley

Members in Attendance: Cllrs J G Jamieson
M A G Versallion

Others in Attendance: Mr A Caton – Chairman of the Local Safeguarding Children Board

Officers in Attendance:

Mrs K Allen	– Head of Children and Maternity Services Redesign, BCCG
Mrs P Coker	– Head of Service, Partnerships - Social Care, Health & Housing
Ms D Derby	– Director of Commissioning
Mrs S Hobbs	– Committee Services Officer
Mr S Mitchelmore	– Assistant Director, Adult Social Care
Mrs A Murray	– Director of Nursing and Quality, Bedfordshire Clinical Commissioning Group
Ms P Scott	– Strategic Safeguarding Partnership Manager
Mrs C Shohet	– Assistant Director of Public Health
Mrs S Tyler	– Head of Child Poverty and Early Intervention

HWB/16/27. **Chairman's Announcements and Communications**

The Chairman had received the following:

- A letter from the Department of Health - Winter Planning for Adult Social Care and Supporting Delivery into 2017. See Minute no. HWB/16/33 for further details.

- A reply from the Department of Health in response to the concerns raised by the Health and Wellbeing Board on the Bedfordshire, Luton and Milton Keynes Transforming Care Partnership at their meeting on 27 July 2016.

- A letter from the Rt Hon Jeremy Hunt MP - Police and Crime Commissioners and Health and Wellbeing Boards. The Board had previously concluded that the current composition of the Board was appropriate for the stage of its development reached. The Police and Crime Commissioner and Police Force had representation on other boards which fed into the work of the Health and Wellbeing Board.

- A letter from David Mowat MP about end of life care. This letter had been passed to the Bedfordshire Clinical Commissioning Group and it would be considered as part of the Sustainability and Transformation Plan.

HWB/16/28. **Minutes**

RESOLVED

that the minutes of the meeting of the Central Bedfordshire Health and Wellbeing Board held on 19 October 2016 be confirmed as a correct record and signed by the Chairman.

HWB/16/29. **Members' Interests**

None were declared.

HWB/16/30. **Public Participation**

There were no members of the public registered to speak.

HWB/16/31. **Giving Every Child the Best Start in Life: School Readiness**

The Board considered a report that summarised progress with school readiness. There had been a steady improvement but compared with the statistical neighbour cohort, Central Bedfordshire ranked 9th out of 11, as in 2015.

For those children eligible for Free School Meals, there was a 21 percentage point difference, an improvement of 4 points against the 2015 figure. Amongst the statistical neighbours the ranking had increased from 10th to 9th.

Work was continuing with schools, settings, parents and health colleagues to ensure a continuation of the improved results. Data analysis would also continue to ensure that work was targeted to the most appropriate groups.

RESOLVED

1. **that the progress and continued work in giving every child the best start in life in school readiness be noted; and**

2. **that a further progress report be considered by the Board on 24 January 2018.**

HWB/16/32. **Health and Wellbeing Strategy Performance**

The Board considered a report that set out performance for the four key outcomes within the Joint Health and Wellbeing Strategy. The Board discussed each key measure:-

- the proportion of people in need accessing psychological therapies had increased slightly, but it still remained significantly below target and the recovery rates for those in treatment had fallen slightly. Due to the importance of improving mental health, the Board would need to understand what actions were planned by commissioners and providers to address the situation. The Board agreed to invite providers to a future meeting;

- the Council's Communications Team would help to publicise the Bedfordshire Wellbeing Services (www.bedfordshirewellbeingservice.nhs.uk);

- the Board would consider a report at their meeting on 29 March 2017 on the rising rates of diabetes and the low proportion of people with diabetes meeting their treatment targets; and

- the Board would consider a report at a future meeting on the rates of premature mortality for cardiovascular disease.

RESOLVED

1. **that the progress in delivering the Joint Health and Wellbeing Strategy, as set out in the scorecard, be noted; and**

2. the Board would consider the following areas at a future Board meeting:

- **Mental Health**
- **Diabetes**
- **Premature mortality due to cardiovascular disease.**

HWB/16/33. **Winter Planning for Health and Social Care Delivery into 2017**

The Board considered a report on winter planning preparations, given the anticipated challenges for the Health and Social Care system. The discharge arrangements in Central Bedfordshire were being managed and there was a joint approach to sourcing additional community beds for local residents. There were challenges in sourcing domiciliary care packages in the Ivel Valley and West Mid Bedfordshire localities, although two more providers were now active and the Council was working with colleagues in Cambridgeshire.

As there was not a hospital in Central Bedfordshire, residents currently went to seven hospitals that bordered the area. The Council had representation on the Bedford and Luton and Dunstable Hospitals A&E Delivery Boards and work was being carried out to ensure adequate representation at the other relevant Delivery Boards.

RESOLVED

that the preparations for winter planning for Health and Social Care delivering into 2017 be noted.

[NOTE: The Director of Children's Services arrived during this item.]

HWB/16/34. **Child and Adolescent Mental Health Services (CAMHS) Transformation Plan**

The Board considered a report that provided an update on the refreshed Future in Minds Local Transformation Plan for Children and Young People. The Plan set out recommendations that, if implemented, would facilitate greater access to and standards of CAMHS services, promote positive mental health and wellbeing for children and young people, greater system co-ordination and a significant improvement in meeting the mental health needs of children and young people from vulnerable backgrounds.

It was anticipated that by March 2017, the waiting times for the CAMHS service would be down to 5 weeks. There had been a challenge with recruitment to vacancies as people were not applying for the positions and the service had to rely on bank and agency staff and overtime working to reduce the waiting list. Recruitment was a national problem that needed addressing.

The impact of the recommendations would be monitored through the Health and Wellbeing Strategy scorecard and the Board supported a move to planning for the needs of all age groups, not least to ensure more effective transition planning.

RESOLVED

that the key priorities identified in the Local Transformation Plan, as set out in Appendix A to the report, be approved.

[NOTE: The Leader of the Council left during this item.]

HWB/16/35. **Sustainability and Transformation Plan 2016-2020**

The Board considered a report that included the published Sustainability and Transformation Plan (STP) for Bedfordshire, Luton and Milton Keynes (BLMK).

Healthwatch Central Bedfordshire was holding a consultation event on 31 January 2017 to seek the publics' views on the draft STP.

The Chairman had visited The Local Pharmaceutical Committee (LPC) to seek their views on their role in helping to keep people out of hospital. It was agreed to invite a presentation from the Committee to a future Health and Wellbeing Board meeting at an appropriate time.

RESOLVED

1. **that the publication of the Draft Sustainability and Transformation Plan be noted; and**

2. **that the STP be endorsed on the basis that the priorities reflected in the Plan align with the Central Bedfordshire's aspirations for greater emphasis on prevention; reduced reliance on acute services; strengthened primary care services delivered close to where people live and integrated wherever possible with social care and other services.**

HWB/16/36. **Aiming for the Best for Children, Young People and Families in Central Bedfordshire: Annual Public Health Report by the Director of Public Health**

The Board considered a report that highlighted key issues and made a series of evidence-based recommendations that had the potential to make a real difference to the lives of children, young people and their families. The report highlighted the areas where health and wellbeing for children and young people in Central Bedfordshire could be further improved. It identified specific recommendations for improvement and importantly a 'Call to Action' to highlight the areas most in need of attention. A joint partnership approach was required to ensure progress was made.

The Board was concerned that those agencies responsible for the delivery of improvements identified within the report should be held accountable for those improvements. Where the Director of Public Health and appropriate colleagues judged it appropriate, those agencies should be required to account to the Board on what steps were being taken to deliver improvements.

RESOLVED

1. **to endorse, champion and ensure that, together with children, young people and their families, the Board achieves its aspiration of aiming for the best for children, young people and families in Central Bedfordshire; and**

2. **to use the report, particularly the Call to Action and areas for improvement, to influence the refinement of the Joint Health and Wellbeing Strategy; and**

3. **that where the Director of Public Health judges it to be appropriate, relevant agencies be required to account to future meetings of the Board on the steps they were taking to deliver improvements identified as necessary within the report.**

HWB/16/37. **Local Safeguarding Children Board Annual Report - 2015/2016**

The Board considered the annual report from the Central Bedfordshire Safeguarding Children Board (LSCB) which provided a detailed account of the work undertaken by the LSCB throughout the year, progress made against the priorities contained within the LSCB Business Plan and the outcomes achieved.

RESOLVED

that the information contained within the 2015/16 Annual Report from the LSCB be noted.

HWB/16/38. **East of England Ambulance Service in Bedfordshire**

The Board considered a report that set out the performance and quality of the East of England Ambulance Service (EEAST). EEAST's performance was measured across a number of indicators, covering response times, handover delays, clinical quality and workforce. The BCCG area remained one of the best performing across all measures.

A Dispatch on Disposition (DoD) model was being piloted across a number of ambulance trusts and was rolled out by EEAST on 4 October 2016. Data from this trial model was not yet available.

RESOLVED

that the report be noted.

HWB/16/39. **2016 Autism Self Assessment Framework Return**

The Board considered a report that set out the 2016 Autism Self Assessment Framework (SAF) that had been submitted to Public Health England on 17 October 2016. It provided an update on the local area partnership's progress in key areas of the Strategy which sought to assist people with autism to reach their potential, to have full lives and to live as independently as possible.

The report also identified areas for further work through the SAF to ensure a systematic method of identifying the unmet health and social care needs of people with Autism.

RESOLVED

1. **to note that an updated Health Needs Assessment for Autism would be undertaken to refresh the last evaluation undertaken in 2010; and**

2. **that further work identified would be progressed through the Think Autism Partnership Board and an associated action plan would be developed.**

HWB/16/40. **Healthwatch Central Bedfordshire Carers Film**

The Board watched a film produced by Healthwatch Central Bedfordshire in which local adult carers shared their experiences. A second film was due to be produced on local young carers in March 2017.

[NOTE: the Director of Community Services left during this item.]

HWB/16/41. **Work Programme 2017**

The Board considered their work plan for 2017.

RESOLVED

that the following items be added to the work programme:

- **Giving Every Child the Best Start in Life – School Readiness - 24 January 2018**
- **diabetes – 29 March 2017**
- **mental health – to be timetabled**
- **premature mortality from cardiovascular disease – to be timetabled**
- **to invite a LPC presentation at a future meeting**
- **actions to deliver the improvements identified within the Director of Public Health's Annual report – to be timetabled**

(Note: The meeting commenced at 2.00 p.m. and concluded at 4.50 p.m.)

Chairman …….……

Dated ……..

CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of meeting 29 March 2017

Health and Wellbeing Strategy Performance

Responsible Officer: Muriel Scott, Director of Public Health
Email: Muriel.Scott@centralbedfordshire.gov.uk

Advising Officer: Celia Shohet, Assistant Director of Public Health
Email: celia.shohet@centralbedforshire.gov.uk

Public

Purpose of this report

1. To present the latest performance data in the priority areas of the Joint Health and Wellbeing Strategy.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. **to review the scorecard and assess the progress in delivering the Joint Health and Wellbeing Strategy; and**

2. **to consider the areas for further focus arising from the performance in each of the Priority Areas, outlined in paragraphs 4-8.**

Background

2. 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 against target, direction of travel and a comparison with benchmarks. The performance of statistical neighbours will be added to the scorecards in July.

3. 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.

Ensuring good mental health and wellbeing at every age

4. The performance data this month for access to psychological therapies continues to give some cause for concern. Although the proportion in need accessing psychological therapies has increased slightly, it remains significantly below target and the recovery rates for those in treatment is also below target. The scorecard outlines a number of actions to improve performance but given the importance that the Board places on improving mental health, it may wish to consider inviting the provider to attend a future Board meeting to outline the current situation, progress challenges and opportunities.

Giving every child the best start in life

5. Although performance shows a mixed picture for giving every child the best start in life, there are encouraging signs with a number of outcomes continuing to move in the right direction with some either at or near target. The successful completions (alcohol) of clients who live with children is now in the top quartile and particularly encouraging, the corresponding performance for opiates is just below target but remains above the national average.

Enabling people to stay healthy for longer

6. The proportion of people with diabetes who meet all 3 treatment targets has improved very marginally (from 37.4% to 37.6%) and actions to improve this further will be presented to the Board in July.

Improving outcomes for frail older people

7. Outcomes for improving outcomes for Frail Older People (many of which form part of the Better Care Plan metrics) show a mixed picture, reflecting the ongoing challenge of meeting the needs an aging population with increasingly complex needs. Permanent admissions of older people to residential and nursing care homes, which is a cumulative measure, is performing well against the target. The proportion of people at home 91 days after discharge from hospital stayed the same as the previous month.

Performance on delayed transfer of care improved. The target for non elective admissions into hospital remains challenging and remains below the BCF target.

8. An appraisal of the current Better Care Plans is underway, particularly in relation to falls, stroke and end of life care. The output of which will be reported initially to the BCF Commissioning Board and then to the July meeting of this Board in the context of the Better Care Fund Plan for 2017-19.

Financial and Risk Implications

9. There no financial implications directly associated with this proposal.

Governance and Delivery Implications

10. The scorecard will be reported to the Health and Wellbeing Board on a quarterly basis.

Equalities Implications

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.

Implications for Work Programme

12. The scorecard is currently reported to the Health and Wellbeing Board at each meeting. .

13. The Board may want to consider the proposal to consider the outcomes for access to psychological therapies, for diabetes and the outcomes for frail older people in more detail at future meetings.

Conclusion and next Steps

14. The scorecard shows some improving performance and some areas of concern. A number of areas have been identified for further consideration at future board meetings.

Appendices

The following Appendix is attached: Summary scorecards for each of the priority areas.

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Ensuring good mental health and wellbeing at every age

Outcomes

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

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

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

	Latest Data	DoT	Latest Data	Target	Current Status	England
Proportion in need accessing psychological therapies	Dec 16	↑	8.87 %	15.00 %	▲	n/a
CAMHs waiting for intervention for more than 18 weeks	Dec 16	→	0 %	0 %	★	n/a
Hospital admissions for mental health 0-17 years	Dec 15	n/a	73.4		n/a	87.4
Hospital admissions for self-harm 0-18 years (CBC Population)	Dec 16	↓	21		n/a	399
Emotional wellbeing of looked after children	Sep 16	↑	13.4	13.0	●	n/a
Recovery rates for those completing psychological therapies	Dec 16	↑	43.0 %	50.0 %	▲	48.4 %
Premature mortality (<75 years) in adults with serious mental illness	Dec 13	n/a	1,232		n/a	1,319
Proportion of adults in contact with secondary mental health services in paid employment	Sep 15		6.5 %	13.2 %	▲	5.8 %

▲ Target missed by 10% or more ● Target missed by less than 10% ★ Target achieved
↑ Performance is improving → Performance remains unchanged ↓ Performance is worsening

Performance of the proportion in need accessing psychological therapies indicator is currently under the agreed recovery trajectory however East London Foundation Trust (ELFT) are working on a number of work streams to increase referrals into the service. Referrals from GPs have been analysed and low referring practices will be contacted and offered support; ELFT will be attending locality meetings to promote the Improving Access to Psychological Therapies (IAPT) model; Roadshows will be taking place in GP surgeries to encourage self referrals.

The recent deterioration in performance of recovery rates for those completing psychological therapies has been impacted by the resolution of the historical waiting list. The Trust has implemented clear processes and clinical protocols to maintain a high recovery rate during the reduction of the waiting list. However, due to the large numbers of patient inherited and the severity of the presentation of these patients, the impact is now being realised. Nevertheless the service will continue to implement the clinical standards required to achieve the 50% recovery rate.

