This meeting may be filmed.*

Central Bedfordshire Health and Wellbeing Board

Agenda

Meeting Title:	Central Bedfordshire Health and Wellbeing Board
Date:	Wednesday, 12 July 2017
Time:	2.00 p.m.
Location:	Council Chamber, Priory House, Monks Walk, Shefford

1. **Apologies for Absence**

   Apologies for absence and notification of substitute members.

2. **Election of Vice-Chairman 2017/18**

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 29 March 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.	**Joint Strategic Needs Assessment Executive Summary** To provide a comprehensive summary of the Health and Wellbeing needs in Central Bedfordshire and the areas which require further focus.	11 - 48	MS
8.	**Enabling People to Stay Healthy for Longer**		
	a) To receive a report on the actions being taken to reduce excess weight in the context of reducing the prevalence of diabetes.	49 – 54	MS
	b) To receive a report on the actions being taken to reduce the prevalence of diabetes and increase the proportion of people with diabetes meeting their treatment targets.	55 – 64	AL
9.	**Ensuring Good Mental Health and Wellbeing at Every Age - Children and Young People are Emotionally Resilient**		
	a) To receive the Child and Adolescent Mental Health Services Local Transformation Action Plan.	65 – 102	AM
	b) To receive the Children and Young People's Early Intervention and Prevention Mental Health and Wellbeing Action Plan.	103 - 120	SC
10.	**Ensuring Good Mental Health and Wellbeing at Every Age - Bedfordshire Wellbeing Service** To receive a **presentation** from ELFT regarding access to the service, the challenges and opportunities to improving access and recovery rates.		SC/RA
11.	**Health and Wellbeing Strategy Performance** To present the latest performance data in the priority areas of the Joint Health and Wellbeing Strategy.	121 - 132	MS

OTHER BUSINESS

Item	Subject	Page Nos.	Lead
12.	**Better Care Fund Plan 2017/18 - 2018/19** To receive an update on the Better Care Fund Plan 2017/18 – 2018/19.	133 - 148	JO
13.	**Strategic Partnership Leadership Arrangements for Children** To receive a **presentation** on the Strategic Partnership Leadership arrangements including the emerging Children and Young People's plan for 2017-2019.		SH
14.	**Work Programme 2017/2018** 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.	149 - 154	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, Central Bedfordshire Council
Mrs S Harrison	Director of Children's Services, Central Bedfordshire Council
Cllr C Hegley	Executive Member for Social Care and Housing and Lead Member for Children's Services, 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, Central Bedfordshire Council
Cllr B Spurr	Chairman of the Health and Wellbeing Board and Executive Member for Health, Central Bedfordshire Council

please ask for	Sandra Hobbs
direct line	0300 300 5257
date published	30 June 2017

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CENTRAL BEDFORDSHIRE COUNCIL

At a meeting of the **HEALTH AND WELLBEING BOARD** held in Room 14, Priory House, Monks Walk, Shefford on Wednesday, 29 March 2017

PRESENT

Cllr B J Spurr (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
Mrs S Harrison	Director of Children's Services
Cllr Mrs C Hegley	Executive Member for Social Care and Housing
Dr A Low	Chair, Bedfordshire Clinical Commissioning Group
Mrs J Ogley	Director of Social Care, Health and Housing
Mrs M Scott	Director of Public Health

Apologies for Absence: Cllr S Dixon
Mr C Ford

Members in Attendance: Cllrs Mrs T Stock
M A G Versallion

Officers in Attendance:	Mrs P Coker	– Head of Service, Partnerships - Social Care, Health & Housing
	Mrs S Hobbs	– Senior Committee Services Officer
	Mrs C Shohet	– Assistant Director of Public Health
	Mrs S Tyler	– Head of Child Poverty and Early Intervention
Others in Attendance:	Mr S Fraser	– Customer Service Operations Manager, DWP

HWB/16/42. **Election of Chairman**

Following the retirement of Councillor Jones, nominations were invited for the position of Chairman.

Councillor Brian Spurr was nominated and seconded.

RESOLVED

that Councillor Brian Spurr be elected Chairman of the Health and Wellbeing Board for the remainder of the Municipal Year 2016/17.

The Board took the opportunity to thank Councillor Jones, for his hard work and wished him well in the future.

HWB/16/43. **Chairman's Announcements and Communications**

The Chairman had no announcements.

HWB/16/44. **Minutes**

RESOLVED

that the minutes of the meeting of the Central Bedfordshire Health and Wellbeing Board held on 25 January 2017 be confirmed as a correct record and signed by the Chairman.

HWB/16/45. **Members' Interests**

None were declared.

HWB/16/46. **Public Participation**

There were no members of the public registered to speak.

HWB/16/47. **Health and Wellbeing Strategy Performance**

The Board considered a report that presented the latest performance data in the priority areas of the Joint Health and Wellbeing Strategy. The Board considered each key measure:-

- the performance data for accessing psychological therapies gave some cause for concern as the proportion in need accessing this service was still below target and the recovery rates for those in treatment was also below target. The Board agreed to invite the provider to the next meeting on 12 July 2017 to explain the current position, challenges and opportunities;

- 2 new indicators, Childhood Excess Weight – Reception Year Children and Teenage pregnancy, had been added to the performance scorecard for giving every child the best start in life; and

- the Board would consider a report at their meeting on 12 July 2017 on the rising rates of diabetes and the low proportion of people with diabetes meeting their treatment targets.

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 its meeting on 12 July 2017:**

    - **accessing psychological therapies; and**
    - **diabetes.**

HWB/16/48. **Employment Support Allowance**

The Board considered a report that provided information about the Employment Support Allowance (ESA) and how claimants were being supported, including to access work. In order to claim ESA a Work Capability Assessment was undertaken by an Approved Healthcare Professional on behalf of the Department of Work and Pensions (DWP). The Assessment tested the claimant's suitability to work.

The Board welcomed Mr Fraser, Customer Service Operations Manager, DWP to the meeting. Mr Fraser provided the Board with information on how the DWP supports claimants and on introduction of the Personal Support Package from April 2017 that included £330 million of additional employment support over 4 years for people who due to an illness or disability were unable to work at the current time, but may be able to in the future.

This included:

- 300 new Disability Employment Advisers in Jobcentres across the country;
- a one-to-one health and work conversation with a Jobcentre Plus Work Coach to help raise confidence in managing a health condition, when appropriate;
- the introduction, from the summer, of a new Employment and Support Allowance (ESA) Claimant Commitment for disabled people or those with a health condition who were out of work, setting out the support the Jobcentre would provide and what was expected of claimants; and
- personalised support provided to new ESA claimants placed in the work-related activity group, and new claimants of Universal Credit's equivalent group, to help them move closer to the jobs market and, when they were ready, into work.

Central Bedfordshire Council had produced a booklet 'Helping residents' deal with welfare reform' offering support to people who were impacted by the changes to the welfare system. The Council's Housing and Regeneration Services were helping tenants and residents back into work and supporting local businesses in filling vacancies.

RESOLVED

1. that the report be noted; and

2. that an update be provided to the Board at a future meeting.

HWB/16/49. **Better Care Fund Plan 2017/18 - 2018/19**

The Board considered a report that set out the details for a two year Better Care Fund (BCF) Plan for 2017/18 – 2018/19. Building on work to date, the Plan should also set out the local vision and approach to integration and demonstrate alignment with the Sustainability and Transformation Plan and the General Practitioner Forward View.

Guidance had been significantly delayed and it was anticipated that when it was finally published, there would lead to tight timeframes for developing, approving and submitting plans.

RESOLVED

1. that the timetable for the submission of the Better Care Fund Plan for 2017/18 – 2018/19, be noted; and

2. to authorise the Director of Social Care, Health and Housing and the Director of Commissioning, in consultation with the Chairman of the Health and Wellbeing Board, the approval of the BCF Plan 2017/18 – 2018/19 submission.