The average waiting times across the combined clinics in Bedfordshire CAMHS is currently 7.5 weeks for routine assessment appointments; this is significantly reduced in some local areas with 12 weeks being reported as the longest wait for assessment in the Looked After Children's team.

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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	DoT	Latest Data	Target	Current Status	England
Smoking at the time of delivery (L&D deliveries only)	Sep 16	↓	17.1 %	15.0 %	▲	n/a
Breastfeeding rate 6-8 weeks	Sep 16	↓	48.8 %	50.0 %	●	n/a
Early access to antenatal care (all L&D deliveries)	Sep 16	↓	83.1 %	90.0 %	●	n/a
Mothers who receive a maternal mood review by the time the infant is 8 weeks	Sep 16	↑	67.7 %	90.0 %	▲	n/a
Successful completions (opiates) of clients who live with children under 18	Dec 16	↓	9.3 %	10.1 %	●	7.7 %
Successful completions (alcohol) of clients who live with children under 18	Dec 16	↑	39.1 %	38.4 %	★	43.1 %
No. of Domestic Abuse incidents reported	Dec 16	↓	789	n/a	n/a	n/a
Children who received an integrated 2-2.5 year review	Sep 16	↑	76.3 %	90.0 %	▲	n/a
Number of disadvantaged 2 year olds placed in early education/childcare	Dec 16	↑	645	773	▲	n/a
School readiness - % of children achieving a good level of development at the Early Years Foundation	Sep 16	↑	68.5 %	71.7 %	▲	69.0 %
Childhood Excess Weight: Reception Year Children (4-5 years)	Jul 16	↑	19.6 %	18.8 %	●	22.1 %
Teenage pregnancy	Dec 14	↑	18.8	23.2	★	22.8

▲ Target missed by 10% or more ● Target missed by less than 10% ★ Target achieved
↑ Performance is improving → Performance remains unchanged ↓ Performance is worsening

In summary, the latest data relating to giving every child the best start in life shows improvements in:

- the number of disadvantaged 2 year olds placed in early education/childcare
- the successful completion of clients (alcohol) who live with children under 18

However successful completion of clients (opiates) who live with children under 18 has fallen from 11.3% previous quarter to 9.3% and now below target. This will be raised at P2R's next performance meeting.

The number of domestic abuse incidents reported has decreased but it is not possible to ascertain whether this is a true decrease in incidents or under reporting of incidents. The Council encourages the reporting of domestic abuse and monitors numbers as part of its commitment to protecting the vulnerable.

Two new indicators (teenage pregnancy and childhood excess weight YR) have been included this quarter with respect to the Director of Public Health (DPH) Report which focuses on aiming for the best for Children and Young People.

The under 18 conception rate in Central Bedfordshire has fallen by 5% between 2013 and 2014 and rates are below both the national and East of England average. In order to continue this downward trend, the work of the Teenage Pregnancy Strategy needs to continue with a sustained focus on prevention and early intervention with targeted intervention in hot spot wards, Dunstable Northfields and Dunstable Manshead.

Rates of childhood excess weight in reception year children (4-5 years) has seen an improvement from last year, 14/15 although the annual target has not been met. The focus on children, young people and families is a key priority for partners in the implementation of the Central Bedfordshire Excess Weight Strategy across all systems and services, incorporating early years settings, schools and the 0-19 health visiting and school nursing services.

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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	DoT	Latest Data	Target	Current Status	England
Smoking prevalence 18+	Dec 15	↑	16.7 %		n/a	16.9 %
Adult Excess Weight	Jul 15	↑	67.1 %	68.1 %	★	64.8 %
Percentage of adults classified as inactive	Jan 16	↑	22.7 %	23.3 %	★	28.7 %
Health Checks Delivered % of Target	Dec 16	↑	77.32	100.00	▲	n/a
Recorded diabetes	Nov 15	n/a	6.0 %	5.3 %	▲	6.4 %
% people with diabetes meeting all 3 treatment targets (blood sugar, blood pressure & cholesterol)	Feb 16	↑	37.6 %		n/a	40.4 %
Premature mortality	Dec 15	↑	280	272	●	335
Premature mortality for cardiovascular disease	Dec 15	↓	63.8	57.7	▲	74.6
Premature mortality for respiratory disease	Dec 15	↓	25.2	23.5	●	33.1
Premature mortality for liver disease	Dec 15	↓	12.2	13.2	★	18.0

▲ Target missed by 10% or more ● Target missed by less than 10% ★ Target achieved
↑ Performance is improving → Performance remains unchanged ↓ Performance is worsening

In summary, the latest data relating to enabling people to stay healthy longer shows a slight improvement in the proportion of people with type 2 diabetes meeting their treatment targets. This continues to be worse compared to the England average and therefore remains an area of focus for the CCG.

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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	DoT	Latest Data	Target	Current Status	England
Total non-elective admissions into hospital (general & acute) all-age per 100,000 pop (Monthly)	Dec 16	↓	876	770	▲	n/a
Permanent Admissions of Older People (65+) to residential & nursing care homes (BCF)	Jan 17	↓	309.2	362.8	★	n/a
Proportion of 65+ still at home 91 days after discharge from hospital	Jan 17	↓	78.0	95.5	▲	n/a
Emergency hospital admissions due to falls (65+) per 100,000	Mar 15	↓	2,016	n/a		n/a
Dementia diagnosis rate (65+)	Jan 17	↑	61.47 %	66.72 %	●	67.70 %
Social isolation-Adult carers who have as much contact as they would like	Mar 14	↓	41.0 %	41.6 %	●	38.0 %
Delayed transfers of care (days) from hospital per 100,000 pop.	Dec 16	↑	197.6	145.7	▲	n/a

▲ Target missed by 10% or more ● Target missed by less than 10% ★ Target achieved
↑ Performance is improving → Performance remains unchanged ↓ Performance is worsening

The rate for Delayed transfers of care from hospital show an improvement in performance in relation to the previous month (November). In December, there were 429 delayed days of which 106 were from social care and 33 from social care and NHS. Of the 106 delayed days, 35 were due to waiting to move into a residential home whilst 47 related to waiting for a care package in their own home. The provider for the majority of the social care delays was Bedford Hospital which has consistently been the poorest performer for the last 5 months.

The target for total non elective admissions into hospital remains challenging. Work is ongoing through the Accident and Emergency delivery boards to address unplanned admissions. Appraisals of BCF projects are also being undertaken particularly in relation to falls and end of life partnerships. This will be included as part of the BCF report.

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CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of Meeting 29 March 2017

Employment Support Allowance

Responsible Officer: Julie Ogley, Director of Social Care, Health and Housing
Email: Julie.ogley@centralbedfordshire.gov.uk

Advising Officer: Sue Tyler, Head of Child Poverty and Early Intervention
Email: sue.tyler@centralbedfordshire.gov.uk

Public

Purpose of this report

1. To provide detail about the Employment Support Allowance (ESA) and what Central Bedfordshire Council is doing to support claimants.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. note the report.

Background

2. The benefits system has been undergoing a range of changes since 2008, in an attempt both to simplify the system, provide greater incentive to work and ultimately to be able to reduce the national budget spent on welfare benefits.

3. The ESA was introduced in 2008 as a replacement for Incapacity Benefit. It was rolled out in 2008 for new claimants. From autumn 2010 the system extended to existing Incapacity Benefit Claimants. The ESA introduced for the first time the Work Capability Assessment, there was greater conditionality and time limits were introduced for the non-means tested part of the entitlement for those in the work-related activity group.

4. ESA is one of the benefits included in the basket for the Benefit Cap.

Claiming ESA

5. In order to claim ESA a Work Capability Assessment has to be undertaken. This is carried out by Approved Healthcare Professionals (AHP) on behalf of the Department of Work and Pensions (DWP), and it tests the claimant's eligibility to work. Most claimants, except those with the most severe impairment, will have to complete an ESA50 form and have a face-to-face assessment with an approved healthcare professional. During the assessment points will be given depending on the levels of activity which can be attained. It is intended to find out what capacity for work the claimant has at what level. It will normally be carried out within the first three months immediately after a claim is made.

6. The test considers 17 activities and descriptors: 10 physical and 7 mental, cognitive and intellectual. The headings for these are:

   a) Mobility and need to be helped by another person, use a walking stick, manual wheelchair or other aid.

   b) Standing and sitting, and moving from one to the other without help.

   c) Reaching.

   d) Picking up and moving or transferring by the use of the upper body and arms.

   e) Manual dexterity e.g. cannot press a button (such as a telephone keypad) with either hand or cannot turn the pages of a book with either hand. Cannot single-handedly use a suitable keyboard or mouse.

   f) Making self understood through speaking, writing, typing, or other means which are normally or could reasonably be used, unaided by another person.

   g) Understanding communication by verbal means (such as hearing or lip reading) alone; non-verbal means (such as reading 16-point print or Braille) alone; or a combination of the two.

   h) Navigation and maintaining safety using a guide dog or other aid if either or both are normally or could reasonably be used.

   i) Absence or loss of control whilst conscious leading to extensive evacuation of the bowel and/or bladder, other than enuresis (bed-wetting), despite the wearing or use of any aids or adaptations which are normally or could reasonably be worn or used.

j) Consciousness, or loss of, during waking moments.

k) Being able to learn to carry out simple tasks.

l) Awareness of everyday hazards (such as boiling water or sharp objects).

m) Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks).

n) Coping with change.

o) Getting about e.g. unable to get to a specified place with which the claimant is familiar, without being accompanied by another person.

p) Coping with social engagement due to cognitive impairment or mental disorder.

q) Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder.

7. With 15 points or more the claimant is considered to have limited capability for work and will be eligible for ESA. If 14 points or less are achieved it there is no entitlement as there is not considered to be a limited capability for work. In these circumstances Job Seekers Allowance will be considered the appropriate benefit.

8. For those who are eligible there are further tests and interviews to decide whether a claimant is to be allocated to a support group or Work Related Activity Group (WRAG). Depending on the actual levels of assessment the claimant will either be immediately referred to a work programme (where they can remain for up to 2 years) or if they are further away from being capable for work they will start by working with a Work Coach at the Job Centre. Claimants in the WRAG must attend the job centre a minimum of twice in a 52 week period.

9. The ESA support group is for people who are judged to be unable to work or even to attend interviews intended to help sick and disabled people move into work. Claimants in the support group get slightly more money than ESA claimants in the work-related activity group. In many cases these claimants will also be able to claim Disability Living Allowance (or the Personal Independence Payments which are gradually replacing the Disability Living Allowance), depending on their National Insurance record.

10. For claimants who are deemed able to work they are put into the ESA Work Related Activity group. These claimants are not considered well enough to work at the moment but the DWP believes that with the right levels of support they could move into work. Claimants in this group have to attend a series of work-focused interviews.

11. This aspect of the ESA is time-limited and if a return to the workplace is not made within 12 Months, a move will be made to other benefits.

Levels of Employment Support Allowance

12. During the Assessment Period (normally up to 13 weeks) the weekly rates of payment are up to £57.90 a week if you're aged under 25 and up to £73.10 a week if you're aged 25 or over.

13. Once assessment is complete the rates are:

- up to £102.15 a week if you're in the work-related activity group
- up to £109.30 a week if you're in the support group.

14. For claimants in the support group and in receipt of income-related ESA, there is the enhanced disability premium at £15.75 a week, and some will also qualify for the severe disability premium at £61.85 per week.

Claimants in Central Bedfordshire

15. Data regarding numbers of ESA claimants are published every quarter. There has been a steady increase in the number of claimants, which more or less correlates to the reduction in Incapacity Benefit claimants over the same period, in line with the phasing out of Incapacity Benefit.

16. Central Bedfordshire Claimants

Date	**ESA Claimants**	**Incapacity Benefit Claimants**
2013 Feb	4020	2100
2013 May	4400	1700
2013 Aug	4650	1365
2013 Nov	4820	1215
2014 Feb	4980	1060
2014 May	5190	965
2014 Aug	5450	810
2014 Nov	5530	685
2015 Feb	5650	580
2015 May	5640	540
2015 Aug	5710	460
2015 Nov	5820	400
2016 Feb	5870	345
2016 May	5910	320

17. The most recent localised data available is May 2016. The DWP are still using the 2003 wards for data collection.

The areas with the highest number of claimants are:

2003 Ward	Total No Claimants	Claimants age 16-24	Claimants age 25-49	Claimants age 50+	Male	Female
Northfields, Dunstable	280	35	135	110	145	135
Houghton Hall, H.Regis	270	20	135	115	135	135
Parkside H.Regis	245	20	115	110	130	115
Manshead, Dunstable	240	25	130	85	125	115
Biggleswade Ivel	235	20	95	120	115	120
Grovebury L.Buzzard	225	20	115	90	105	120
Tithe Farm H.Regis	225	15	100	110	105	120
Dunstable Central	215	15	100	100	100	115
All Saints L.Buzzard	205	20	105	80	110	95
Sandy Pinnacle	180	15	80	85	80	100
Shefford,Campton & Gravenhurst	180	15	100	65	90	90
Plantation, L.Buzz	180	10	90	80	90	90

The areas with the lowest number of claimants are:

2003 Ward	Total No Claimants	Claimants age 16-24	Claimants age 25-49	Claimants age 50+	Male	Female
Harlington	20	0	5	15	10	10
Flitton, Greenfield & Pulloxhill	25	0	5	20	15	10
Aspley Guise	30	5	10	15	20	10
Silsoe	30	0	10	20	15	15
Woburn	35	0	10	25	20	15

What are Job Centre Plus doing?

18. A dedicated Work Coach is available to all ESA claimants. They work on a 1:1 basis with claimants to assess their needs and expedite their return to work. Some claimants who are in the Support Group, without an expectation to work are also eligible for this level of support.

19. Work Experience is made available to all claimants along with employability courses (which are specifically designed to support ESA customers) and Permitted Work.

20. Permitted Work is available to all on ESA and means that the claimants are able to work Part Time for a year without their benefit being affected. They are able to work a maximum of 16 hours per week and earn no more than £104 per week. This is averaged out over 1 calendar month. However due to Universal Credit coming into full service soon these figures are now subject to change.

21. The DWP are currently developing new roles to support clients which will be known as Health and Wellbeing consultants or Community Partners. Another role which is being developed is that of the Disability Consultants, part of whose remit is to work with GPs on issues regarding the fit note and signposting around working with medical conditions.

What is being done by Central Bedfordshire to help claimants back to work?

22. The Council's Employment and Skills Service (BESS) receives money (currently just over £1.1 million) from the Skills Funding Agency (SFA) to deliver programmes designed to support the upskilling of individuals both into and through employment. This includes, as a priority group, those receiving Employment and Support Allowance (ESA) who are in the work-related activity group (WRAG), as well as a range of other vulnerable groups. Work is done in Partnership with the Job Centre.

23. The programmes offered are designed to support people into further learning, education and employment. They address barriers to employment, including basic skills, childcare, transport, ill health (including mental illness) and confidence.

24. The Employment Support Officer and Housing team also support ESA claimants. The Service provides a number of training opportunities for tenants seeking employment, in addition the Employment Support Officer works with colleagues across the council to provide Employment Events which are also supported by Job Centre Plus, this activity also supports and enables signposting to appropriate services.