HWB/16/50. **Joint Local Government Association Peer Review: Reablement and Rehabilitation**

The Board considered a report that presented the findings of the Joint Local Government Association (LGA) Peer Review into reablement and rehabilitation. The review took place in October 2016 across Central Bedfordshire and Bedford Borough Councils and involved representatives from the Bedfordshire Clinical Commissioning Group and the South Essex Partnership Trust. The review focused on the current state of the services and to understand where these might be better streamlined or duplication avoided.

The Board thanked Healthwatch Central Bedfordshire for conducting a telephone survey of 131 customers and carers.

The review noted that, at a strategic level, there was an awareness and recognition amongst partners of the need to work together better to deliver effective services and therefore better outcomes for customers.

RESOLVED

1. **that the LGA Peer Review Report on Reablement and Rehabilitation services in Central Bedfordshire be noted;**

2. **that the findings and recommendations of the review be noted; and**

3. **that the next steps, as set out in the report, be endorsed.**

HWB/16/51. **Sustainability and Transformation Plan 2016-2020**

The Board considered a report that provided an update on the development of the Sustainability and Transformation Plan (STP) for Bedfordshire, Luton and Milton Keynes (BLMK). The STP aimed to address:

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

The BLMK submission identified five priorities:

- Prevention
- Primary, community and social care
- Sustainable secondary care
- Digitisation
- System redesign.

Communication plans had been put in place to ensure staff, stakeholders and local people were involved and engaged in developing the plans. At this stage the plans were very high level with specialist proposals still to be developed.

RESOLVED

1. **that the progress of the STP be noted;**

2. **that progress on the priorities of the STP be endorsed 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. **that the plans for wider engagement on the STP be noted.**

HWB/16/52. **Work Programme 2017/18**

The Board considered their work plan for 2017.

It was noted that there was a large number of items to be considered at the meeting on 12 July 2017 and some of these items might be deferred to a future meeting.

RESOLVED

that the following items be added to the work programme:

- **ELFT to be invited to the meeting on 12 July 2017 to outline the current position, challenges and opportunities for accessing psychological therapies;**

- **an update on the Better Care Fund to be scheduled for the 12 July 2017; and**

- **an update on the Welfare Reform Agenda be scheduled.**

(Note: The meeting commenced at 2.00 p.m. and concluded at 3.20 p.m.)

Chairman …….……

Dated ……..

CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of Meeting 12 July 2017

Joint Strategic Needs Assessment Executive Summary

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 provide the Board with a comprehensive summary of the Health and Wellbeing needs in Central Bedfordshire and the areas which require further focus.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. **consider and endorse the 2017 Executive Summary of the Joint Strategic Needs Assessment for Central Bedfordshire; and**

2. **consider the areas of focus requiring action across the system which the Health and Wellbeing Board may also wish to incorporate into a re-freshed strategy.**

Issues

2. There are a number of common themes which have emerged from the JSNA:

   a) The need to increase healthy life expectancy and promote independence by increasingly 'mainstreaming prevention'. This is important to both local residents and to the local health and care system that will need to meet rising demand if healthy life expectancy does not improve.

   b) The need to reduce inequalities and disadvantage which can start from birth – so giving every child the best start in life is essential.

c) The need to give mental and physical health parity – there is no health without mental health.

d) The need to be ambitious – whilst outcomes in Central Bedfordshire appear better than average – they should be as it is a relatively affluent area – so we should aim to be among the best.

2. To gain a full picture of the need, the executive summary should be read in full, however some of the main areas of focus for each chapter are outlined in the following paragraphs.

3. **Population and Place**

a) Whilst life expectancy continues to increase for men and women, the number of years lived in good health has fallen – for men from 65.8 years to 64.7 years and for women from 64.8 years to 63.1 years.

b) The gap in life expectancy between the most and least deprived deciles continues to narrow for men from 6 years to 4.8 years but for women the gap is widening from 5.2 years to 5.7 years.

4. **Wider Determinants of Health**

a) The impacts of Air Pollution are gaining in recognition as a public health issue and although air quality is generally good in Central Bedfordshire, tackling the effects of pollution in the three air quality management areas (Dunstable, Ampthill and Sandy) remains a high priority.

b) Central Bedfordshire is a safe place to live and work there are pockets where crime and community safety concerns are higher. Hotspot areas continue to be the town centres, with Dunstable Town Centre remaining the largest generator of incidents. Compared to the previous year, levels of serious acquisitive crime have increased by 7%, domestic burglaries have increased by 22%, antisocial behaviour has fallen by 4% and domestic abuse incidents noted to have a child resident at the location of the incident has decreased by 4%.

c) Based on long-term migration trends and local demography issues, between 20,000 - 30,000 homes are needed to meet local demand up to 2031. The demand for predominately family housing (2, 3 and 4 bedroom homes) is expected to continue.

5. **Starting and Developing Well**

a) Improving educational outcomes remain a priority particularly for Key Stage 2 and for disadvantaged pupils.

b) Evidence from Looked After Children case reviews suggests that there are a number of core issues leading to family breakdown which need to be tackled – notably domestic abuse, substance misuse, parental mental health and disengagement of parents from the support offered and their capacity to effect lasting change. Criminality was also found to be a parental risk factor.

c) Adverse Childhood Experiences (stressful events that children can be exposed to whilst growing up) are one of the strongest predictors of poor health and social outcomes in adults, therefore minimising the impact of these through early identification and support is key.

d) Emotional health and wellbeing of parents, children and young people remain a high priority.

6. **Living and Working Well**

a) The population level challenges around improving lifestyle remain with a higher percentage are classified as being overweight or obese and the impact of alcohol abuse continues to rise as indicated by alcohol related admissions. However the proportion of adult smokers continues to fall and the proportion of the population classified as active has increased.

b) Driven in part by high levels of excess weight, the prevalence of diagnosed diabetes in adults aged 17 and over continues to rise and premature mortality from coronary heart disease (CHD) remains higher compared to statistical neighbours.

c) The rising aging population is contributing to an increasing incidence of newly diagnosed cancers and the prevalence of chronic obstructive pulmonary disease (COPD).

7. **Ageing Well**

a) Social isolation remains an issue and can have damaging effects on physical and mental health.

b) The rates of injuries due to falls (and admissions to acute care) continues to increase and is now worse than statistical neighbours.

c) There was a sharp increase in the reporting of concerns about individuals, resulting in a rise of safeguarding investigations and a reverse in the downward trend between the number of safeguarding alerts and safeguarding investigations. This may be because the safeguarding system is working better and a greater awareness of the need to report.

d) Less than half of Carers in Central Bedfordshire feel they have the social contact they need.

e) The rate of statutory homelessness is rising and the numbers residing in temporary accommodation has increased significantly.

8. The JSNA executive summary should be widely disseminated to ensure that the findings inform strategic planning and commissioning. The JSNA has already informed the re-procurement of Community Health Services, the Better Care Plan, the STP and emerging quadrant plans. It will also inform the development of the Children and Young People's Plan, the Joint Health and Wellbeing Strategy and the Out of Hospital Strategy.

Financial and Risk Implications

9. The financial implications which result from changes to commissioning will be taken through the normal commissioning arrangements. The needs identified are significant and some will require changes or additional service provision if they are to be met.

Governance and Delivery Implications

10. The production of the JSNA is a requirement of the Health and Wellbeing Board discharged through the JSNA steering group.

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.

12. The JSNA has a consistent focus on identifying any inequalities and makes recommendations about how these could be reduced.

Implications for Work Programme

13. None directly.

Conclusion and next Steps

14. Generally, outcomes for residents of Central Bedfordshire are good, especially when compared to England, however the picture is more challenging when outcomes are compared with statistical neighbours.

15. The Health and Wellbeing Board may also wish to incorporate, some areas of focus requiring action across the system, into a re-freshed strategy. These include improving the emotional health and wellbeing of children and young people, preventing and minimising the impact of air pollution, the prevention and management of falls, reducing social isolation, the prevention and management of diabetes.