25. These services are advertised to ESA claimants through email alerts and Housing Matters, although take-up is low.

What is being done to help all ESA Claimants?

26. The Council's offer 'Helping residents deal with welfare reform' brings together a range of work offered to residents under the headings for helping people back to work, improving housing and building resilience. In addition to the items specifically listed above under back to work the Council is:

- Providing apprenticeships.

- Helping people with learning disabilities through the supported employment approach, including the Preparing for adulthood programme.

- Offering special help to tenants who require it – specialist employment and skills provision is commissioned to support people with additional needs, e.g. mental health difficulties.

- Providing mental health self-help guides which are available to download from the Central Bedfordshire website.

- Commissioning additional employment support to people suffering with mental health.

- Provision of Travel Aid bus passes for people seeking work enabling attendance at training and work interviews.

- Providing information, advice and advocacy services. This includes not only funding Citizens Advice Bureaux across the area, but PohWER which is an independent advocacy services, to support residents with additional needs.

Appendices

None

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CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of Meeting 29 March 2017

Better Care Fund Plan 2017/19

Responsible Officer: Julie Ogley, Director of Social Care, Health & Housing (Julie.ogley@centralbedfordshire.gov.uk); and
Donna Derby, Director Commissioning - Bedfordshire Clinical Commissioning Group (donna.derby@bedfordshireccg.nhs.uk)

Purpose of this report

1. To advise the Board of the requirement to produce a two year BCF Plan for 2017/18 – 2018/19.

2. To delegate the BCF Commissioning Board to take forward the necessary activities to develop and agree the Better Care Fund 2017-2019 and the required S75 agreement.

3. To ask for delegated authority to be put in place to sign off the BCF Plan submission ahead of the next scheduled meeting of the Health and Wellbeing Board (HWB).

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. **note the timetable for the submission of the Better Care Fund Plan (BCF) for 2017/19; and**

2. **delegate approval of the Plan submission to the Director of Social Care, Health and Housing and the Director Commissioning, in consultation with the Chairman of the Health and Wellbeing Board.**

Background

4. NHS England has confirmed that the Better Care Fund will continue in the 2017/18 and 2018/19 financial years. The Plan should build on the 2016/17 BCF plan.

5. Publication of the BCF guidance was due in November but has been significantly delayed pending the issue by the Department of Health of the BCF Policy Framework which informs the NHS guidance, requirements and financial allocations.

As a result of this delay, the size of the fund, national conditions and planning requirements for 2017-18 and 2018/19 remain unclear. The delay in publishing the guidance means tight timeframes for developing, approving, and submitting plans.

6. However, early indications suggest that the policy framework will be broadly similar to previous years. HWBs are required to submit a narrative plan, outlining the local vision for integration and case for change. The Plan should also include a detailed expenditure plan setting out the initiatives and projects that will be funded via the BCF pooled fund.

7. The 2017/19 BCF plan should build on the approved 2016/17 plan and demonstrate that local partners have reviewed progress in the first two years of the BCF as the basis for developing plans for 2017-19.

8. The Plan should also set out the local vision and approach to integration and demonstrate alignment with local strategic visions for the STP and the GP Forward View.

Reasons for the Action Proposed

9. The Better Care Fund Planning Guidance requires that Plans are signed off by HWBs and by the constituent Council and Clinical Commissioning Group.

10. The 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.

11. 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.

12. 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

13. The timetable for the BCF submission will be tight and likely to be before the next scheduled meeting of the Health and Wellbeing Board.

14. It is therefore necessary to seek delegated authority to develop and submit the initial plan on behalf of the HWB. Though this and future iterations will be brought to the Board for approval, where possible and ratification.

15. The BCF Commissioning Board will oversee the development of the 2017/19 Plan and ensure its alignment with the local vison for Integration and STP priorities for Primary, Community and Social Care.

Governance & Delivery

16. Progress on the Better Care Fund Plan will be reported to the HWB 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.

17. A review of the role of the BCF Commissioning Board is underway. The new Board will consolidate 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 HWB.

Financial

18. 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)

19. 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.

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

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CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of meeting 29 March 2017

Joint LGA Peer Review: Reablement and Rehabilitation

Responsible Officer: Julie Ogley, Director of Social Care, Health and Housing
Email: Julie.Ogley@centralbedfordshire.gov.uk

Advising Officer: Stuart Mitchelmore, Assistant Director Social Care
Email: Stuart.Mitchelmore@centralbedfordshire.gov.uk

Public

Purpose of this report

1. To present the findings of the Joint LGA Peer Review into Reablement and Rehabilitation, in October 2016 across Central Bedfordshire and Bedford Borough Councils.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. **receive the LGA Peer Review Report on Reablement and Rehabilitation services in Central Bedfordshire;**
2. **note the findings and recommendations of the Review; and**
3. **endorse the next steps.**

Background

2. Central Bedfordshire Council (CBC) and Bedford Borough Council (BBC) asked the Local Government Association (LGA) to carry out an Adult Social Care Peer Review as part of the East of England's Association of Directors of Adult Social Services (ADASS) Programme of Regional Peer Reviews focussing on the Councils' work on Reablement and Rehabilitation. It was agreed with Bedfordshire Clinical Commissioning Group (BCCG) and SEPT Community Health Services to cover health and social care services.

3. The Peer Challenge provides an external view on the quality of the reablement and rehabilitation services in order to consider how to improve the delivery of good outcomes for those who access these services.

4. Although not an inspection, the Peer Challenge offers a supportive approach, undertaken by friends – albeit 'critical friends. ' It is designed to help an authority and its partners assess current achievements, areas for development and capacity to change. It aims to help an organisation identify its current strengths, as much as what it needs to improve and should also provide it with a basis for further improvement.

5. The members of the Peer challenge team were:

- **Professor Graeme Betts**, Care and Health Improvement Adviser, LGA
- **Cllr Philip Corthorne**, (Cons) Cabinet Member for Adult Social Care, Health and Housing, LB Hillingdon
- **Cllr Stewart Golton**, (Lib Dem) Leeds City Council
- **Gerald Pilkington**, Rehabilitation and Reablement Expert
- **Benedict Leigh**, Lead Commissioner for Adult Social Care, Oxfordshire County Council
- **Fiona Day**, Head of Partnership, Quality and Performance, Hertfordshire County Council
- **Marcus Coulson**, Programme Manager, Local Government Association.

6. The focus for the review was:

- The current 'as-is' state of the service across the organisations with a focus on offering a good, accessible, consistent experience for the customer regardless of their entry-point
- It also sought to understand where the service could better streamlined or avoid duplication

7. The benchmark for this Peer challenge was the amended Commissioning for Better Outcomes Standards for Reablement and Rehabilitation created by Suffolk County Council.

8. The scoping meeting for the Peer Challenge included representatives from both Bedfordshire Clinical Commissioning Group (BCCG) and the provider organisation South Essex Partnership Trust (SEPT) who, along with the two Councils completed self-assessments or this review.

9. Central Bedfordshire's Self Assessment concluded that:

- CBC provides a good service to customers.
- CBC listens to what customers want and has worked hard to improve processes.

- It sometimes takes too long to arrange Domiciliary Care, but staff are working on fixing this through a new provider framework.

- All staff are well trained and feed back ideas through regular meetings.

- CBC could work more closely with Health colleagues but this is difficult while our customer records systems are so different and there are different points of access.

- Work has been undertaken to implement the recommendations from a review of the Council's Reablement Service in August 2014. The Peer Review team was asked to consider how the changes had been embedded.

10. The review team met with elected Members, staff and managers from Central Bedfordshire council, Bedford Borough council, Bedfordshire Clinical Commissioning Group, South Essex Partnership Trust and two General Practitioners.

11. Healthwatch Central Bedfordshire conducted a telephone survey of 131 customers and carers from details provided by Central Bedfordshire Council, Bedford Borough Council and SEPT, from which they obtained 89 answers. See Appendix 1.

12. The Peer Review was conducted under five key domains:
    1. Well led
    2. Person-centred and outcomes-focused
    3. Promotes a sustainable and diverse market place
    4. Integration with health
    5. Seamless and effective service delivery

Review Findings

13. The review noted that at strategic level there is an awareness and recognition between partners of the need to work better together to deliver effective services and therefore outcomes for customers. There are good examples across the patch to build on, of joint or integrated services such as the successful work on Adult Safeguarding, Carers and Advocacy.

14. The team noted the important role of the STP to drive progress at a strategic level and for elected representatives to be included in the STP process to ensure the democratic mandate is addressed and local people's views are effectively included.

15. CBC has taken a lead in developing primary care-led, jointly delivered, integrated out of hospital care services. Whilst onsite, the team heard about the newly created plan for several Health and Social Care Hubs that will house multi-disciplinary teams working to deliver preventative care and thereby address potential illnesses before they need acute treatment and promote wellbeing and thus deliver efficiencies

16. Both CBC and BBC are taking forward initiatives to invest in social capital including investment in sports centres and community development and prevention. The Councils are place leaders due to their democratic mandate and engagement with local people through the services they deliver.

17. In discussions with CBC, BBC, BCCG and SEPT the overriding view with regards to their relationships is that they all feel something needs to change in order for further progress to be made. They all recognise that they need to work together more effectively to address ongoing financial pressures. This Peer Review is an opportunity for change and there is a new sense of purpose and energy in order to consider how to move forward.

18. From various discussions, it became clear that there is wide spread confusion about the nature, focus and purpose of rehabilitation versus reablement. It was often assumed, for instance, that because therapists are involved within both SEPT and the CBC service, they must be the same and seeking to support the same type of need. This results in referrals being made to both SEPT and the CBC Reablement services and whoever answers first gets the client / patient, rather than the decision being made on the basis of which service can best support the person's needs.

19. The Peer Review team noted the need for a clear understanding of the purpose and eligibility criteria of the three different reablement services and that these are communicated to all across the whole system. Furthermore, that the ongoing pressures on Homecare and Acute beds in the footprint should be better understood.

20. It was clear to the Peer Review team that all organisations will miss the opportunity to improve reablement services if they do not address the issues of market capacity and access to care packages.

21. There is a good proposed process in CBC to allocate a named worker on entry to the reablement pathway which will ensure the appropriate management of clients as they progress into, through and out of the reablement service. This will assist clients to know who to contact as their treatment progresses and increases their understanding.

22. There is a need for a greater collaboration and alignment across services at the commissioning and operational level.

23. The Peer Reviewers recognised the positive relationships between the partners. However, now is the time for action – "failure to respond appropriately to the challenges facing everyone will have serious implications for local people".

24. There needs to be acknowledgement by all parties that the current arrangements are fragmented, cost ineffective and are not delivering the best outcomes for residents. A new approach starting with the person at the centre needs to be developed and all parties need to commit to achieving this goal regardless of the impact on organisations.

25. Organisations were asked to consider how to move towards an improved level of shared intelligence to deliver better outcomes for residents.

Key Recommendations

26. The Peer Review Team set out a number of recommendations against the five key areas (see Appendix 2). These include:

27. - A key strategic message from the Peer Review team is that both CBC and BBC with its partners in the STP need to create a Place Based Plan.

28. - A recommendation that CBC and BBC set up a joint Transformation Board for service development. This Board would focus on identifying what would improve performance and ensuring it is delivered. For example, ensuring people being discharged from local hospitals are placed on the correct pathway should be a consistent activity across the Councils and the providers to ensure better outcomes for residents. The leadership for ensuring this takes place would lie with the Transformation Board.

29. - That any service redesign that takes place in the footprint should put those who access services at the very heart of the work to ensure their views and expectations are central to the outcomes delivered.

30. - That elected members should be involved in identifying opportunities for developing the social inclusion aspect of reablement in communities, drawing on their first hand community knowledge. This may take the form of working with for example, faith based groups, older peoples' organisations and other less formal groups which have existing local networks and connections which are capable of being harnessed. Members are the leaders in their communities and their leadership is critical in galvanising local communities and community organisations to support initiatives which prevent admissions and which enable safer, quicker discharges and support for carers

31. - That any service redesign that takes place in the footprint should put those who access services at the very heart of the work to ensure their views and expectations are central to the outcomes delivered.

Next steps:

32. CBC, BBC, SEPT and BCCG are currently meeting to discuss how to implement the recommendations. In response to paragraph 28 (above) Transformation Boards have recently been established in Central Bedfordshire and Bedford Borough with the CCG and key health provider partners.

33. An Action Plan is in development and will form part of the 2017/19 BCF Plan. The intention is to move to join up oversight of customers/patients across the SEPT and Council services, to align staff and to look to joint management arrangements. The timeline for this will be set out in the forthcoming BCF Plan.

34. The Council is taking part in the re – procurement of Community Health Services that includes the Council's current investment in the SEPT Reablement services (c£500,000). The intention to consider integration of other services in the coming months has been included in the Service Specification.

Financial and Risk Implications

35. Financial and risk implications of implementing the recommendations of the Peer Review will be considered as part of the BCF 2017/19 Plan.

Governance and Delivery Implications

36. Delivery of the recommendations will be overseen by the BCF Commissioning Board. Progress on delivery will be reported to the Health and Wellbeing Board and the Central Bedfordshire Transformation Board.

Equalities Implications

37. Central Bedfordshire Council has a statutory duty to promote equality of opportunity, eliminate unlawful discrimination, harassment and victimisation and foster good relations in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

38. The effective working of the Reablement and Rehabilitation services across the whole Bedfordshire area is very important to vulnerable residents leaving hospital.

39. This review and subsequent steps to improvement have been taken with a view to improve outcomes and experience for the customer.

40. 131 current and recent customers were contacted by Healthwatch to give their views which were included in the Review and taken into consideration. In future surveys the responses will be broken down by different types of disability in order to more closely examine the impacts on different customer groups.

41. Any subsequent changes to service or provision will involve further engagement with customers and will be managed through Equalities Impact Assessments

Implications for Work Programme

42. Implementation of the recommendations of the Peer Review will be taken forward as part of the BCF Plan 2017/19.

Appendices

The following Appendices are attached:

1. Appendix 1:Rehab and Reablement Telephone Survey report by Healthwatch

2. Appendix 2: Central Beds Bedford Borough Peer Review Report Final

Background Papers

None

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Reablement and Rehabilitation Telephone Survey results

September 2016

Contents Page

Introduction

Reablement, Enablement and Rehabilitation services, also known as 'Advanced Help at Home' are services provided by Central Bedfordshire Council, Bedford Borough Council and South Essex Partnership Trust, across Bedfordshire, to help people who have experienced changes to their health as a result of illness, injury or surgical procedure. The local authority and their partners work with people to restore their independence by addressing their physical limitations and using adaptations to reduce the overall impact on their life.

There is an emerging view that a patient who is admitted into hospital following an emergency is seen as soon as possible after they have been admitted. It is also thought that every person going into hospital for a planned procedure should be given a rehabilitation plan before even being admitted to hospital. In both scenarios, the purpose is to enable rehabilitation to start as soon as a patient is ready on the ward, with the aim of getting the patient home quickly and enabling them to live as independently as possible.

Reablement and Rehabilitation includes the following services:

- **Advanced Help at Home** – Carers calling at home
- **Intermediate Care** – 7 day service; Physiotherapist / Occupational therapist who work with rehabilitation support staff to enable patients to regain abilities and independence within their own homes.
- **Community Physiotherapy** – provides assessment and treatment for patients who are having difficulties at home.
- **Community Occupational Therapy** – visits a person in their home and makes recommendations for equipment, like a grab rail, to help with their independence.
- **Neuro Rehab Team** – for people with a newly diagnosed or existing neurological condition who would benefit from rehabilitation to improve their quality of life.

Background

Central Bedfordshire Council has invited the Local Government Association (LGA) to undertake a joint Peer Review for the Reablement and Rehabilitation service delivered across Central Bedfordshire and Bedford Borough, to understand current service delivery with a focus on offering a good, accessible, consistent experience for the customer regardless of how they accessed the service. The Review will also seek to understand where the Council could better streamline or avoid duplication.

Healthwatch Central Bedfordshire was invited by the Director of Adult Social Care, Health & Housing at Central Bedfordshire Council to design a telephone survey for current and previous users of the Reablement and Rehabilitation service.

The outcome of the survey is to be used to inform the joint LGA Review.

A representative sample of current and previous users of the Reablement and Rehabilitation service, across Bedfordshire, was used for the survey, as follows:

▪ Central Bedfordshire Council	52
▪ Bedford Borough Council	28
▪ South Essex Partnership Trust	51

Total	**131**

Methodology

The aim of the quantitative research was to collate views and opinions of service users who had gone through the six week Reablement / Rehabilitation Programme. The information was gathered via telephone interviews using a questionnaire. (See appendix 1 for a copy of the questionnaire). A total of 89 telephone interviews were conducted.

The questions were designed to examine the impact of Reablement / Rehabilitation taking account of service user views with regard to how they accessed the service, the type of support received, satisfaction levels and any arising issues within the remit of a telephone survey. These questions were devised within a narrow time frame and therefore offer limited depth of information. In addition the limitation of using volunteer callers with limited experience to ask the questions meant that we could not use 'defined probes' to refine respondent's experiences as we would normally expect to do so. We were also unaware of the health details of the individual concerned in order to determine condition based responses. No comparator group was involved.

The language and format of the questionnaire was tested briefly prior to conducting the telephone survey by a user panel comprised of volunteers and carers. The panel advised on small changes to the original format.

The group of HWCB Volunteers who conducted the telephone interviews received training and guidance prior to making the calls which included information about services delivered within Reablement and Rehabilitation. A script template and 'general prompts' for each question was also given to each Volunteer to ensure consistency.

The service users identified by the Local Authorities and SEPT were all sent a letter prior to the telephone call to advise that a Healthwatch Central Bedfordshire representative would be calling to ask a few questions about the service they received.

In a small number of cases a family member provided the information required to complete the questionnaire.

Calls logged as follows:

Total number of surveys completed: (Mon 26th, Tues 27th & Wed 27th September)	89
Unanswerable Calls:	
'No answer' or 'voicemail' (3 attempts)	18
Permanent engaged tone:	7
Wrong Number:	2
Unable to answer questions (confused):	5
Refused to answer survey questions:	3
Claimed no support offered:	1
In a Nursing Home:	1
In Hospital:	1
Too unwell to answer questions:	1
Claimed not to have received services at home: (or did not need service)	3

TOTAL:	**131**

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Analysis of Telephone Surveys

In Question 1, service users were asked how they were referred into the Reablement and Rehabilitation support service.

As would be expected the single largest group of service users (57%) identified the hospital social work team as the referral point for the Reablement and Rehabilitation service and it is reasonable to presume that this service would be prescribed as a hospital discharge package.

Community social workers made up the next largest group of 'named' referrers at 17%. Interestingly only three people in our sample identified GP's as the referral point for Reablement and Rehabilitation services. This appears to be quite a low number of people; however, there may be system based explanations for this. Indeed, this may fit into the established parameters and referral routes for the service. It could, for example, be common practice for GP's or other primary care practitioners to refer patients they see as in need of rehabilitation services to community social work teams which would mask the origins of the referral.

Alternatively, this very low level of referrals for Reablement and Rehabilitation services by GP's may bear further examination; given that no other primary care sources were quoted as referral points in the 'other' category. Speculatively; it's a reasonable assumption that GP's and other primary care practitioners regularly see people who are managing long term conditions / co – morbidities in the local community with varying degrees of success. In terms of preventative therapeutic prescription there may be scope for GP's to consider whether greater access to the Reablement and Rehabilitation service at an earlier stage may prevent hospital admissions. A reason perhaps not to consider this practice may of course be the potential volumes of referrals that may be involved.

22% of respondents said they were referred by 'other' agencies than those named in the survey. Analysis of the 'other' shows that four respondents did not know how they had been referred, three respondents told us that they had been referred by Community Occupational Health Services and another three were self-referrals. Two people said that they were referred by a private care home and another two were referred by third sector agencies (Age Concern and the MS Therapy Centre). The remainder (7%) were referred by services connected to main 'named' referrers, the hospital or the community social work provision e.g. staff nurse on ward, Falls team etc.

In Question 2, service users were asked what type of support they received, for example Occupational Therapist, Community Physiotherapist, Home Carer or Equipment fitted at home etc.

It appeared that the majority of service users received more than one type of service which made this a difficult question to analyse without some more detailed work on the combination of services that individuals have received and the relationship between these combinations and the care pathways. At first glance there do not appear to be any obvious patterns or correlations between patient pathways and service combinations.

In Question 3 service users were asked if they understood the support service that was being offered to them.

Over half the sample, 63% felt that they really understood what the purpose of the service was with another approximate 15% saying that they mostly understood. 23% said that they

either hadn't fully understood or hadn't understood at all what their support was meant to achieve. There was no obvious correlation with referral routes and some of these answers may be condition based.

In Question 4 service users were asked if the support service began when *they* needed it to.

A large majority of customers (93%) felt that they had received this service either at the point they needed it or very soon afterwards with little delay. Of the remaining 7% of respondents one person told us that the service was not at all timely and the rest felt that there had been a delay.

Overall this represents a good positive response and on the balance of probability, unlikely to be improved upon when such issues as location, specialist requirements and circumstances are factored in alongside general supply and demand.

It would appear from this response that the service is getting it right for most people most of the time.

In Question 5 (a) service users were asked whether they were involved in setting goals or targets with the support staff to help them do certain tasks by themselves.

A small percentage of the respondents (15%) did not feel that independence targets were appropriate to their situation. Of the remainder, 37% were involved in independence target setting and felt that they were to a large degree involved in the setting of these targets, with 17% agreeing that they had made a moderate contribution to the setting of independence targets.

A minority of respondents, 7%, said that they were only involved in such target setting to a small degree and 25% of the people we asked about involvement in setting their own goals for independence told us they were not at all involved. Interestingly this answer correlates with the answers to Question 3 where 23% of the respondents told us that they were not sure what the Reablement and Rehabilitation service was offering them.

Further work may be required here to compare referral / care pathways with user engagement. It may be that it is clearer after a traumatic / acute health event why you now need Reablement / Rehabilitation and support, than it is in a situation of chronic health and independence decline. It would also be useful to compare patient outcomes to levels of perceived patient engagement.

Question 5 (b) asked service users if they thought the support team helped them to achieve the tasks set.

In answer to this particular question, 18% of the sample identified the question as inapplicable to their circumstances. Not surprisingly (given previous answers) a total of 27% of our sample felt that their rehabilitation or support targets had either not been achieved or were only achieved to a small degree. At first glance this is a worryingly high proportion of service users who say that the intervention was of little value to them. However, we should not presume exactly what is being said here, this is to a large extent a 'tick box' survey; surveys of this nature can be notoriously inaccurate at eliciting complex information particularly that which involves perception rather than concrete evidence. As a general rule data of this nature would be supported by at least one focus group.

Question 5 (c) asked service users what did they think about the idea of setting goals or targets and then achieving them.

Overall these comments only came from the individuals who had already told us that they were involved in setting their own rehabilitation targets. The feedback was overwhelmingly positive in that people clearly had enjoyed the experience regardless of their levels of success. Interestingly a number of people spoke about safety and the 'safe way' to do things. In addition, particularly for those people who described themselves as being very' independent', were reassured to be told they needed to go at their own 'comfortable' pace and not to rush. The comments overall indicated a fairly enthusiastic group of service recipients.

In Question 5 (d) service users were asked to comment on the things that were most important to them to relearn or that they wanted to do again for themselves.

Not surprisingly, increasing their mobility and performing their own personal care were the most common targets shared by our respondents.

Question 6 asked service users how the support service had helped them to maintain their independence at home.

It is noticeable that more people told us that the service they had received assisted them with their own personal care and mobility in the home than other categories in this question. Given the comments in Question 5(d) this may reflect the service user's personal priorities as much as the rehabilitation programme targets.

The next highest category was 'helping you have control over your daily life'. Which of course the personal care and mobility would be significant factors in this matter. In addition, 34% of respondents said that they had been supported to prepare food and drink and an equal number indicated that they had been helped to stay safe.

Sadly, a much smaller group of people indicated that the support that they received had assisted them in keeping in touch with other people in their community; only 11% felt that their rehabilitation had included this benefit.

When asked to identify 'other' ways that the support respondents received had helped to achieve independence, the feedback demonstrated some confusion on the subject; two people mentioned that they needed help with cleaning and another person talked about being means tested for home care etc. In this respect the question was unsuccessful in eliciting added value although quite a number of people commented that they could cope better with a 'walk in ' shower.

Question 7 (a) asked service users how they had found the staff supporting them through the service.

A large percentage (89%) of respondents, when asked about the staff who supported them through the service was overwhelmingly positive, describing them as 'very helpful and supportive'. The remaining 11% thought that staff were only partly or moderately helpful.

In Question 7 (b) service users were asked if there was anything else that people wanted to tell us about the overall experience of the support they received from staff within the service provided.

The majority of responses to this question were positive; most commented to praise the staff involved in the delivery of their services. There was, however, in the comments section of this question, as well as comments given in the 'others' section at times, an underlying feeling that respondents were often mixing up different services especially 'on going' home care services with the 'Reablement and Rehabilitation Support Service'.

Question 8 asked service users what they felt about the length of time they received the service for.

Approximately two thirds of respondents (66%) felt that the service they received was either 'just right' or 'long enough' to meet their needs. The remaining 34% of the people surveyed were either unsure whether they had had sufficient Reablement / Rehabilitation support or felt that the service had not lasted long enough. To some degree this correlates with the number of people who did not feel that they had been helped to achieve their goals for independence.

In Question 9 (a) service users were asked how satisfied they were with the service provided to them.

Many of the respondents (67%) were very satisfied with the support they received which related to the positive answers given in Question 6, which referred to the ways in which the support had helped to maintain their independence. However there was a small number of respondents (22%) who indicated 'satisfied' or 'neither satisfied nor dissatisfied' (8%) with the service they received who did not feel that the support they received had helped them in any significant way. Of the remainder, 1% said they were 'dissatisfied' or very dissatisfied (1%).

Many of the respondents who said they were 'satisfied' with the service added that they did not feel they had benefited from it. One older man indicated that as his dementia cannot be cured the support is mainly for his wife and he thought the service *'could be improved by providing more support for my wife'.* Another gentleman who was 'satisfied' with the service stated that *'his wife has looked after him for years and the 'helpers' wanted to interfere and change things that had worked for years'*.

Question 9 (b) asked service users how they thought the service could be improved.

The majority of people we surveyed largely continued to be positive about the services they had received. There was however a number of themes that emerged, the most commonly suggested being, 'An improvement in advanced home care provision'. The main issue appeared to be the continuity of personnel and timeliness of the service; *'I don't want to be put to bed at 8.00pm'* and '*I wish the same person could come each time'* (Healthwatch Domiciliary Care Survey 2016 also found that continuity of carer was the single most important issue to the care recipient).

The other clear theme to emerge was the issue of equipment; only one person mentioned having to wait for equipment but there were a surprising number of complaints about equipment not being collected for recycling. It is difficult to fully understand what the issue is here because the 'equipment' was rarely itemised. As, for example, some items of equipment are not cost effective to collect and recycle, however this does need investigation in case the short term nature of the Reablement and Rehabilitation intervention means that early closure by the original prescriber does not result in a recycling request being made to the equipment

provider. If this is the case, then potentially there is a lot of unnecessary wastage at the council's expense.

The third theme to emerge was that a number of people felt they would have benefited from a longer period of rehabilitation.

In Question 10 participants in the survey, who had completed their course of Reablement and Rehabilitation, were then asked how they have coped since the service stopped.

Roughly a third of our sample (34%) were still in receipt of the support service so did not answer this question.

Disappointingly only 11% of this group said that they were coping well, with ease. An overwhelming majority of people (54%) told us they were coping but with some difficulty, of which 38% were optimistic about overcoming their difficulties but 16% were less optimistic and were struggling to cope. It is questionable whether this figure should be used to gauge the efficacy of the service as this would be problematic; the obvious problem we have in forming a view is that we have not surveyed any people in similar circumstances who did not receive this service – a comparator group. Equally we do not have any understanding of this group's expectation at the start of the programme and how realistic they were. Rather than overall efficacy of rehabilitation these responses may point to an issue about the management of those patient expectations overall if anything at all.

Finally, volunteers were asked to add any additional comments captured during the call they felt were pertinent to the service being delivered, as follows:

- Excellent, very patient and professional.
- Very independent - is gaining more independence on small things and trying hard to get even better.
- One incident, wanted a little bin emptied; carer said it wasn't her job but would do it on this occasion. But washed my hair and helped get between toes. Wanted to write a thank you note but can't post it!
- Really appreciative of the service.
- Very impressed with the service as were all the family.
- Very adamant that they should be re-using the equipment they install.
- Was quite confused about the service she received. She has four carers come in every day as she has no legs but that happened four years ago. She received an occupational health assessment but that was only one or two visits to put in a wet room.
- This gentleman was becoming quite distressed about the state of his home, re cleaning etc.
- Fine, no problems - nice to have been asked their opinion – may be calling social services regarding extra help with personal care.
- If all teams were this good they couldn't improve.
- Will not take back equipment.
- Physio was rude and just abandoned her.
- Physio Great, Carers Useless.
- This gentleman could not understand why his condition is deteriorating - weakness in hands, now can't walk. He used to drive but was told to stop.

- Medication: Some confusion regarding what medication he should be taking - someone is sorting it out but it is taking a long time and he is nervous about taking the wrong pills.
- Wife has looked after Derek for years. Helpers wanted to interfere and change things that have worked for years. Didn't want targets etc, just help in the mornings.
- Husband has dementia. Support is mainly for wife. Husband cannot get better so no goals.
- No ongoing support - phones ******* when there's a problem.
- I still need help and am waiting for an assessment from ******** home care team in Dunstable. They come once a day now to help me get up.
- Mrs N said that Mr N did have an OT visit twice before he was admitted to hospital; about his walking. To be followed up. She was pleased with re-enablement service.
- This lady seemed to be unaware that her carers were for six weeks only. She said that she had to pay an Indian lady £500 to do her live in care. The lady carer has returned to India. She feels that all she requires now is a walk in shower and then she can cope on her own. She says that the carers did not come very often.
- This lady has macular degeneration and is unable to heat meals for herself. Hopefully her care will be extended. Has to return to hospital after a recall.
- This lady is a wheelchair user and lives in ********. The lift has been out of order for 7 weeks and therefore she is unable to leave her flat unless someone carries her wheelchair down and then helps her down. She only leaves her home one day a week (Sunday).
- This lady is very articulate and is aware that following her hip joint replacement she will be unable to do certain things for herself in the short term. She is worried that she will not get extra help.
- Ms P said she was "fit as a fiddle" two years ago when she then had a urine infection, fell out of bed and her health deteriorated.
- This gentleman will miss the chat etc with the support staff. Can't speak highly enough of the staff.
- Main Comment: physio to continue for as long as it can improve my mobility.
- Had to have private carers - not walking very well, needs a lot more aftercare. Evergreen - terrible heat, nowhere to sit outside, needed the Sun.
- Physio. Mr M said his wife was getting on Lovely when a physio used to visit. This suddenly stopped; Mrs M tried to find out why but has not been able to. They got a special chair but no physio to help her move around.
- A confusing one! Very articulate client who didn't remember much at all or what service she was receiving. She thought Rehab. She said she is active and takes her dog out twice a day.
- Lots of trouble with communication doesn’t know what is happening.
- Look at what the patients actually need - some things are more important than others.
- ********* is a diamond, he has been very helpful. Asked about benefits he would be entitled to. Will call back with social services number.
- Spot on. Deserves a medal.
- Staff very easy to talk to.
- Speeding up the housing department and get them to understand individual's circumstances. We are all different
- I have been satisfied and have regained much of my mobility

Summary

Overall there appeared to be a relatively high level of positive responses to the questions asked and therefore satisfaction with the Reablement and Rehabilitation services that people are currently receiving / have received in their own homes across Bedfordshire.