Appendices

Appendix A - Joint Strategic Needs Assessment Executive Summary

Background Papers

None

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NHS
Bedfordshire
Clinical Commissioning Group

Central Bedfordshire
great lifestyles

Joint Strategic Needs Assessment

Executive Summary for Central Bedfordshire 2016/17

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Published by Central Bedfordshire's JSNA Steering Group on behalf of Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group.

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Contents

1.0 Introduction

What is the Joint Strategic Needs Assessment?

The Joint Strategic Needs Assessment (JSNA) is a process by which the current and future health and wellbeing needs of the local population are described in order to inform commissioning decisions and strategy development. The production of a JSNA is a statutory requirement for the Health and Wellbeing Board.

Central Bedfordshire's JSNA is a living document. It is published in its entirety at: www.jsna.centralbedfordshire.gov.uk – with over 50 chapters, each covering a different aspect of health and wellbeing and the many contributing factors. The chapters are refreshed annually, on a rolling basis, when new information becomes available.

Wherever a phrase appears as a hyperlink, the dedicated chapter can be found on the website with all the relevant statistics, evidence and detailed recommendations.

The Executive Summary

The executive summary distils the key issues from the JSNA and highlights the top priorities for Central Bedfordshire.

In producing this document the JSNA Steering Group was mindful of the need to minimise duplication with other complementary reports, such as the recent Director of Public Health Report on Children, Young People and their Families. They also recognised that it was not feasible to summarise the JSNA in its entirety.

Consequently the Steering Group agreed to limit the scope of this executive summary to those areas and topics that demonstrated a significant change, positive or negative; or where there has been a continuation of an upward or downwards trend in key demographics, wider determinants or health and wellbeing outcomes.

Call for input

The JSNA can only be as good as the contributions it receives. If you or your organisation feels that there are gaps or errors in any of the chapters on the website, or you would like to be involved in producing the next version, we would like to hear from you. Please email: sion.james@centralbedfordshire.gov.uk

2.0 Population and Place

Central Bedfordshire, a predominantly rural area in the East of England, is considered to be a highly desirable place to live and work. As a consequence the population is growing, rising from 254,400 in 2011 to approximately 274,000 in 2015. Further estimated growth of 20% will see the population rise to 333,000 by 2031.

The population is aging as well as growing. Between 2015 and 2021 the number of people aged 65 and over is forecast to increase from 47,100 to 74,400, a 58% increase.

The main drivers of population growth are:

- Increasing life expectancy
- A rising birth rate, which exceeds the mortality rate
- A net migration gain due to more people arriving in the area than moving away

Life expectancy

Life expectancy at birth provides a good overall indicator of health and wellbeing.

In Central Bedfordshire:

- Life expectancy for men (81.7 years) and women (83.7 years) continues to remain significantly better than the England average.
- Life expectancy is increasing at the rate of about 4.0 years for men and 2.1 years for women each decade.

The slope index of inequality in life expectancy at birth is the average difference in life expectancy between the most deprived and the least deprived deciles.

In Central Bedfordshire:

- The gap in male life expectancy is reducing, now 4.8 years compared to 6.0 years in 2011-13.
- The gap in female life expectancy has increased slightly; now 5.7 years compared to 5.2 years in 2011-13.

Many deaths before the age of 75 years are avoidable, with the most common causes being cancer (particularly lung cancer), heart disease and stroke, and lung diseases (predominantly chronic obstructive pulmonary disease).

Healthy life expectancy

Healthy life expectancy refers to the number of years lived in 'good' health, which is driven largely by health behaviours and wider determinants of health such as housing and employment. The gap between healthy life expectancy and total life expectancy is the period spent in poor health when people are likely to need more care and support. The period spent in poor health tends to be longer for those living in more deprived circumstances.

In Central Bedfordshire:

- Male healthy life expectancy decreased from 65.8 years in 2009-11 to 64.7 years for 2013-15.
- Female healthy life expectancy fell from 64.8 in 2009-11 to 63.1 years for 2013-15.
- The inequality in healthy life expectancy at birth was 7.7 years for males and 7.2 years for females. This means that on average those in the least deprived 10% live for 7 more years in good health compared to those from the most deprived 10%.

These figures place Central Bedfordshire in the top 10% in England, i.e. among those areas with the smallest gap.

3.0 The wider determinants of health

There are a number of factors which will impact upon an individual's health and wellbeing such as their income, employment, education and the place in which they live. Understanding the local impact of wider determinants and what needs to be done is crucial to improving health and wellbeing across Central Bedfordshire. This is particularly important for those areas and populations that are more deprived. Wider determinants are cited throughout the JSNA Executive Summary, but here we describe the impact of:

Air Pollution

Poor air quality is a significant public health issue. Long-term exposure can contribute to the development of chronic diseases, risk of respiratory illness and premature deaths.

In Central Bedfordshire:

- Air quality is generally good.
- In 2015, the fraction of all cause adult mortality attributable to particulate air pollution was 4.9% and has been falling since 2013.
- Air Quality Management Areas must be established where national air quality objectives are being or are likely to be exceeded. There are three Air Quality Management Areas in Central Bedfordshire:
- Dunstable Town Centre
- Ampthill Town Centre
- Sandy (adjacent to the A1)

Areas for focus:

- Quantifying the health impacts of air pollution in the Central Bedfordshire Air Quality Management Areas, tackling them proportionately and developing a comprehensive air quality strategy, with strong links to the green space and climate change strategies.

Community Safety

Central Bedfordshire is a safe place to live and work, although as is common in all areas, it does have pockets where crime and community safety concerns are higher.

In Central Bedfordshire:

- Hotspot areas continue to be the town centres, with
- Dunstable Town Centre remaining the largest generator of incidents.

Between November 2015 and October 2016:

- Levels of serious acquisitive crime rose by 233 offenses, from 3,096 to 3,330, representing an increase of 7% compared to the previous year.
- Domestic burglaries rose by 222 offenses, from 825 to 1,010, representing an increase of 22% compared to the previous year.
- Antisocial behaviour has fallen by 301 offenses, from 7,847 to 7,546, representing a decrease of 4% compared to the previous year.
  Reported domestic abuse incidents have remained stable at 3,370, whilst domestic abuse incidents noted to have a child resident at the location account for 48% of all incidents.

Housing

Housing projections for Central Bedfordshire take into account factors including migration and demographic change:

- Based on long-term migration trends and local demography issues, between 20,000 - 30,000 homes are needed to meet local demand up to 2031.
- Based on current employment trends, projected growth of the economically active population and projected change in job numbers, total employment in Central Bedfordshire will increase by 26,700 jobs between 2011 and 2031.
- The demand for predominately family housing (2, 3 and 4 bedroom homes) is expected to continue.
- Based on the current unmet need for affordable housing future household projections and existing households living in unsuitable

housing, a total of 7,278 affordable homes are required to meet local demand up to 2031.

- This equates to an annual requirement of 364 affordable homes per annum.

Areas for focus:

- Taking account of commuting patterns, changes to the employment rate and demographic projections, there is a need to increase housing delivery to ensure that there will be enough workers for the likely increase in jobs in the area.
- Future investment should focus enabling younger people to access affordable housing, and supporting people with specific health & mobility should be emphasised.

Income

Income deprivation increases financial pressures and impacts on a Resident's lifestyle, eating habits and mental health.

In Central Bedfordshire:

- 9.3% of the population experience income deprivation relating to low income compared to 14.5% in England.
- Tithe Farm (21%), Dunstable Manshead (19.9%) and Parkside (19.8) experience the greatest income deprivation.

Skills and Employment

Central Bedfordshire has a growing economy of £5.4 billion with over 11,500 businesses employing almost 92,000 people.