The responses to Question 4 suggested that generally speaking the service is timely, delivered soon enough for people post an ill health episode to maximise rehabilitation efficacy. However, with regard to efficacy, there was some conflict within the responses gathered.

It was noticeable, for example, that many people told us that the service they had received assisted them with managing their own personal care and mobility in the home, than other categories in this question. Also, when asked about how successful they had been in achieving independence, 25% of people said they had not been able to achieve their goals. When asked to reflect on whether or not they had understood the purpose of the services they had received, a sizable minority, 23% reported that they either had not understood the purpose of the service at all or not entirely understood the purpose of the service.

This approximate level of negative minority responses was consistently reflected on ‘engagement‘ questions throughout the survey, for example, ‘were you involved in setting your targets and goals by support staff to help you do tasks on your own’ a similar number of people, 25%, also said they were not involved with target setting.

Because of the vulnerable and recuperative nature of the group questioned, the lack of any personal health details, and the lack of a comparator group it is difficult for this data to give any clear indication whether the 23% of people who did not appear to have been fully engaged by the service had less successful outcomes or less positive experiences of the service.

It is clearly an area of further investigation which a focus group(s) or ‘one to one’ interviews may support.

Key Findings:

The results of this telephone survey would suggest the following:

- The service was generally well received and valued;
- That the staff involved in the service were well liked and appreciated, although the consistency of carers / therapist was important to people;
- That the introduction point to the service was generally in good time to be effective;
- That the majority of people served felt considerable benefit from the service;
- That many people would have liked the service to continue;
- A significant minority of people were confused about the origins and purpose of the service;
- A similar minority felt that the service had not achieved as much for them as they would have liked;
- That some people had unrealistic expectations of the service;
- Many people were confused about the discrete nature of this service and blurred their responses to include comments on disparate longer term services;

- People generally wanted aids to daily living removed when they no longer needed them and viewed the Council / NHS as wasteful for not recycling them.

Recommendations / Suggested Actions:

This is an important service; research shows us that if delivered in a timely manner with the full productive engagement of the service user, Reablement and Rehabilitation support services are an extremely effective way to help people to remain living independently at home. The evidence of this survey suggests that, in Bedfordshire, this service is delivered in a timely manner to considerable effect. However it would also suggest that:

- The service needs to be rebadged / branded with a new name e.g. hospital at home etc. in a way that suggests its function, is distinct from other long term community support services and is memorable.

- A short film using positive rehabilitation experiences is prepared to properly introduce patients to the service, and fully explain its objectives. One that can be played in their own homes on a CD or website and can be left with patients and their families for them to play as many times as they need in order to reinforce understanding and objects.

- Consideration be given to the provision of stills of exercises or tasks in rotation in an electronic photo frame (a technique successfully used with young disabled people for independence training in schools).

- Further, properly considered investigation is undertaken to compare service user outcomes with referral points and pathways in order to determine scope to properly manage supply and demand, and also increase efficacy.

Contact:

Healthwatch Central Bedfordshire can be contacted as follows:

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Silsoe
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Email: info@healthwatch-centralbedfordshire.org.uk
Tel: 0300 303 8554
www.healthwatch-centralbedfordshire.org.uk

APPENDIX A

LGA PEER REVIEW TELEPHONE SURVEY – SEPTEMBER 2016

NAME OF CALLER/VOLUNTEER: _____

DATE OF CALL: _____

NAME OF PERSON CALLED: _____

TELEPHONE NUMBER: _____

GENDER: _____

AGE BAND: _____

ETHNICITY: _____

GEOGRAPHICAL AREA: _____

DATE SUPPORT SERVICE STARTED/ FINISHED (if it has):

_____

QUESTIONS

Question 1:

Can you tell me how you were referred into the Reablement / Rehabilitation support service?

- ☐ Through a social worker at the hospital
- ☐ Through social services (social worker)
- ☐ By referral from my GP
- ☐ Other, please specify

_____

_____

Question 2:

What type of support did you receive?
(REMEMBER TO TRY AND TAKE THE NAME OF THE CARER/SUPPORT WORKER/THERAPIST IF YOU CAN AND WRITE IT HERE:

……

- ☐ Home Carer (help at home)
- ☐ Occupational Therapist
- ☐ Rehabilitation Support Worker
- ☐ Community Physiotherapist
- ☐ Neuro Rehabilitation Worker
- ☐ Equipment fitted at home
- ☐ Other, please specify _____

Question 3:

Did you understand what the support service was offering you?

- ☐ Fully understood
- ☐ Partly understood
- ☐ Mostly understood
- ☐ Did not understand at all

Question 4:

Did the support service begin when <u>you</u> needed it?

- ☐ Yes
- ☐ Not immediately, but soon after
- ☐ Not at all
- ☐ There was some delay

If answered other than yes, to this question, please use the prompts to explore further:

Question 5:

(a) Were you involved in setting goals / targets with the support staff to help you do certain tasks by yourself?

- ☐ To a large degree
- ☐ To a moderate degree
- ☐ To a small degree
- ☐ Not at all

(b) Did the support team help you to achieve these tasks?

- ☐ To a large degree
- ☐ To a moderate degree
- ☐ To a small degree
- ☐ Not at all

(c) What did you think about the idea of setting goals / targets and then achieving them?

(d) What are the things that were most important to you to relearn or that you wanted to do?

Question 6:

How has the support service helped you to maintain your independence at home? (Tick all that apply)

- ☐ Helped you to get around within your own home
- ☐ Looked after your personal care needs e.g. washing and dressing
- ☐ Helped you to prepare meals and drinks
- ☐ Helped to keep you safe
- ☐ Helped others to care for you
- ☐ Helped you have more control over your daily life
- ☐ Helped you to communicate and keep in touch with other people / community
- ☐ None of the above
- ☐ Other, please specify

_____

_____

_____

Question 7:

(a) How have you found the staff supporting you through the service?

- ☐ Very supportive and helpful
- ☐ Not at all supportive or helpful
- ☐ Moderately helpful
- ☐ Partly helpful

(b) Is there anything else you would like to tell me about your overall experience of the staff supporting you?

_____

_____

_____

Question 8:

Did you feel that the length of time you received support from the Service was:

- ☐ Long enough
- ☐ Just right
- ☐ Too short
- ☐ Not sure

Question 9:

(a) Overall, how satisfied are you with the service?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Very dissatisfied
- ☐ Not sure / No comment
- ☐ Other, please specify

(b) How do you think the Service could be improved?

Question 10: (for those who are no longer accessing the service):

How have you coped on your own since the support service stopped?

- ☐ Easy no problems
- ☐ Coping but with some difficulty, which can be overcome
- ☐ With difficulty
- ☐ Coping but with some difficulty, not easy to overcome

ADD HERE ANY OTHER COMMENTS YOU WANT TO MAKE ABOUT THE PHONE CALL:

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Local Government Association

Central Bedfordshire and Bedford Borough Councils **Peer Review Report Reablement and Rehabilitation**

October 2016

Final

Table of contents

Executive Summary

Central Bedfordshire Council (CBC) and Bedford Borough Council (BBC) asked the Local Government Association (LGA) to run an Adult Social Care Peer Review as part of the East of England ADASS Programme of Regional Peer Reviews focussing on the Councils' work on Reablement and Rehabilitation. The work was commissioned by Julie Ogley, Director of Social Care, Health and Housing, Central Bedfordshire Council and Kevin Crompton, Director of Children's and Adult Services, Bedford Borough Council who were the clients for this work. The scoping meeting included representatives from both Bedfordshire Clinical Commissioning Group (BCCG) and the provider organisation South Essex Partnership Trust (SEPT) who completed self-assessment documentation for this work. All were seeking an external view on the quality of the reablement and rehabilitation services in order to consider how to improve the delivery of good outcomes for those who access these services. They intend to use the findings of this peer review as a marker on their improvement journeys. The focus for the review was:

- The current 'as-is' state of the service across the organisations with a focus on offering a good, accessible, consistent experience for the customer regardless of their entry-point
- It will also seek to understand where we could better streamline or avoid duplication

The peer team gave feedback on two broad areas. Firstly the strategic engagement issues with the STP and secondly on the work of rehabilitation and reablement services in the overall footprint.

The Milton Keynes, Bedfordshire and Luton STP covers four local authorities, three CCG and three hospitals. It recognises the challenges faced in the system that commissioning in the patch is weak and primary care is fragmented and lacks resilience. There is also the added issue that all the Community Health Service contracts are due for renewal by beginning of April 2018.

The STP however also recognises the solutions to these issues which are the need to radically upgrade prevention, early intervention and self-management of care whilst also developing high quality, scaled and resilient out of hospital services as well as modernising secondary care, reconfiguring services across the three hospitals and developing information systems and commissioning to enable these changes.

The key strategic message from the peer review team is that both CBC and BBC with its partners in the STP need to create a Place Based Plan. To achieve this the STP has to be used to make progress at a strategic level. As with all STPs across the country, elected representatives need to be included in the STP process to ensure the democratic mandate is addressed and local people's views are effectively included.

The peer review team recommend that CBC and BBC set up a joint Transformation Board for service development. This Board would focus on identifying what would improve performance and ensuring it is delivered.

The team recommend that any service redesign that takes place in the footprint should put those who access services at the very heart of the work to ensure their views and expectations are central to the outcomes delivered.

With regards to rehabilitation and reablement the peer review team recommend that CBC, BBC, BCCG and SEPT develop a clear understanding of the purpose of the three different reablement services in the footprint in the context of the whole system and the ongoing pressures on Homecare and Acute beds.

Furthermore they should model population demand, define the capacity required and source each service accordingly. Then agree a consistent prioritisation protocol across the system for the use of available home care capacity and available reablement capacity and implement a process to match demand to capacity on an ongoing basis using the agreed prioritisation protocol.

When this shared clarity is achieved it will improve service delivery and lead to better outcomes for residents and will also provide the basis for reviewing the services from the perspective of integrating services more effectively and potentially offering cost savings.

Other issues and details are covered in the remainder of the report.

Report
Background

1. Central Bedfordshire Council (CBC) and Bedford Borough Council (BBC) asked the Local Government Association (LGA) to run an Adult Social Care Peer Review as part of the East of England ADASS Programme of Regional Peer Reviews focussing on the Councils' work on Reablement and Rehabilitation. The work was commissioned by Julie Ogley, Director of Social Care, Health and Housing, Central Bedfordshire Council and Kevin Crompton, Director of Children's and Adult Services, Bedford Borough Council who were the clients for this work. The scoping meeting also included representatives from both Bedfordshire Clinical Commissioning Group (BCCG) and the provider organisation South Essex Partnership Trust (SEPT) who completed self-assessment documentation for this work. All were seeking an external view on the quality of the reablement and rehabilitation services in order to consider how to improve the delivery of good outcomes for those who access these services. They intend to use the findings of this peer review as a marker on their improvement journeys. The focus for the review was:

    a) The current 'as-is' state of the service across the organisations with a focus on offering a good, accessible, consistent experience for the customer regardless of their entry-point

    b) It will also seek to understand where we could better streamline or avoid duplication

2. A peer challenge is designed to help an authority and its partners assess current achievements, areas for development and capacity to change. The peer review is not an inspection. Instead it offers a supportive approach, undertaken by friends – albeit 'critical friends'. It aims to help an organisation identify its current strengths, as much as what it needs to improve. But it should also provide it with a basis for further improvement.

3. The benchmark for this peer challenge were the amended Commissioning for Better Outcomes Standards for Reablement and Rehabilitation created by Suffolk County Council with specific areas and questions identified as relevant to this area of adult social care work. These were used as headings in the feedback with an addition of the scoping questions outlined above. The three CBO domains were used with two others added to make five key headings:

    - Well led
    - Person-centred and outcomes-focused
    - Promotes a sustainable and diverse market place
    - Integration with health
    - Seamless and effective service delivery

4. Commissioning in adult social care is the Local Authority's cyclical activity to assess the needs of its population for care and support services, then designing, delivering, monitoring and evaluating those services to ensure appropriate outcomes. Effective commissioning cannot be achieved in isolation and is best delivered in close collaboration with others, most particularly people

who use services and their families and carers. Successful outcomes are described in the Adult Social Care Outcomes Framework, Making it Real Statements and ADASS top tips for Directors, but above all must be described and defined by people who use services.

5. The members of the peer challenge team were:

   - **Professor Graeme Betts**, Care and Health Improvement Adviser, LGA
   - **Cllr Philip Corthorne**, (Cons) Cabinet Member for Adult Social Care, Health and Housing, LB Hillingdon
   - **Cllr Stewart Golton**, (Lib Dem) Leeds City Council
   - **Gerald Pilkington**, Rehabilitation and Reablement Expert
   - **Benedict Leigh**, Lead Commissioner for Adult Social Care, Oxfordshire County Council
   - **Fiona Day**, Head of Partnership, Quality and Performance, Hertfordshire County Council
   - **Marcus Coulson**, Programme Manager, Local Government Association

6. The team was on-site from Monday 10th October – Friday 14th October 2016. To deliver the strengths and areas for consideration in this report the peer review team reviewed over sixty documents, held 53 meetings and met and spoke with at least 99 people over five on-site days spending 51 working days on this project the equivalent of 357 hours. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. These activities included:

   - interviews and discussions with councillors, officers, partners and providers
   - focus groups with managers, practitioners and frontline staff
   - Information from those who access services
   - reading a range of documents provided by the councils, including a self-assessment against key questions from each council and the CCG

7. The LGA would like to thank Julie Ogley, Director of Social Care, Health and Housing, Central Bedfordshire Council and Kevin Crompton, Director of Children's and Adult Services, Bedford Borough Council and their colleagues Rebecca May, Project Manager, CBC and Larraine Sears, Business Analyst, BBC for the excellent job they did to make the detailed arrangements for a complex piece of work across two councils with two key partners with an unusually wide range of members, staff and those who access services. The peer review team would like to thank all those involved for their authentic, open and constructive responses during the review process and their obvious desire to improve services, the team were all made very welcome.

8. Our feedback to CBC, BBC, BCCG and SEPT and others involved in the timetable for the week on the last day of the review gave an overview of the key messages. This report builds on the initial findings and gives a detailed account of the review.

Strategic context

- Recognition that parts of the system cannot change without changing the whole
- Awareness and recognition of the need to work better together to deliver effective services
- There are good examples across the patch to build on of joint or integrated services e.g. Safeguarding, Carers, Advocacy
- CBC, BBC, BCCG and SEPT feel stuck
- Addressing financial pressures through working more effectively together
- Peer Review an opportunity for change
- New sense of purpose and energy

9. To understand the issues involved in this peer review that on the one hand focuses on the work of reablement and rehabilitation, the peer review team needed to understand the strategic context within which the work takes place. This particularly focuses on the role of the STP in designing change across the footprint.

10. From all of the people with whom we spoke at a strategic level there is a clear recognition that parts of the system cannot change without changing the whole. There is also awareness and recognition of the need to work better together to deliver effective services. There are good examples across the patch to build on of joint or integrated services such as the successful work on Adult Safeguarding, Carers and Advocacy.

11. In discussions with CBC, BBC, BCCG and SEPT the overriding feeling with regards to their relationships is that they all feel stuck. They all recognise that they need to work together more effectively to address ongoing financial pressures. This Peer Review is an opportunity for change and there is a new sense of purpose and energy in order to consider how to move forward.

Strategic key messages 1

The STP recognises challenges in the system

- Commissioning in the patch is weak
- Primary care is fragmented and lacks resilience
- All the Community Health Service contracts are due for renewal by beginning of April 2018

The STP recognises solutions

- Radically upgrading prevention, early intervention and self-management of care
- Developing high quality, scaled and resilient out of hospital services
- Modernising secondary care and reconfiguring services across the three hospitals
- Developing information systems and commissioning

12. Sustainability and Transformation Plans (STPs) were announced in the NHS planning guidance published in December 2015 and will create place-based, multi-year plans built around the needs of local populations. The idea of STPs is to help drive a genuine and sustainable transformation in health and care outcomes between 2016 and 2021. They are expected to help build and strengthen local relationships, enabling a shared understanding of the present situation, the ambition for 2021 and the concrete steps needed to get there. To deliver these plans NHS providers, Clinical Commissioning Groups, Local Authorities, and other health and care services are expected to come together. Draft plans were submitted in June 2016 and final plans are expected to be completed in October 2016.

13. The Milton Keynes, Bedfordshire and Luton STP covers four local authorities, three CCG and three hospitals. It recognises the challenges faced in the system that commissioning in the patch is weak and primary care is fragmented and lacks resilience. There is also the added issue that all the Community Health Service contracts are due for renewal by the beginning of April 2018.

14. The STP also recognises the solutions to these issues, which are; the need to radically upgrade prevention, early intervention and the self-management of care whilst also developing high quality, scaled and resilient out-of-hospital services. As well as modernising secondary care, reconfiguring services across the three hospitals and developing information systems and commissioning to enable these changes.

Strategic key messages 2

- Create a Place Based Plan
- Use the STP to make progress at a strategic level
- Elected representatives need to be included in STP process
- Consider the most effective governance to take this forward
- CBC has taken a lead in developing primary care-led, jointly delivered, integrated out of hospital care services
- CBC and BBC are taking initiatives to invest in social capital and are place leaders
- Co-produce changes with those who use services building on the outcomes based approach
- Create a shared recognition that it is possible to do things better together while retaining your own identity

15. The key strategic message from the peer review team is that both CBC and BBC with its partners in the STP need to create a Place Based Plan. To achieve this the STP has to be used to make progress at a strategic level. As with all STPs across the country, elected representatives need to be included in the STP process to ensure the democratic mandate is addressed and local people's views are effectively included. At the time of writing both Simon Stevens, Chief Executive of NHS England and Social Care Minister David Mowat have voiced support for the necessity of local authority involvement in STPs and their full sign off. Further the peer review team also recommend that all those involved urgently consider the most effective governance to take this forward.

16. CBC has taken a lead in developing primary care-led, jointly delivered, integrated out of hospital care services. Whilst onsite, the team heard about the newly created plan for several Health and Social Care Hubs across the borough that will house multi-disciplinary teams working to deliver preventative care and thereby address potential illnesses before they need acute treatment and promote wellbeing and thus save money.

17. Both CBC and BBC are taking forward initiatives to invest in social capital including investment in sports centres and community development and prevention. The Councils are place leaders due to their democratic mandate and engagement with local people through the services they deliver.

18. It is key to keep in mind the wishes and expectations of those who use services when involved in the planning and designing phases for activity. The peer team encourage both Councils to co-produce any necessary changes with those who use services, building on the outcomes based approach. This ensures that services deliver what people want and can evolve as their needs change.

19. CBC and BBC were created from the previous county council and there is an oft expressed wish not to return to this structure. Whilst this is understandable however, this mind-set appears to sometimes prevent discussions about the delivery of services across the joint footprint as it is feared it will re-create what is now gone. Therefore it is necessary to create a shared recognition that it is possible to do things better together while retaining the identity of both organisations, what they stand for and what they do. There are already examples of effective working in place upon which to build.

Well Led

Strengths

- The Councils' leadership expressed an appetite for greater collaboration between Councils, local hospitals and Bedfordshire CCG as reflected in the joint commissioning of this Peer Review
- This desire for service improvement through greater integration was shared by all elected members interviewed
- STP is recognised as a valuable opportunity for further integration and to produce more locally responsive and sustainable community care services
- HWBs driving the change agenda. Developing a sustainable care economy to respond to employment pressures for domiciliary and reablement staff locally
- Joint Safeguarding work is well led and effective

Areas for Consideration

- Put residents at the heart of your work
- Recent stability in CCG and SEPT leadership is a good place to develop
- Uncertainty over the future of Bedford Hospital has influenced the rate of operational development, but there is a commitment that it will not be an obstacle to collaboration, and the pursuit of wider health and social care integration.
- Involve elected members in identifying opportunities in developing the social inclusion aspect of reablement in communities
- Maintain focus on whole system solutions not detailed problems
- A joint Transformation Board for service development

20. The peer review team heard from senior leaders from CBC, BBC, BCCG and SEPT about the strategic issues they are dealing with. The Councils' leadership of both members and officers expressed an appetite for greater collaboration between the Councils, local hospitals, BCCG and SEPT as reflected in the joint commissioning of this Peer Review.

21. The desire for service improvement through greater integration and closer working was shared by all elected members interviewed and whilst elected members from CBC and BBC do not come from the same political party or have the same local priorities, they are all equally committed to improving the wellbeing of those who use health and social care services and expect to be involved in discussions about the design of those services.

22. The STP is recognised by everyone with whom the peer team spoke as a valuable opportunity for further integration and closer working and that it has

significant potential to produce more locally responsive and sustainable community care services. Given the requirement for all local partners to approve plans, there is scope to shape plans which properly reflect distinctive local opportunities to transform service delivery.

23. The two Health and Wellbeing Boards (HWBs) are driving the change agenda and developing a sustainable care economy to respond to employment pressures for domiciliary and reablement staff locally.

24. Adult Safeguarding is run across both the CBC and BBC footprint and this joint working is mature, well led and effective.

25. As has been suggested in paragraph 18 above, the changes being discussed by the STP and the possible alterations to social care models of activity in CBC and BBC should be delivered through a joint commitment to co-production, putting residents at the heart of the work so that they feel genuinely involved, listened to and engaged throughout.

26. The recent stability in leadership at both BCCG and SEPT is good place to develop as trust needs to be created to allow key post holders to be able to discuss what is possible and how it can be delivered.

27. Uncertainty over the future of Bedford Hospital has influenced the rate of operational development, but there is a commitment that it will not be an obstacle to collaboration, and the pursuit of wider health and social care integration.

28. A key recommendation from the peer review team is that elected members should be involved in identifying opportunities for developing the social inclusion aspect of reablement in communities, drawing on their first hand community knowledge. This may take the form of working with for example, faith based groups, older peoples' organisations and other less formal groups which have existing local networks and connections which are capable of being harnessed. Members are the leaders in their communities and their leadership is critical in galvanising local communities and community organisations to support initiatives which prevent admissions and which enable safer, quicker discharges and support for carers.

29. Whilst working through the myriad issues in this work, the peer team urge all those involved to maintain focus on whole system solutions and not on detailed problems. Keeping the former in mind enables development and change, staying with the latter can hinder possible improvement narratives.

30. The peer review team recommend that CBC and BBC set up a joint Transformation Board for service development. This Board would focus on identifying what would improve performance and ensuring it is delivered. For example, ensuring people being discharged from local hospitals are placed on the correct pathway should be a consistent activity across the Councils and the providers to ensure better outcomes for residents. The leadership for ensuring this takes place would lie with the Transformation Board.

Person Centred and Outcome Focused

Strengths

- BBC DTOC low levels a success
- CBC propose to allocate a named worker on entry to reablement pathway
- New SEPT service of early supported discharge is seen as positive
- Overall user and patient experience is good

Areas for Consideration

- Consider how to put those who access services at the heart of your service redesign
- Seek to create information about services and pathways that are clear for all users and staff
- Not just about the patient experience – are the resources in the service being maximised

31. There is clear evidence that the BBC Delayed Transfers of Care (DTOC) from hospital which are attributable to adult social care per 100,000 population are very low standing at 0.7 for the 2014/15 year and 1.5 for 2015/16, which is a success.

32. There is a good proposed process in CBC to allocate a named worker on entry to the reablement pathway which will ensure the appropriate management of clients as they progress into, through and out of the reablement service. This will assist clients to know who to contact as their treatment progresses and increases their understanding.

33. There is a new SEPT service of early supported discharge which is reported as a positive development.

34. For all the reablement and rehabilitation services across both councils and with SEPT, the overall user and patient experience is consistently good, which indicates good services where frontline staff deliver effective outcomes.

35. The team recommend that any service redesign that takes place in the footprint should put those who access services at the very heart of the work to ensure their views and expectations are central to the outcomes delivered. The peer team make this point on a number of occasions to emphasise its importance.

36. Both Councils and providers should seek to create information about services and pathways that are clear for all users and staff. The peer team heard a lack of clarity from all those involved in relation to the reasons why a person would be put into any particular service and patient pathway. It should be clear to all.

37. Whilst the patient experience was consistently high across the rehabilitation service and both reablement services, it can be argued that other issues also

need to be taken into account when assessing the effectiveness of any one of these services. The key question here is to assess whether resources in the services are being maximised and if the same outcomes could be achieved more efficiently. The organisations need to assure themselves of this.

Promotes a sustainable and diverse market place

Strengths

- Development by public health of shared outcomes across the partners is a positive step forward
- Free training is provided for the private and voluntary sector in order to ensure an appropriately skilled workforce
- Delivering best practice solutions e.g. UHFRS, Community Equipment

Areas for Consideration

- You will miss the opportunity to improve reablement if you do not address the issues of market capacity and access to care packages
- Constitute a simple and direct information and intelligence sharing activity across CBC, BBC and SEPT to provide standard information to commissioners
- Use the Market Position Statement process to drive a sustainable and diverse market place
- Consider partnership working to deliver capacity in hard to reach areas
- Explore all options to develop diversity in the market place to result in a mature portfolio of options for those who access services

38. The development by public health of shared outcomes across the partners is a positive step forward. Public health have identified an outcomes framework to underpin the tendering process for rehabilitation services which at the time of the peer review was in draft form.

39. Free training is provided for the private and voluntary sector in order to ensure an appropriately skilled workforce to support the delivery of positive outcomes.

40. The team heard about the delivery of best practice solutions by CBC such as the Urgent Homecare Falls Response Service (UHFRS) and the work on Community Equipment. These are commendable achievements.

41. It was clear to the peer team that both organisations will miss the opportunity to improve reablement services if they do not address the issues of market capacity and access to care packages. Both Council reablement services and the rapid intervention service encounter problems when seeking to move clients on at the end of their active phase of support due to an inadequate level of provision. This results in a blockage preventing clients for whom the services would be beneficial from entering, as well as resulting in a comparatively expensive resource being used to provide routine ongoing support which ordinarily would cost far less. The peer team heard on a number of occasions that this inability to place people in care packages was undermining the rehabilitation and reablement services. This is a key element in the system and the challenge is

recognised by both Councils. While there are no easy answers other authorities such as Oxfordshire and Hertfordshire have addressed this challenge with some success and it should be worth hearing from them about how to solve these issues.

42. Constitute a simple and direct information and intelligence sharing activity across CBC, BBC and SEPT to provide standard information to commissioners. This will enable them to make more informed decisions for better outcomes.

43. Use the Market Position Statement process to drive a sustainable and diverse market place and explore all options to develop diversity in the market place to result in a mature portfolio of options for those who access services.

44. Consider partnership working to deliver capacity in hard to reach areas. The peer team heard about areas that border Cambridgeshire, for example, where it is difficult to resource provider care services due to their remote locations. To address this it is recommended that partnership relationships are built on with neighbouring authorities to solve them. It is very likely that these neighbours are experiencing the same issues from their side of the border.

Integration with health

Strengths

- Frontline staff and their managers engage effectively with their colleagues in health on a day to day basis delivering good services
- CBC use of s106 for Hubs, BBC and CBC mature use of s75

Areas for consideration

- There is a need for a greater collaboration and alignment across services at the commissioning and operational level
- The Councils and the CCG need to ensure there is a clear voice for community and primary care services within the STP
- Consider how to move towards an improved level of shared intelligence to deliver better outcomes for residents

45. Across the two reablement services it was clear to the peer team that frontline staff and their managers engage effectively with their colleagues in health on a day to day basis delivering good services. This is commendable in an environment of reduced resources and increasing demand.

46. CBC is creatively using Section 106 money to simulate the creation of the Health and Social Care Hubs which are planned to reduce demand in acute settings and both BBC and CBC have a mature use of Section 75 monies, enabling the pooling of health and social care budgets to maximise the benefit to service delivery.

47. There is a need for a greater collaboration and alignment across services at the commissioning and operational level. The peer team heard on several occasions that teams in one part of the system were unaware of the activities and practices of other teams in the same system and consequently they were not sharing basic data nor the sort of intelligence which leads to a system working effectively as a whole. In a similar way, there was insufficient joint commissioning taking place to ensure shared outcomes and improved performance and value for money.

48. The Councils and BCCG need to ensure there is a clear voice for community and primary care services within the STP. This is essential to ensure that specific locally identified needs are included to help deliver improved outcomes and sustainability to both sectors. There is widespread recognition that STPs cannot achieve their goals of rationalising acute services without strong community and primary care services. Furthermore residents will not receive the best possible outcomes and services without strong community and primary care services. Therefore it is imperative that these services set out a clear vision and a strategic plan for delivering the outcomes required to achieve this goal.

49. CBC, BBC, BCCG and SEPT should consider how to move towards an improved level of shared intelligence to deliver better outcomes for residents. All

organisations on the footprint collect a significant amount of data about local people and their needs. It should be possible to pool not only the data but also to consider the implications of it much more effectively to make decisions about the way services are delivered to improve outcomes for people.