In Central Bedfordshire:

- Skills attainment is generally high. In 2016, 75.4% of people in Central Bedfordshire had achieved at least Level 2 qualifications, compared to 73.4% in England. The percentage of people with no qualifications (6.9% in Central Bedfordshire) was lower than the England average (8.4%).
- People in Central Bedfordshire (74.7%) are more likely to be economically active than the England average (69.9%). Economic activity includes both people in employment and those who are unemployed but actively looking for work.
- Unemployment is generally lower than the England average. In September 2015, 0.6% of the Central Bedfordshire population were claiming Job Seeker's Allowance, compared to the England rate of 1.2%.
- Central Bedfordshire residents earn more than the England average. The average weekly earnings of residents in 2016 (£545) is greater than the England average (£495).
- Residents also earn more than people who work in Central Bedfordshire; the difference is about £96 per week. This is likely to be a result of better paid opportunities available to those who commute out of the area.

4.0 Starting Well

There are 65,200 children aged between 0-19 years in Central Bedfordshire 2015, an increase of 1,000 children since 2014.

A child's experience during the early years has a major impact on their future life chances and is crucial to reducing health inequalities throughout life.

In Central Bedfordshire:

- There are around 3,200 **live births** each year with a significantly lower infant mortality rate compared to England.
- **Breastfeeding** initiation rates have fallen slightly but the rate of breastfeeding at 6-8 weeks after birth is now better than the national level (although there is some variation across wards).
- For most **childhood immunisations**, coverage is over 95%. Uptake of MMR (Measles, Mumps, Rubella) in 2 year old children and completion of two doses of MMR and DTaP (Diptheria, Tetanus, Pertussis) given to children from the age 3 years 4 months until 5 years (preschool booster) remain a concern.
- In 2015/16, 13.9% of **babies lived in a household with a smoker** (a reduction from 16.7% in 2014/15).
- Trend data over an 8 year period (from 2008) shows a gradual reduction in excess weight for children in Year R and a small rise in excess weight for Year 6**.**

Areas for focus:

- Pregnancy: Midwifery services should identify vulnerable women and families as early as possible. Relevant information should be shared between professionals to ensure a co-ordinated response and prompt access to services. (Director of Public Health Report)

Poverty and Adverse Childhood Experiences: Mitigating the Risks

Research suggests that:

- **Mothers under the age of 20** are 22% more likely to be living in poverty at the age of 30 and less likely to be employed.
- **Young fathers** are more likely to have a poor education and have a greater risk of being unemployed in adult life.
- **Babies** born to mothers under 20 have a higher risk of a low birth weight, infant mortality and a risk of experiencing child poverty.

There has been a downward trend in the under 18 conception rate in Central Bedfordshire since 2010, with the greatest reduction seen in the under 16s. The most recent annual data (2015) shows a slight decrease in under 18 conception rates in Central Bedfordshire between 2014 (18.8 per 1,000, actual number 85) and 2015 (18.6 per 1,000 actual number 84). There were 2 higher rate wards in 2012-2014: Dunstable Northfields and Dunstable Manshead.

Compared to other parts of the country levels of deprivation in Central Bedfordshire are relatively low. However there are eight small areas in Central Bedfordshire where 34% to 40% of **children live in income deprived households**.

Central Bedfordshire Lower Super Output Areas (LSOAs) with the highest proportion of children living in income deprived households, 2015	
Central Bedfordshire LSOAs (in the most deprived 20% of England) and ID number.	**% of children living in income deprived households (and approximate number of children in brackets)**
Houghton Hall 580	**40% (250)**
Dunstable Northfields 595	**39% (100)**
Dunstable Manshead 594	**37% (260)**
Houghton Hall / Tithe Farm 618	**37% (170)**
Leighton Buzzard North 609	**35% (150)**
Parkside 601	**34% (150)**
Leighton Buzzard North 605	**34% (130)**
Tithe Farm 619	**34% (210)**
Central Bedfordshire average	**14%**
England average	**20%**

Source: DCLG Indices of Deprivations, Income Deprivation Affecting Children Index (IDACI) 2015.

Approximately 8.2% of Central Bedfordshire school children were known to be **eligible for free school meals** (January 2016 school census) compared to 14.3% in England. However, the rate varies widely – e.g.18% of Houghton Regis school children received school meals, compared to 3% in Ampthill. (Free School Meals eligibility is often used as a measure of deprivation for schools and their pupils.)

'The term **adverse childhood experiences (ACEs)** incorporates a wide range of stressful events that children can be exposed to whilst growing up. These include harms that affect the child directly, such as neglect and physical, verbal and sexual abuse; and harms that affect the environment in which the child lives, including exposure to domestic violence, family breakdown, parental loss, and living in a home affected by substance abuse, mental illness or criminal behaviour.'

Areas for focus:

- Early Years: We need a highly skilled and motivated Early Years workforce capable of high quality assessment, and working in an integrated way. Professionals working with children and families must be able to recognise key risk factors including adverse childhood experiences, sharing information and referring to services where appropriate. (Director of Public Health Report)

Preventing ACEs for future generations could improve health outcomes, by reducing for example levels of substance misuse (cannabis, heroin, crack use), binge drinking, unintended teenage pregnancy and poor diet.

Often risk factors occur together; particularly children living in a family affected by domestic violence, substance misuse and parental mental illness.

Between November 2015 and October 2016, there were 3,370 **domestic abuse** incidents in Central Bedfordshire, which has remained stable compared to the previous 12 months. 48% were noted to have a child resident at the location of the incident. In Central Bedfordshire the Relay Project alerts schools to children whose parents have been involved in a domestic violence incident. This enables schools to consider the support required for the individual child in a family context. Following 1,066 incidents with school aged children in the household between April 2015 and March 2016, 1,767 notifications to schools for individual children were made. The current position is that the majority of schools have received at least one Relay notification.

Poor **maternal mental health** has important consequences on a child's health. Women are at greater risk of developing their first

episode of mental illness during this time, with more than 1 in 10 women affected. In Central Bedfordshire an estimated 300-500 women are affected by mild to moderate depression during the perinatal period each year. Maternal depression is also the strongest predictor of paternal depression which is estimated at 4% during the first year after birth.

Areas for focus:

- Mental Health: Commissioners and providers must work together to ensure that a comprehensive perinatal mental health pathway is in place. Parents at risk of mental illness during the perinatal period (pregnancy to the first year following birth) should be identified and timely support offered, including for the infant and wider family where appropriate. (Director of Public Health Report).

In Central Bedfordshire it is estimated that 3,225 children aged 5-16 have a mental disorder, with a higher number seen in the 11-16 year old age group and in boys. Promoting resilience, emotional wellbeing and the good **mental health of children and young people** is a priority across Central Bedfordshire.

The biggest worries for 8-11 year olds reported in the School Health Education Unit (SHEU) Emotional Health and Wellbeing Survey 2015 were: being bullied, healthy eating, school work/exams and tests. 13% of pupils aged 8-11 years said that they find it hard to concentrate on anything due to worries.

Areas for focus:

- The early years are important to children in ensuring they have a great start in life. Multi-agency integrated early intervention and specialist support for vulnerable families is a priority – this includes those parents who are very young, those experiencing domestic abuse, poor mental health or substance misuse, or families living in poverty and deprivation in some parts of Houghton Regis, Dunstable and Leighton Buzzard.

Educational Outcomes

A good education is essential to counter socio-economic disadvantage and to break the intergenerational cycle of poor achievement and poverty, and if a child arrives at school **ready to learn** they are much more likely to achieve the best outcomes. The early identification (and accurate assessment) of children with special educational needs and/ or disabilities is also key to ensuring that every child is able to fulfil their potential.

In Central Bedfordshire children at the age of 5 are not doing as well as children nationally or as well as those living in similar areas. Although Good Level of Development results improved in 2016, Central Bedfordshire remains in the 3rd Quartile:

Age 5	**Central Bedfordshire: Early Years Foundation Stage: Good Level of Development** Results show improvement from 63.6% (2015) to **68.5% (2016)** but Central Bedfordshire remains in the 3rd Quartile. Statistical neighbour average (71.6%) national average (69.3%).

Literacy at the Early Years Foundation Stage was highlighted within the 2016 JSNA Executive Summary as an area of learning requiring improvement. There has been improvement from 69% to 73% - with Central Bedfordshire moving from a third quartile to a second quartile

position nationally, but performance in literacy still remains behind other areas of learning.

Age 7

Central Bedfordshire **Key Stage 1** 2016 results are being reported under a new assessment framework.

- **Reading: 77%** of pupils reaching the Expected Standard (Top Quartile)
- **Writing: 69%** of pupils reaching the Expected Standard (2nd Quartile)
- **Mathematics: 76%** of pupils working reaching the Expected Standard (2nd Quartile).

Age 11

Central Bedfordshire Key Stage 2 Results 2016

- **51%** of children reached the expected standard of reading, writing and maths combined.
  Figures are not comparable to earlier years (due to curriculum changes) but these results are below the statistical neighbour (54%) and national (53%) averages. 3rd Quartile.

- **29%** of **Central Bedfordshire Disadvantaged pupils*** achieved the expected standard in Reading, Writing and mathematics – compared to 57% of other pupils (a 27 percentage point difference). This gap is wider than both the statistical neighbour average (24 ppts) and the national average (21 ppts). Bottom Quartile.

  *Disadvantaged pupils are defined: those who were registered as eligible for free school meals at any point in the last six years; children looked after by a local authority and children who left care in England and Wales through adoption or via a Special Guardianship or Child Arrangements Order

Improving educational outcomes at Key Stage 2 and for disadvantaged pupils remains an area of focus. Children at the age of 11 are not doing as well as children nationally or as well as children living in similar areas. Disadvantaged children in Central Bedfordshire are not achieving their potential and more than 70% do not achieve the expected standard in Reading, Writing and Mathematics at age 11.

Pressures at home such as family caring responsibilities can negatively affect a child's educational achievement and life chances. There is a consistent volume of requests for young carers support, and between May 2016 and December 2016 145 referrals for young carers support were received. The majority of referrals were with respect to the need for 1-1 support; however, it has been noted that an increasing number of referrals and enquiries are coming from schools regarding young carers affected by parental mental health issues.

Areas for focus:

- Multi-agency integrated early intervention and specialist support for vulnerable families continues to be a priority as children develop. Children are not doing as well in school in Central Bedfordshire compared to children nationally and compared to children in similar areas. Children living in poverty and deprivation in particular are not achieving at school. Key risks in families need to be identified early and receive effective integrated support from a range of services.

5.0 Developing Well

Adolescence is recognised as the most significant time for establishing behaviours that can have long term health impacts, for example smoking, substance and alcohol misuse. Health during adolescence is strongly linked to educational attainment and employment.

- For under 18s, the hospital admission rate due to **alcohol specific conditions** is 24.2/100,000 - significantly better than the national average of 36.6/100,000. (2012/13-2014/15).

- For 15-24 year olds, the rate of hospital admissions due to **substance misuse** is rising in line with the national trend, and is currently 90.2/100,000 - similar to the national average of 95.4/100,000 (2013/14-2015/16).

- In the local schools' survey data (2014) 1% of 12-13 year-olds (Year 8) and 11% of 14-15 year-olds (Year 10) reported that they had 'taken an illegal drug in the last year'.

- 44% of new **sexually transmitted infection** diagnoses were for young people aged 15-24 years (2015). The Chlamydia detection rate per 100,000 for 2015 in Central Bedfordshire was 1,253 per 100,000, which is lower than England rate of 1,887 per 100,000. (Areas not achieving the recommended 2,300 detection rate should aim to increase their rate.)

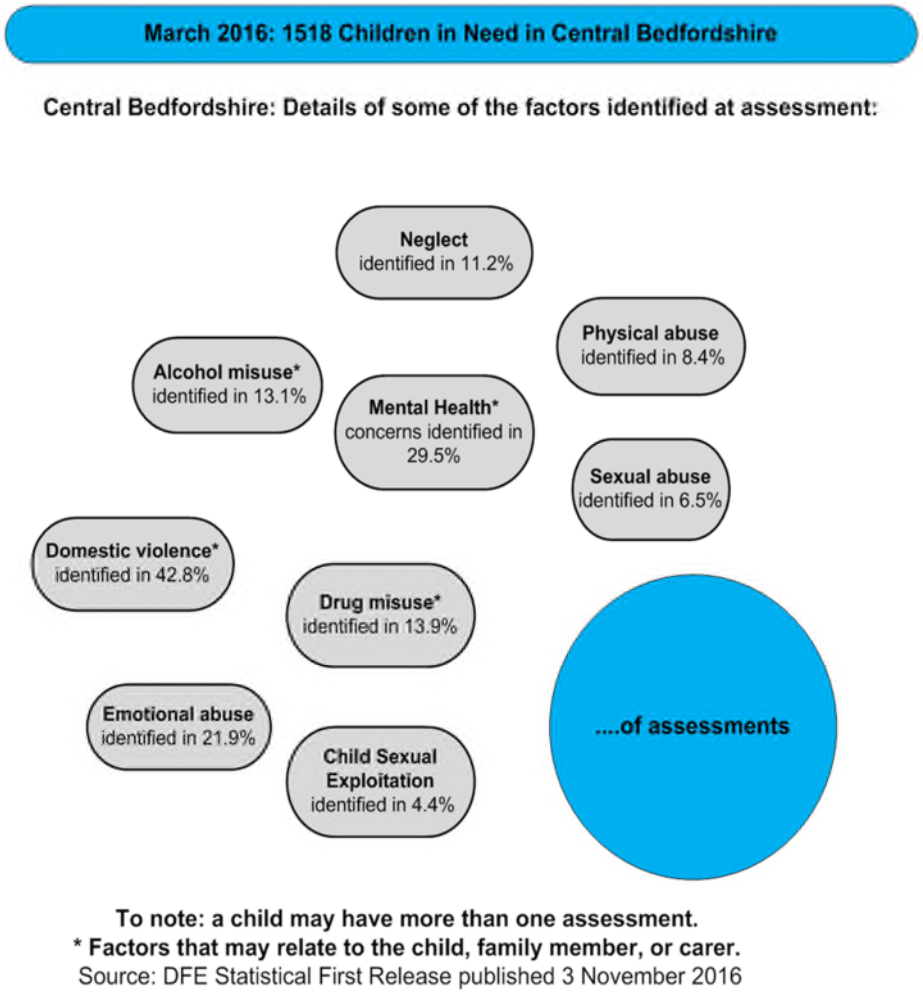
- **Youth offending** is at a low level. There was a significant reduction in First Time Entrants in the 5 year period 2010-2015. Although there has been a small increase in 2015/16, Central Bedfordshire is still performing better than its Family Group, the South East Region and nationally. Central Bedfordshire's reoffending rate for 2013/14 (latest validated data) shows improvement from the previous year (27.8% 2012/13, 27.6% 2013/14). Historically, Central Bedfordshire has had low levels of remand and custody rates but there has been an increase in recent years.

The Starting Well section references **Adverse Childhood Experiences** and provides examples of stressful events that children can be exposed to whilst growing up.

Individuals who experienced four or more Adverse Childhood Experiences have an increased risk of having poorer outcomes as adults e.g. educational and employment outcomes, mental wellbeing, involvement in recent violence and chronic health conditions, and are:

- 4 x more likely to be a regular heavy drinker or smoker
- 9 x more likely to be in prison
- 3 x more likely to be morbidly obese.

A third of children in need (which includes looked after children and children on a child protection plan) are aged 13 and over. Factors at assessment for Children in Need can provide insight into some of the stressful events that children can be exposed to:



For Central Bedfordshire the numbers of all **children in need** and **Looked After Children** are similar to this last time year. The number of **unaccompanied asylum seeking children** has increased from 12.7% (November 2015) to 19.1% (November 2016) of the total Looked After Children population.

There are two key cohorts that drive care entry (those aged 0-1, and those aged 14+ years). 'Abuse and neglect' is the highest primary need for those children referred to Central Bedfordshire Children Social Care.

Recently published national data 2015/16 for children who have been looked after continuously for at least 12 months shows that health measures for Central Bedfordshire's Looked After Children are mostly good (e.g. immunisations, annual health checks and teeth checked by a dentist). There has also been improvement with regard to placement stability, and care leavers engaged in education, training or employment. Educational outcomes for children in need and Looked After Children do however need to be improved.