Seamless and effective service delivery

Central Bedfordshire Council Reablement

Strengths

- Frontline staff work hard and deliver a flexible and responsive service that customers and families like
- Some progress on 2014 review recommendations has been achieved
- In line with best practice there is timely access to therapy, delivered by embedded therapists
- Assessment coordinators established within the service to agree and monitor outcomes
- Plan to use reablement as a 'pause' to deliver a Care Act compliant holistic assessment

Areas for consideration

- Implement agile working for reablement staff
- Ensure for yourselves that you implement charges at the completion of active reablement
- Consider the role for beds in the future reablement pathway and determine the capacity required to provide a cost effective service
- Ensure clarity for frontline staff on therapist pilot

50. The peer review team had the privilege of speaking with staff who deliver reablement services for CBC. It was a pleasure to hear from them and it was clearly evident that they work hard and are committed to delivering a flexible and responsive service that customers and families like.

51. One of the peer team completed a review of reablement in 2014 at CBC and from this onsite work the peer team are able to conclude that there has been some progress on the 2014 review recommendations. These include the creation of a coordinator role, the provision of therapists within the team to improve the outcome focused approach and the implementation of processes to understand the use of paid time resulting in reduced down-time and cost per case.

52. In line with best practice there is timely access to therapy, delivered by embedded therapists. Whilst the majority of people undergoing a phase of reablement do not need input from therapists, for those that do it is important that this is readily available rather than their having to join a long waiting list for community therapy services that will often be available long after they have left their active reablement phase. By embedding therapists within the team it

ensures timely access as well as a mechanism to improve the outcome focus of the service.

53. Assessment coordinators are established within the service to agree and monitor outcomes and there is a clear plan to use reablement as a 'pause' to deliver a Care Act compliant holistic assessment.

54. The team recommend that CBC implement agile working for reablement staff that allows them to work flexibly using their time efficiently. The peer team heard examples of organisational requirements that caused frustration for staff as they ended up serving the needs of the system and not delivering outcomes for clients.

55. Ensure for yourselves that you implement charges at the completion of active reablement. From various discussions it was understood by the peer team that charges are never raised for clients who have completed their active reablement phase but who, for a variety of reasons, are still being supported by the reablement team. The Community Care (Delayed Discharges etc.) Act (Qualifying Services) (England) Regulations 2003 only provides that 'reabling' services are free for up to six weeks. Therefore, charges can be applied after the first six weeks or completion of the active reablement phase, whichever is the sooner.

56. CBC should consider the role for beds in the future reablement pathway and determine the capacity required to provide a cost effective service. Despite one of the two bedded reablement facilities being closed in recent months, it is understood that the remaining unit has still been underutilised. A replacement bedded unit was understood to be under renovation at the time of the peer review visit, but local experience may indicate that this level of capacity is not required.

57. Ensure there is clarity for frontline staff on the ongoing therapist pilot. From a number of discussions the peer review team were unable to ascertain the planned duration for the pilot introduction of therapists within the reablement team, how any improvements are being measured or what the targets or measures are to determine whether this has been beneficial. This needs some work to ensure that there is clarity of the pilot and that others know about it.

Seamless and effective service delivery

Bedford Borough Council Reablement

Strengths

- Frontline staff and their managers demonstrate high levels of enthusiasm and commitment to their work and deliver a positive experience for those who use the service that is valued highly
- Co-location and shared working with the hospital team have enabled a smooth discharge pathway

Areas for consideration

- Consider how the service is able to access timely therapy input
- Whilst utilisation rates appear good, consider how staff activity delivers the service's agreed outcomes and look at the most effective use of their staff time
- Strengthen management arrangements across the hospital social work team, community social work teams, reablement and care sourcing to ensure consistent joined up delivery

58. Members of the peer team met with staff from BBC who deliver the reablement work. These frontline staff and their managers demonstrated high levels of enthusiasm and commitment to their work and deliver a positive experience for those who use the service that is valued highly. They are a commendable group of staff.

59. The BBC staff are co-located with health colleagues at Bedford Hospital which enables them to effectively share information, create solutions to problems as they arise and enables a smooth discharge pathway.

60. BBC could consider how the service is able to access timely therapy input. Whilst the majority of people undergoing a phase of reablement do not need input from therapists, for those that do it is important that this is readily available rather than their having to join a long waiting list for community therapy services that will often be available long after they have left their active reablement phase. By embedding therapists within the team this would ensure timely access as part of their reablement phase.

61. Whilst utilisation rates appear good, consider how staff activity deliver the service's agreed outcomes and look at the most effective use of their staff time. There also is an opportunity to strengthen management arrangements across the hospital social work team, community social work teams, reablement and care sourcing to ensure consistent joined up delivery that would be more efficient.

Seamless and effective service delivery

South East Partnership Trust Rehabilitation and Enablement

Strengths

- This is a therapy led service with a strong outcome focus
- The patient experience is very highly rated

Areas for consideration

- Develop a clear understanding of the purpose of the service in the context of the whole system and ongoing pressures
- Define and communicate eligibility criteria across the whole system
- Clarify timely and appropriate notification of people needing care on exit from the pathway, including those in spot purchased beds

62. The SEPT service is therapy led with a strong outcome focus with staff who are committed to the delivery of positive outcomes.

63. As with the other reablement services within CBC and BBC, the SEPT patient experience is very highly rated by those who have the service. This is a testament to the quality outcomes achieved by the staff.

64. Develop a clear understanding of the purpose of the service in the context of the whole system and ongoing pressures. From various discussions it became clear that there is wide spread confusion about the nature, focus and purpose of rehabilitation versus reablement and it was often assumed, for instance, that because therapists are involved within both SEPT and the CBC service, they must be the same and seeking to support the same type of need. This results in referrals being made to both SEPT and the reablement services and whoever answers first gets the client / patient, rather than the decision being made on the basis of which service can best support the person's needs.

65. The peer team recommend that the eligibility criteria for each of the three reablement services are clearly defined by each and that these are communicated to all across the whole system. This point directly links to and builds on the previous one, and will enable a clear and consistent understanding by all involved, thereby ensuring that referrals are made on the basis of which service best supports the person's needs at that time. It will also ensure any unnecessary overlaps or gaps in provision can be identified, rather than it being assumed that the reablement services provided by CBC and BBC are providers of last resort and therefore expect them to accept people for whom the service is totally inappropriate.

66. It is recommended that SEPT clarify timely and appropriate notification of people needing care on exit from the pathway, including those in spot purchased beds.

From discussions it was understood that the CCG have recently started to place patients with care homes for low level rehabilitation support and the first the Councils know about them is when they are referred to them upon completion of their six week period. It is understood that this has created significant issues for the CBC and BBC who believe that any real opportunities to maximise the person's independence have been lost.

Seamless and effective service delivery

Generic Reablement

Areas for consideration

- Develop a clear understanding of the purpose of the services in the context of the whole system and ongoing pressures on Homecare and Acute beds
- Define and communicate each service's eligibility criteria across the whole system
- Ensure these eligibility criteria enable staff to appropriately place customers on the correct pathway
- Model population demand, define the capacity required and source each service accordingly
- Agree a consistent prioritisation protocol across the system for the use of available home care capacity and available reablement capacity
- Implement a process to match demand to capacity on an ongoing basis using the agreed prioritisation protocol
- Look for the reasons for the different reablement outcomes across CBC and BBC and the reasons for the different exit rates from SEPT across the two areas
- Develop strategies to ensure appropriate capacity in the home care market is available for timely exit
- Consider the scope for joint benefits in the replacement of SWIFT across CBC and BBC

67. The peer review team recommend that CBC, BBC, BCCG and SEPT develop a clear understanding of the purpose of the three different reablement services in the footprint in the context of the whole system and the ongoing pressures on Homecare and Acute beds. Currently there appears to be confusion amongst all of the organisations on the role, purpose and focus of each service and, therefore, which people and types of need are most appropriately supported by which service. This lack of clarity and understanding has clear operational issues and also prevents a shared understanding of potential overlaps and gaps in the range of provision. Not all people can be appropriately supported by rehabilitation and reablement services because they are not providers of last resort but services focused on maximising a person's independence. When shared clarity is achieved it will improve service delivery and lead to better outcomes for residents and will also provide the basis for reviewing the services from the perspective of integrating services more effectively and potentially offering cost savings.

68. As has been suggested previously the peer team recommend each service's eligibility criteria should be defined and communicated across the whole system. This would ensure, for instance, that people are referred to the service most appropriate to supporting their needs at that time rather than to whichever service agrees first, or is required, to accept the referral.

69. Ensure these eligibility criteria enable staff to appropriately place customers on the correct pathway. The organisations should then model population demand, define the capacity required and source each service accordingly and agree a consistent prioritisation protocol across the system for the use of available home care capacity and available reablement capacity.

70. Implement a process to match demand to capacity on an ongoing basis using the agreed prioritisation protocol. In any system it is highly likely that demand will, from time to time, exceed supply and so decisions need to be made as to the basis on which priority is given to the limited resource. This requires a clear shared understanding and active management of cases being referred and accepted by each service on a daily or even hourly basis at critical times.

71. Look for the reasons for the different reablement outcomes across CBC and BBC and the reasons for the different exit rates from SEPT across the two areas. From discussions with Council staff there was no understanding of the significantly different performance levels by SEPT in terms of the two Council services. The peer review team were informed that it was directly related to the availability or not of capacity within the domiciliary care providers. This issue needs further investigation and verification to ensure that the reasons for this difference in performance are understood to maximise performance across the system.

72. Develop strategies to ensure appropriate capacity in the home care market is available for timely exit and consider the scope for joint benefits in the replacement of the SWIFT information technology system across CBC and BBC. It was understood from discussions that both councils are in the same position and need to replace their current SWIFT systems within 18 months with both having explored the same options. This is an opportunity worth exploring.

Moving forward

- The peer reviewers recognise the positive relationships between the partners
- However, now is the time for action – failure to respond appropriately to the challenges facing them will have serious implications for local people
- There needs to be acknowledgement by all parties that the current arrangements are fragmented, cost ineffective and are not delivering the best outcomes for residents
- A new approach starting with the person at the centre needs to be developed and all parties need to commit to achieving this goal regardless of the impact on organisations
- So, the first step is gaining agreement to this approach, then representatives need to work through the evidence and best practice and propose a way forward for the partners which demonstrates benefits for local people and benefits for care and health economy as a whole

73. The peer reviewers recognise the positive relationships between the partners. However, now is the time for action – failure to respond appropriately to the challenges facing everyone will have serious implications for local people. There needs to be acknowledgement by all parties that the current arrangements are fragmented, cost ineffective and are not delivering the best outcomes for residents. A new approach starting with the person at the centre needs to be developed and all parties need to commit to achieving this goal regardless of the impact on organisations.

74. So, the first step is gaining agreement to this approach, then representatives need to work through the evidence and best practice and propose a way forward for the partners which demonstrates benefits for local people and benefits for the care and health economy as a whole.

Contact details

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For more information on adults peer challenges and peer reviews or the work of the Local Government Association please see our website http://www.local.gov.uk/peer-challenges/-/journal_content/56/10180/3511083/ARTICLE

Read the Adults Peer Challenge Reports here http://www.local.gov.uk/peer-challenges/-/journal_content/56/10180/7375659/ARTICLE

APPENDICES

Appendix 1: Reablement / Rehabilitation Peer Review Key Lines of Enquiry

Key lines of enquiry agreed for this review have been based on the following Commissioning for Better Outcomes Domains: (1) Person Centred and Outcome Focussed, (2) Well led, (3) Promotes a sustainable and diverse market

Domain 1: Person Centred and outcome focused
Key lines of Enquiry:
1. How well do we ensure the delivery of outcomes that matter most to an individual?
2. To what extent do support plans and associated tools help deliver strengths and asset based approach?
3. How well does the information, advice and support we provide empower people to have choice and control over their care and support?
4. Are services seamless and does this prevent people from having to tell their story more than once?
5. How effectively do we routinely capture and use what service users, families and carers say about services in order to make improvements?

Domain 2: Well Led
Key Lines of Enquiry:
6. To what extent are the vision and values well understood and owned by staff, partners and the public?
7. To what extent is there a whole systems and integrated approach to commissioning for better outcomes?
8. How well do we support practitioners to understand and implement our approach?
9. To what extent do we use evidence (qualitative and quantitative) about what works well and not so well to improve future service delivery/policy/approach and are reporting mechanisms robust?

Domain 3: Promotes a sustainable and diverse market
Key lines of enquiry:
10. To what extent do we ensure services are widely available, well promoted and consistent?
11. How effectively do we work with staff, providers and partners to ensure the right amount and right quality of reablement/rehabilitation is in place to meet demand?
12. How well do we ensure that we have the right level of skills and capacity in place to delivery good quality and safe services?
13. How well does the Council and its key partners prioritise investment in a whole systems reablement/rehabilitation approach?

Appendix 2: Principles and expectations for good Adult Rehabilitation

Rehabilitation is everyone's business: Principles and expectations for good Adult Rehabilitation
NHS Wessex Strategic Clinical Networks, 2015.

https://www.networks.nhs.uk/nhs-networks/clinical-commissioning-community/documents/principles-and-expectations

The Principles of Good Rehabilitation services, good rehabilitation services will:

1. Optimise physical, mental and social wellbeing and have a close working partnership with people to support their needs.
2. Recognise people and those who are important to them, including carers, as a critical part of the interdisciplinary team.
3. Instil hope, support ambition and balance risk to maximise outcome and independence.
4. Use an individualised, goal-based approach, informed by evidence and best practice which focuses on people's role in society.
5. Require early and ongoing assessment and identification of rehabilitation needs to support timely planning and interventions to improve outcomes and ensure seamless transition.
6. Support self-management through education and information to maintain health and wellbeing to achieve maximum potential.
7. Make use of a wide variety of new and established interventions to improve outcomes e.g. exercise, technology, Cognitive Behavioural Therapy.
8. Deliver efficient and effective rehabilitation using integrated multi-agency pathways including, where appropriate, seven days a week.
9. Have strong leadership and accountability at all levels – with effective communication.
10. Share good practice, collect data and contribute to the evidence base by undertaking evaluation/audit/research.

Appendix 3: The Commissioning for Better Outcomes Standards

These standards set out ambitions for what good commissioning is, providing a framework for self- assessment and peer challenge.
The nine standards are grouped into three domains. There is considerable overlap between these and all elements need to be in place to achieve person-centred and outcomes-focused commissioning.

Domain	Description	Standards
Person-centred and outcome focused	This domain covers the quality of experience of people who use social care services, their families and carers and local communities. It considers the outcomes of social care at both an individual and population level.	1. Person-centred and focused on outcomes 2. Co-produced with service users, their carers and the wider local community
Well led	This domain covers how well led commissioning is by the local authority, including how commissioning of social care is supported by both the wider council and partner organisations.	3. Well led 4. A whole system approach 5. Uses evidence about what works
Promotes a sustainable and diverse market	This domain covers the promotion of a vibrant, diverse and sustainable market, where improving quality and safety is integral to commissioning decisions.	6. A diverse and sustainable market 7. Provides value for money 8. Develops the workforce 9. Promotes positive engagement with providers

CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of Meeting 29 March 2017

Sustainability and Transformation Plan 2016-2020

Responsible Officer: Richard Carr, Chief Executive
Email: Richard.carr@centralbedfordshire.gov.uk

Purpose of Report

1. To update the Health and Wellbeing Board on the development of Sustainability and Transformation Plan for Bedfordshire Luton and Milton Keynes (BLMK).