Evidence from Looked After Children case reviews, and quantitative data suggests that there are a number of core issues that lead to family break down - notably domestic abuse, substance misuse, parental mental health, and disengagement of parents from the support offered and their capacity to effect lasting change. Criminality was also found to be a parental risk factor.

Any child in any community is vulnerable to child sexual exploitation. It is often hidden making prevalence data hard to ascertain.

Given the high national profile of child sexual exploitation, an increase in reporting would be expected in response to national cases e.g. those involving celebrities, or sports personalities coming forward with allegations of historical child sex abuse. Bedfordshire Police sample data suggests the following concerns for Central Bedfordshire:

- Peer on peer
- Older girlfriend / boyfriend model
- Group related child sexual exploitation
- Online grooming

Agencies have referred 21 children to the Child Sexual Exploitation Panel as being at risk of exploitation in Central Bedfordshire during

2015/16, and, to support prevention work there were 21 disruptions carried out by Bedfordshire Police and 5 abduction notices issued.

Areas for focus:

- Vulnerable Children and Young People: All professionals working with children, young people and families must use learning from reviews, audits and inspections to improve practice and outcomes. Progress should be monitored by the Local Children's Safeguarding Board. (Director of Public Health Report).

Mental health and wellbeing:

In Central Bedfordshire it is estimated that 1,640 16-19 year olds have a mental health disorder.

The results of the 2015 Central Bedfordshire Schools' Emotional Wellbeing Survey tell us most children and young people are happy most of the time.

- 70% of male pupils and 50% of female pupils aged 12-16+ said they feel at least 'quite' happy with their life at the moment.
  But:
- 4% of pupils aged 8-16+ said they are 'not at all happy' with their life at the moment.
- 10% of pupils aged 12-16+ said that they find it hard to concentrate on anything due to worries.

Around 38% of Year 8 and 10 males and 20% of Year 8 and 10 females had a high self esteem score in 2014. In 2015, this percentage increased to 47% and 25% respectively. The percentage of Year 8 females with a high self esteem score remained static over this time.

Areas for focus:

- School Years: Schools must be supported to achieve good health, wellbeing and resilience for all pupils, including the most vulnerable, through a whole school approach that includes high quality Personal Social & Health Education, Sex and Relationships Education and Physical Education. (Director of Public Health Report).

Areas for focus:

- Mental Health: Commissioners and providers must work together to ensure that all professionals working with children, young people and families are able to identify mental health issues and refer promptly to accessible, high quality mental health support at the appropriate level. (Director of Public Health Report).

Educational outcomes:

Health during adolescence is strongly linked to educational outcomes, including attainment and employment. Although more children aged 16-18 in Central Bedfordshire are in education, employment or training, they are not achieving the results of children in similar areas at the ages of 15 to 17. They are also not making the progress they should between key stages, and disadvantaged children continue to achieve much lower grades at these ages.

Age 15	**Key Stage 4** 2016 results are reported under a new assessment framework. The average **Attainment 8 score** per pupil is **49.3**. This means in 2016 Central Bedfordshire pupils have achieved **nearly an average 'C' grade** for each of their Attainment 8 subjects. Central Bedfordshire is below the statistical neighbour average (50.7) and above the national average (48.5). 3rd Quartile. The average **Progress 8** score per pupil in Central Bedfordshire is **-0.07**. Central Bedfordshire is statistically significantly below 0 (i.e. the national average). 3rd Quartile. Statistical Neighbour average -0.02. 2016 **Attainment 8 Score gap between Disadvantaged pupils** and all other pupils is 13.4 points (difference of just under 1 ½ grades). Disadvantaged pupils are achieving just under a D grade per subject whereas other pupils are achieving on average just over a C grades per subject. Central Bedfordshire Disadvantaged children have achieved (Progress 8 score) on average of **half a grade** worse per subject than other pupils with the same prior attainment.
Age 16-17	**Key Stage 5** Average point score per entry for all Level 3 qualifications is **30.2**: this equates to an **average C Grade**. Below statistical neighbour (31.2) and national (32.4) averages. 3rd Quartile.
Age 16-18	The percentage of children aged 16-18 who are Not in Education, Employment or Training* is **3.1%** - better than the national (4.2%) and statistical neighbour (3.4%) averages. There has been continued improvement. Top quartile. * Average Nov,15., Dec 15 and Jan 16 Supporting young people aged 18+ who are NEET remains a priority - including where there may be a range of other barriers / issues such as mental health issues that would prevent them from learning.

Attendance at school has a statistically significant impact on attainment and children in Central Bedfordshire have more missed days of school compared to pupils nationally and those living in similar areas. Pupil absence in Central Bedfordshire is 4.7% 2014/15 (Academic Year) and remains higher than Statistical Neighbour (4.4%) and National (4.6%) averages. Key issues include authorised absence (which at 4.0% places Central Bedfordshire in the bottom quartile), absence in primary schools (which at 4.2% places Central Bedfordshire in the 3rd Quartile), and permanent exclusions in primary schools.

Work continues to improve attendance, and educational outcomes at each key stage – (with a particular focus on Key Stage 2 and disadvantaged pupils), and to reduce days lost due to exclusions.

6.0 Living and Working Well

Living well in adulthood is determined a number of factors including wider determinants of health (e.g. environment, housing, education and employment) and individual health behaviours, commonly described as 'lifestyle' factors. Such 'lifestyle' factors include smoking; poor diet, physical inactivity and excessive alcohol consumption, which all contribute to poorer health.

As the adult population spend much of their time in employment, ensuring a healthy workplace, which promotes employee's wellbeing and supports healthy behaviours, is also of great importance.

Premature Mortality

Premature mortality, or early death, refers to the death of an individual before the age of 75 years. Many of the leading causes of premature mortality are preventable, for example cancer, cardiovascular and respiratory diseases, and are strongly linked to health behaviours and the wider living and working environment.

In Central Bedfordshire:

- The premature mortality rate is lower than most other parts of the country (ranked 21st out of 150 Local Authorities) but higher than similar Local Authorities (ranked 14th out 15).
- The premature mortality rate has fallen year-on-year, from 425 per 100,000 in 2000 to 279 per 100,000 in 2014.
- Rates of premature mortality from cancer (lung, colorectal and breast), heart disease, and stroke and lung disease are higher in Central Bedfordshire than similar Local Authorities.

Smoking

Smoking remains the single largest preventable cause of premature mortality in Central Bedfordshire. Smoking causes lung cancer and other respiratory diseases. It is also an established risk factor for other causes of premature death including heart disease and stroke.

In Central Bedfordshire:

- The proportion of adults smoking is falling, with 10.3% of adults estimated to smoke in 2016, compared with 16.7% in 2015 and 18.5% in 2014.
- Large variation in smoking prevalence is observed within the population, with higher proportions of adult smokers in routine and manual occupations (28.1%) compared with the rest of the population.
- Each year the societal costs of smoking in Central Bedfordshire are estimated to be £65.6m, driven primarily by reduced productivity and the costs of treating ill health and subsequent care.

Areas for focus:

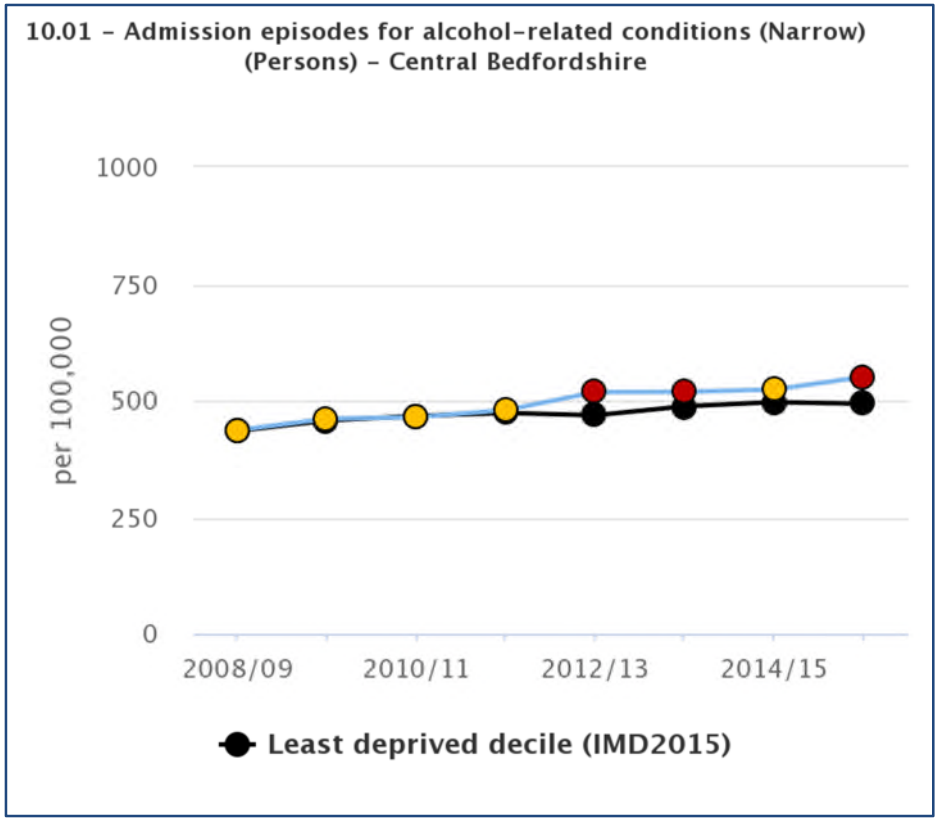
- Support the temporary abstinence for inpatients in Acute and Mental Health settings with the long term aim of stopping smoking all together.

Substance Misuse

The impact of alcohol misuse is far reaching and includes alcohol related harm and mortality, as well as other social impacts such as domestic abuse, violence, teenage pregnancy, lower productivity and increased risk taking behaviours.

In Central Bedfordshire:

- Alcohol related admissions continue to rise, with admission rates significantly worse than its statistical neighbours.



- Using the narrow definition, alcohol-specific admissions increased from 1,019 in 2008/09 to 1,446 in 2015/16.
- Both alcohol-specific mortality and alcohol-related mortality in are significantly better than the England average.

Drug misuse is associated with a wide range of physical and psychological conditions, and the detrimental consequences of this behaviour are often far reaching across society.

In Central Bedfordshire:

- 8.5% of opiate users accessing treatment in 2015 successfully completed and left drug free, compared with 6.7% in England
- 28.1% of non-opiate users accessing treatment in 2015 successfully completed and left drug free, compared with 37.3% in England.
- Successful treatment rates for both opiate and non-opiate users have fallen since 2014, although the reductions have not been significant.

Areas for focus:

- Ensure people drinking at increasing or higher risk are identified and supported early by a systematic roll out of Identification and Brief Advice and NHS Health Checks (GPs, and frontline staff)

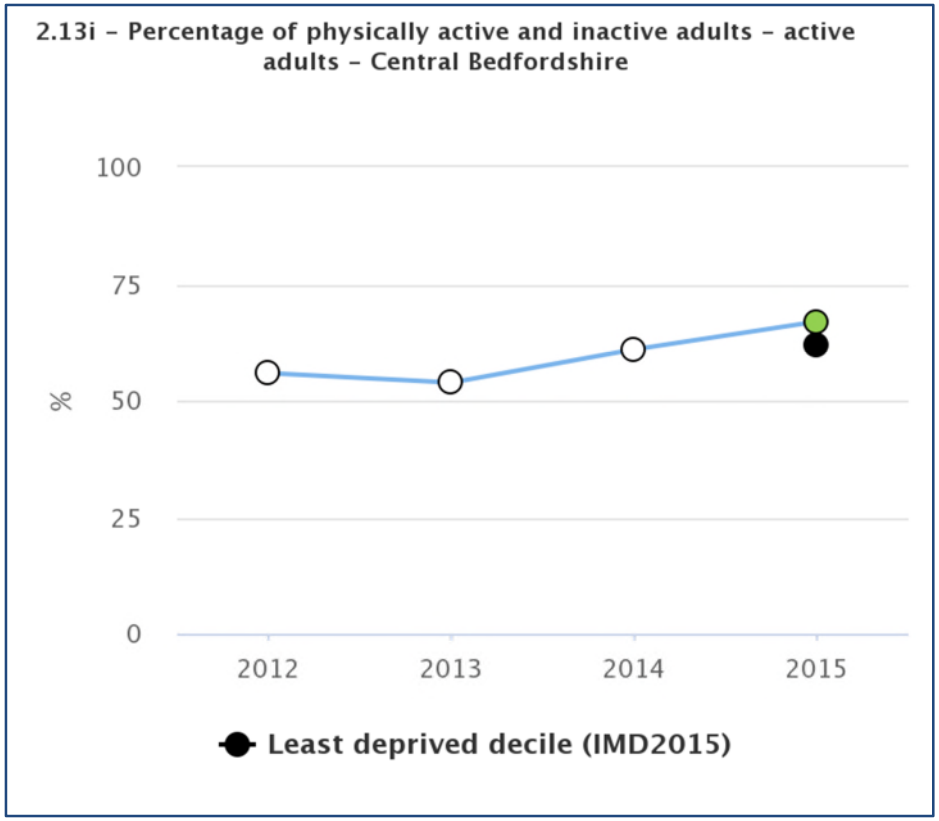
Healthy Weight & Physical Activity

Maintaining a healthy body weight in adulthood relies upon eating a healthy diet and undertaking moderate and regular physical activity.

The additional benefits of being physically active include the prevention of ill health and premature mortality, improved mental health and self-reported wellbeing, the delay in the need for care in older adults, and the reduction of health inequalities.

In Central Bedfordshire:

- Between 2013 and 2015 a higher proportion of adults (67.1%) were classified as being overweight or obese compared with the England average (64.8%).
- A higher proportion of the adult population (66.9%) are classified as physically active compared to its statistical neighbours.
- However more than 1 in 5 adults do less than 30 minutes of physical activity per week



Areas for focus:

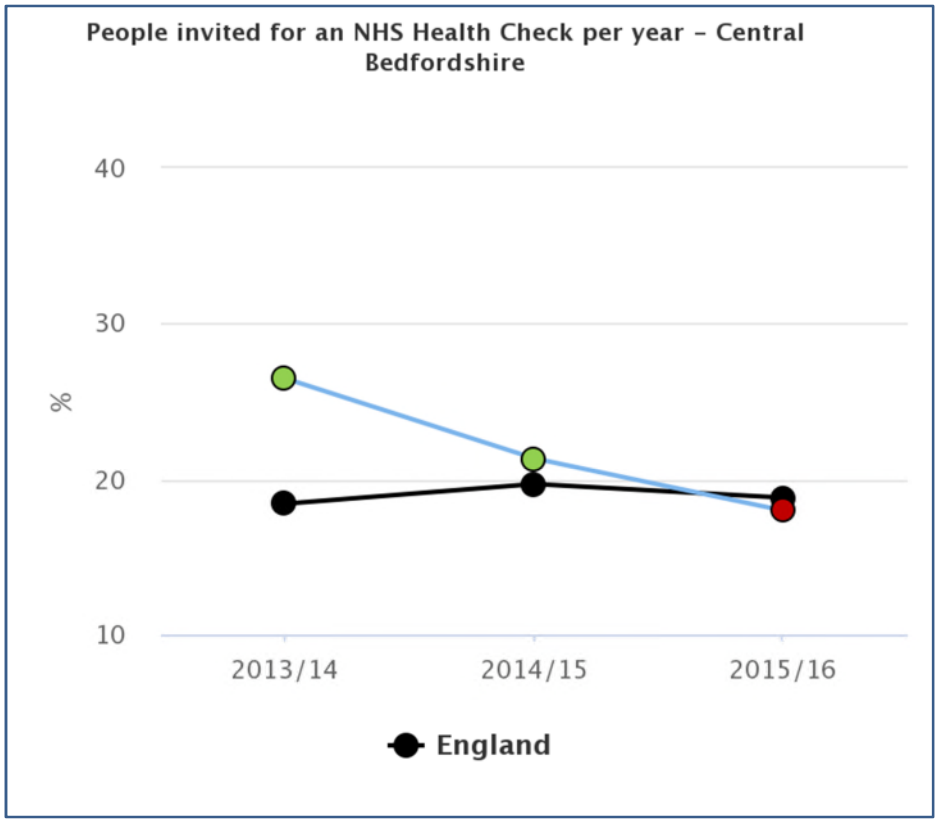
- Concentrate on increasing physical activity in groups that are less likely to be active including women and girls, people from lower socio-economic groups, older people, disabled people and those with or at greater risk of long-term health conditions.