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. **note the progress of the Sustainability and Transformation Plan;**
2. **to endorse progress on the priorities of the STP on the basis that the priorities align with the Council's aspirations for prevention; reduced reliance on acute services; primary, community and social care services delivered close to where people live; and**
3. **to note the plans for wider engagement on the STP.**

Background

2. The NHS Shared Planning Guidance for 2016/17- 2020/21, 'Five Year Forward View' published on the 22nd December 2015, required health and care systems to develop a Sustainability and Transformation Plan (STP). These place-based, multi-year plans, built around the needs of local populations, are seen as a means to build and strengthen local relationships, enabling a shared understanding of local issues and challenges, and should define the ambitions for 2020.

3. 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) to address the health and care triple aim as set out in the Five Year Forward View:

   - The health and wellbeing gap;
   - The care and quality gap; and
   - The finance and efficiency gap. .`

4. Draft plans for BLMK were published in November 2016. Plans continue to be developed with involvement from all 16 partner organisations. A website providing more information, news and details of engagement events has also been launched http://www.blmkstp.co.uk/. The full technical document can also be accessed via the same link.

5. Engagement events took place in January 2017 and further engagements on key priority areas are planned.

Current position on the STP for BLMK

6. The BLMK submission identified five priorities. These priorities underpin the local vision for health and social care and fall into two categories: 'frontline' and 'behind the scenes':

Frontline	Behind the scenes
Prevention Encourage healthy living and self care, supporting people to stay well and take more control of their own health and wellbeing	**Digitisation** Transform our ability to communicate with each other, for example by having shared digital records that can be easily accessed by patients and clinicians alike, using mobile technology (e.g. apps), for better coordinated care.
Primary, community and social care Build high quality, resilient, integrated primary, community and social care services across BLMK. This will include strengthening GP services, delivering more care closer to home, having a single point of access for urgent care, supporting transformed services for people with learning disabilities and integrated physical and mental health services.	**System redesign** Improving the way we plan, buy and manage health and social care services across BLMK to achieve a joined-up approach that places people's health and wellbeing at the heart of what we do.
Sustainable secondary care Make hospital services clinically and financially sustainable by working collaboratively across the three hospital sites, building on the best from each and removing unnecessary duplication.	

7. **Priority 1 – Prevention:** aims to improve healthy life expectancy and reduce health inequalities across BLMK, and thereby reduce avoidable pressures on health and care services. This will be achieved by embedding a culture of prevention and early intervention across BLMK.

8. Three initial system-wide priorities for prevention have been identified:

- A BLMK-wide approach to Falls & Fracture Prevention which will help to deliver:
  - ✓ A new fracture liaison service at Bedford Hospital Trust from April 2017
  - ✓ An upgraded fracture liaison service at Milton Keynes University Hospital
- Development of a Social Prescribing business case (one of the GP Forward View '10 High Impact Areas') by March 2017 setting out:
  - ✓ The projected benefits of social prescribing including reductions in primary and secondary care attendances and hospital admissions
  - ✓ The estimated costs for a BLMK-wide social prescribing model ranging from enhanced signposting to a comprehensive social prescribing system
- A plan to significantly increase the contribution of self-managed care; informed by the triangulation of the Health & Wellbeing gap, Care & Quality gap and Right Care, which identifies significant opportunities for improve management of long term conditions. The goals of the plan will include:
  - ✓ Empowering service users and family carers to do more through measures including active patient programmes, health coaching and easier access to shared care records
  - ✓ Extending the role of pharmacists in care management

9. Progress against specific Prevention Plan actions will be an early indicator of the impact of the workstream. Impact on health and wellbeing outcomes will be measured through a set of system-wide targets which are being finalised.

10. **Priority 2 - primary, community and social care services**: focuses on health and social care delivered to people in community settings and in the home. Its goal is to oversee a "once in a generation" improvement in the strength, resilience and modernity of health and social care provided by the statutory services in primary, community and social care settings in BLMK. This is to be accompanied by a shift to self-managed care for those individuals (or family carers) that are able and content to do more by themselves, given the right support.

11. During 2016/17, Priority 2 has focused its work on establishing four place-based Boards in BLMK and familiarising itself with the raft of initiatives being taken forward that fall into the Priority 2.

12. In addition, **Priority 2** has been used as the vehicle to produce BLMK's consolidated submission to NHS England on the GP Forward View setting how investment plans for BLMK's share of GP5YFV funding (which amounts to circa £7.2m over the next two years) to improve primary care and in a way that furthers stated STP goals. A workshop in January confirmed that the BLMK would use the National Association of Primary Care Model, as the basis for the design of primary care services across the BLMK footprint.

13. Further investment in a) care homes and b) how mental health workforce works with and in primary care, is expected to be released by NHS England in the coming weeks and **Priority 2** will again, be used to formulate a cross-BLMK response.

14. The joint procurement of community health services between Bedfordshire Clinical Commissioning Group; Central Bedfordshire Council and Bedford Borough Council has completed the first stage and the top five bidders have been invited to Participate in Dialogue (ITPD). Dialogue sessions will take place during March 2017 with written submissions in April.

15. As Priority 2 confirms the community model of care, any estates consequences will need to be identified. Through the One Public Estate (OPE) framework, the Primary Care – Estates Transformation and Technology Fund (ETTF) and momentum already generated locally to deliver Integrated Health and Care Hubs, there are real opportunities for partners to collaborate to achieve better value and closer alignment between service model and population need.

16. **Priority 3 - sustainable secondary care services**: the focus of this on hospital-based care. Its goal is to modernise secondary care across the footprint, rendering it both clinically and financially sustainable in the long term.

17. The planning work programme for Priority 3 is being overseen by a Secondary Care Services Transformation Board (SCSTB). This comprises clinical and operational leaders from Bedford Hospital NHS Trust, Luton & Dunstable University Hospital NHS Trust and Milton Keynes University Hospital NHS Trust. In addition, since January 2017, this Board has benefited from senior representation by BLMK CCGs.

18. The SCSTB is overseeing five discrete workstreams namely:
    - Workstream 1 - to identify ways in which specialty hospital services can be delivered differently to improve quality and sustainability
    - Workstream 2 – to deliver clinical support services (for example, pathology, radiology and pharmacy) in the most effective way across BLMK
    - Workstream 3 – to deliver professional support services (for example, HR, ICT,finance & procurement, estates maintenance and management, communications) in the most effective way across BLMK
    - Workstream 4 – to identify and implement opportunities for improving the clinical and cost effectiveness of BLMK's non-medical clinical workforce (including temporary staffing)

- Workstream 5 – to streamline access to urgent and emergency services across BLMK, via an integrated urgent care access platform (or Hub)

19. During March a further round of public engagement, specifically on the early ideas around the future of hospital services, will be launched.

In preparation for this public dialogue in March, the Priority 3 programme team has been engaging clinicians in developing their ideas abut the future.

These have been articulated in a discussion document, entitled "Seeking your views …transforming care in Bedfordshire, Luton and Milton Keynes".

In this document, six separate domains of care will be highlighted, namely:

- Urgent and emergency care
- Planned care
- Specialist care
- Out-of-hospital care
- Maternity services
- Children's' services

The discussion document is to be launched during the week commencing 27th February.
A series of facilitated engagement event on ideas for transforming hospital based care will be held during the month, including two on 7 March at the Rufus Centre in Flitwick (each commencing at 2pm and 6.30pm).

Additionally there will be an on line consultation document and questionnaire which residents will be invited to respond to by 31st March 2017.

The BLMK STP group are keen to stress that this engagement is for early dialogue and is positioned ahead of any decision making, none of which will happen without further formal consultation.

20. **Priority 4 – digitisation:** is working to deliver a BLMK-wide digital solution. The programme team has been working collaboratively since Autumn 2016 to access digital transformation funds and has secured £1.7m of digital investment towards strengthening primary care. Short and medium term focus of this priority includes:

- Shared Health and Care Records
- Innovations in Care Homes Project
- Development of information sharing agreements
- Provider system upgrades and improvement.

21. **Priority 5 - re-engineering the system**: is seeking to address is how the various components of prevention, demand management, commissioning, contracting and health and social care supply can be transformed to create a positive and lasting environment within which solutions emerging from other STP priorities can be implemented, operationalised and their effect sustained.

22. The work programme is being overseen by the Priority 5 Oversight Board, to which a Priority 5 Working Group reports. Research and development work has been undertaken, assisted by NHS England's New Care Models team, and NHS Improvement, to identify the nature and scale of the work programme that is likely to be required when designing, developing and implementing Accountable Care.

Engagement

23. During 2016, the STP established a communications and engagement collaborative, comprising communications leads (or delegated representatives) from all STP partners. This group, chaired by the designated communications and engagement lead officer for the STP, seeks to ensure all STP priorities and the overarching STP has appropriate tactical and strategic communication and engagement plans in place.

24. In addition, and to make sure staff, stakeholders and local people are involved and engaged in developing the plans the STP created other engagement platforms, such as:

- A **Staff Voice Partnership** - this partnership informs the type of communications and engagement that will be most effective to inform, involve and engage staff in all STP partner organisations
- A **Public Voice Partnership** – this partnership informs the type of communications and engagement that will be most effective to inform, involve and engage local people
- A **Trade Union Partnership** – this partnership informs communication and engagement with staff employed in organisations that may be affected by the plans as they develop

25. A series of STP development and engagement events, aimed primarily at STP partners, their staff and local clinicians, have taken place.

Next Steps

26. The plans will continue to be developed locally, with the involvement of local communities, staff and other stakeholders.

27. Engagement activity in the coming weeks and months will help progress work being undertaken in Priority 3, but also take into account wider service planning across all settings that features as part of Priority 1 (prevention) and Priority 2 (primary, community and social Care).

Reasons for the Action Proposed

28. 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.

29. 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 March 2021. NHS England will assess each STP. Plans of the highest standard will gain access to transformation funding from April 2017.

30. The STP has implications for Central Bedfordshire's vision for integration and Out of Hospital services.

Governance & Delivery

31. The BLMK STP programme has been overseen and 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 used 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

Financial

32. One of the triple aims of the STPs is to secure financial balance across the local health system and improve the efficiency of NHS services.

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.

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CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of Meeting 29 March 2017

WORK PROGRAMME 2017/18

Responsible Officer: Richard Carr, Chief Executive, CBC
Email: richard.carr@centralbedfordshire.gov.uk

Public

Purpose of this report

1. To present an updated work programme of items for the Health and Wellbeing Board for 2017/18.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

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

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 programme 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 for 2017/18.

5. The work programme ensures that the Health and Wellbeing Board remains focused on key priority areas and activities to deliver improved outcomes for the people of Central Bedfordshire.

Governance and Delivery Implications

6. The Health and Wellbeing Board is responsible for the Health and Wellbeing Strategy. The work programme contributes to the delivery of priorities of the strategy and includes key strategies of the Clinical Commissioning Group.

Equalities Implications

7. 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.

Conclusion and next Steps

8. 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.

Appendices

9. Appendix A – Health and Wellbeing Board Work Programme

Background Papers

10. None.

Health and Wellbeing Board
Work Programme 2017/18

Issue for Decision	Description	Indicative Meeting Date	Lead Director and contact officer(s)
Diabetes	To receive an update on the rising rates of diabetes and low proportion of people with diabetes meeting their treatment targets	12 July 2017	Matthew Tait, Chief Accountable Officer, BCCG
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.	12 July 2017	Julie Ogley, Director of Social Care, Health and Housing, CBC Contact Officer: Patricia Coker, Head of Partnership and Performance, CBC
Enabling People to Stay Healthy for Longer - Excess Weight Partnership Strategy	To receive an update on the Excess Weight Partnership Strategy.	12 July 2017	Muriel Scott, Director of Public Health, CBC Contact Officer: Celia Shohet, AD Public Health, CBC
Health and Wellbeing Scorecard	To receive the latest performance monitoring of the progress in delivering the priorities in the Health and Wellbeing Strategy	12 July 2017	Muriel Scott, Director of Public Health, CBC Contact Officer: Celia Shohet, AD Public Health, CBC
Child and Adolescent Mental Health Services Transformation Plan	To receive a report from the Future in Minds Steering Group.	12 July 2017	Anne Murray, Director of nursing and Quality, BCCG Contact Officer: Karlene Allen, Head of Children's Young People and Maternity Services, BCCG

Health and Wellbeing Board
Work Programme 2017/18

Issue for Decision	Description	Indicative Meeting Date	Lead Director and contact officer(s)
HWB Strategy: Ensuring good mental health and wellbeing at every age - Children and young people are emotionally resilient.	To receive an update on the Children and Young People's Early Intervention and Prevention Mental Health and Wellbeing Strategy.	12 July 2017	Anne Murray, Director of Children's Services, BCCG Muriel Scott, Director of Public Health, CBC Contact officers: Sarah James Principal PH Officer (Children and Young People) Sanhita Chakrabarti Clinical Lead Bedfordshire Clinical Commissioning Group
Joint Strategic Needs Assessment	To receive the Executive Summary of the Joint Strategic Needs Assessment.	12 July 2017	Muriel Scott, Director of Public Health, CBC Contact Officer: Celia Shohet, AD Public Health, CBC
Improving Outcomes for Frail Older People	To receive an update on the outcomes for frail older people.	18 October 2017	Julie Ogley, Director of Social Care, Health and Housing, CBC Contact Officer: Patricia Coker, Head of Partnership and Performance, CBC
Health and Wellbeing Scorecard	To receive the latest performance monitoring of the progress in delivering the priorities in the Health and Wellbeing Strategy	18 October 2017	Muriel Scott, Director of Public Health, CBC Contact Officer: Celia Shohet, AD Public Health, CBC

Health and Wellbeing Board
Work Programme 2017/18

Issue for Decision	Description	Indicative Meeting Date	Lead Director and contact officer(s)
Giving Every Child the Best Start in Life: School Readiness	To provide an update on school readiness.	24 January 2018	Sue Harrison, Director of Children's Services, CBC Contact Officer: Sue Tyler, Head of Early Intervention/Prevention & Barbara Rooney, Public Health Manager, CBC
Health and Wellbeing Scorecard	To receive the latest performance monitoring of the progress in delivering the priorities in the Health and Wellbeing Strategy	24 January 2018	Muriel Scott, Director of Public Health, CBC Contact Officer: Celia Shohet, AD Public Health, CBC
Health and Wellbeing Scorecard	To receive the latest performance monitoring of the progress in delivering the priorities in the Health and Wellbeing Strategy	21 March 2018	Muriel Scott, Director of Public Health, CBC Contact Officer: Celia Shohet, AD Public Health, CBC
To be Timetabled			
Ensuring Good Mental Health	To review the target for accessing Psychological Therapies.		Julie Ogley, Director of Social Care, Health and Housing, CBC
Enabling People to Stay Healthier Longer	To receive a report on premature mortality for cardiovascular disease.		Muriel Scott, Director of Public Health, CBC Contact Officer: Celia Shohet, AD Public Health, CBC
Local Pharmaceutical Committee (LPC)	To invite a representative from the LPC to give a presentation.		Muriel Scott, Director of Public Health, CBC Contact Officer: Celia Shohet, AD Public Health, CBC

Health and Wellbeing Board
Work Programme 2017/18

Issue for Decision	Description	Indicative Meeting Date	Lead Director and contact officer(s)
East of England Ambulance Service in Bedfordshire	To receive an update on the discussions between the Bedfordshire Clinical Commissioning Group and the EEAST.		Matthew Tait, Chief Accountable Officer, BCCG
Director of Public Health's Annual report	To consider the actions to deliver the improvements identified within the Director of Public Health's Annual report.		Muriel Scott, Director of Public Health, CBC Contact Officer: Celia Shohet, AD Public Health, CBC