NHS Health Checks

The NHS Health Check programme aims to prevent heart disease, stroke, type 2 diabetes and kidney disease, and raise awareness of dementia. Local authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74 years once every five years.

In Central Bedfordshire:

- The number of people invited for a NHS Health Check continued to fall in 2015/16 to 14,810 from 17,281 the previous year, and is now significantly lower that the England average.



Areas for focus:

- Increase the accessibility of Health Checks to those of working age with a focus on those at highest cardiovascular risk and providing good quality and onward referrals to relevant lifestyle services.

Screening programmes

National cancer screening programmes operate across Central Bedfordshire, with the aim of ensuring early detection of breast, cervical and bowel cancer in adults.

In Central Bedfordshire:

- In 2015/16, screening uptake for Diabetic Eye Screening, Breast Screening, Bowel and Cervical screening in women age 50-64 years all met the required national minimum standards of 80%, 70% and 52% and 80 respectively.
- The abdominal aortic aneurysm (AAA) screening programme achieved 81.2% in 2015/16, meeting the required target 75%.

Areas for focus:

- Increase Cervical Cancer screening uptake among 25-49 year old women.

Cancer

Newly diagnosed cancers in Central Bedfordshire:

- A total of 686 men and 656 women were newly diagnosed with cancer in 2014.
- The incidence is slowly increasing mainly as a result of our population ageing.
- In 2014 the most common cancer diagnoses were prostate (30%) and colorectal (13%) in men and breast (29%) and colorectal (13%) in women.

Premature cancer mortality in Central Bedfordshire:

- Premature mortality from cancer in Central Bedfordshire is falling and 202014 was 140 deaths per 100,000 for men and 115 deaths per 100,000 for women.
- The most common cancers resulting in death in those aged 75 years or under were lung, colorectal, oesophageal and prostate cancers for males and breast, lung, ovary and colorectal cancers for females.

Cancer survival in Central Bedfordshire:

- Cancer survival rates are increasing in line with the national trend.
- In 2014, 57.9% of cancer diagnoses were made at an early stage, better than the rate in similar local authorities (51.7%).

Areas for focus:

- Increased awareness by the commissioners of those patients with poor health and disability as a result of side effects of cancer treatment
- Continued emphasis on the delivery of an effective stop smoking service

Cardiovascular disease and diabetes

Hypertension (high blood pressure) is an important risk factor for cardiovascular disease:

- In 2014/15 there were 35,150 people in Central Bedfordshire with diagnosed hypertension, but prevalence estimates suggest that there may be a further 24,570 adults with undiagnosed hypertension.
- In 2013/14 79.8% of patients with hypertension received lifestyle advice in the past 12 months, although this varied by GP practice, ranging from 63.5% to 98.2%.
- In 2015/16 80.7% of patients with hypertension had their blood pressure well controlled (<150/90 mmHg).

Coronary heart disease in Central Bedfordshire:

- In 2016 a total of 8,615 people (3.0% of the population) had a recorded diagnosis of Coronary Heart Disease (CHD).
- Premature mortality is higher compared with statistical neighbours.

Stroke in Central Bedfordshire:

- In 2015/16, the diagnosed prevalence was 4,420 (1.5%).
- The proportion of patients with a diagnosed stroke whose blood pressure was above 150/90mmHg (a risk factor for further complications) has remained stable at 16%.

Atrial fibrillation (AF), a form of irregular heartbeat, is an important risk factor for stroke that can be treated effectively with medication.

- In 2013/14 there were 3,902 people in Central Bedfordshire with diagnosed AF, but prevalence estimates suggest that there may be a further 2,052 people

Areas for focus:

- Bedfordshire CCG is currently reviewing all clinical pathways scheduled for completion mid 2017. At which point, a full analysis of service provision, gaps and service needs will be summarised and shared with system partners.

Diabetes

Diabetes in Central Bedfordshire:

- The prevalence of diagnosed diabetes in adults aged 17 years and older has continued to rise and in 2015/16 was 6.0%.
- Estimates suggest there are 2,850 people with undiagnosed diabetes.
- The prevalence of diabetes is higher in areas with higher deprivation, and people from Asian and Black ethnic groups are more likely to have diabetes and develop the condition earlier.
- 67.9% of patients with Type 2 diabetes received the eight recommended care processes in 2015/16, which is higher than the national average (53.9%); but only 38.1% achieved the treatment targets for blood glucose, blood pressure and cholesterol, which is lower than the national average (40.4%).
- 89.2% of patients with diabetes diagnosed in 2014 were offered a structured education course (compared to 81.3% nationally) and 17.0% attended a course within 12 months (national average 7.

Areas for focus:

- Improve the early identification of high blood pressure, atrial fibrillation and diabetes, including non-diabetic hyperglycaemia ('pre-diabetes').
- Increase the availability and participation in structured education programmes for the management of long term conditions.

Respiratory disease

Chronic Obstructive Pulmonary Disease (COPD) is an umbrella term that includes chronic bronchitis and emphysema. This disease is predominantly caused by smoking.

In Central Bedfordshire:

- The prevalence of COPD was 4,945 (1.7%) in 2015/16, an increase since 2010/11.
- This increase is mainly due to the ageing population, as COPD is strongly associated with age.

Mental health

One in four adults will experience mental illness at some stage in their life, with one in six suffering mental illness at any given point in time. Mental wellbeing is a fundamental component of overall health, and it is fundamentally related to physical health.

Mental illness affects many people across all ages and for 75% of people with a lifelong mental illness their symptoms started before their mid-twenties with 10% of 15-16 year olds experiencing mental illness.

In Central Bedfordshire:

- The number of men aged 18-64 who have a common mental disorder (e.g. anxiety, depression, obsessive compulsive disorder) is projected to rise from 10,075 in 2014 to 10,075 in 2030 – an increase of nearly 10%.
- For women the number is projected to rise from 16,115 in 2014 to 17,454 in 2030 – an increase of 8%.

Areas for focus:

- Continue to promote 5 Ways to Wellbeing.
- Ensure good access to healthy lifestyle support for people with mental illness to improve their physical health.

Sexual health

Good sexual health is important to individuals and to society. The prompt diagnosis and treatment of individuals with a sexually transmitted infection (STI), and the identification and treatment of infected sexual partners, reduces the duration of infection, onward transmission and the possible complications of untreated infections.

As STIs are often symptomless and regular testing is important for individuals in higher risk groups. Early detection and treatment can reduce onward transmission and long-term consequences, such as infertility and ectopic pregnancy.

STIs in Central Bedfordshire:

- Rates of newly diagnosed STIs have continued to fall with 1,215 new sexually transmitted infections diagnosed in 2015.
- This represents a rate of 451.4 per 100,000 compared to the England rate of 767.6 per 100,000.

Gonorrhoea in Central Bedfordshire:

- While the overall rate of STI diagnoses has fallen the rate of gonorrhoea diagnosis has doubled since 2012: from 40 cases per 100,000 to 82 per 100,000.
- This remains similar to the East of England rate and significantly lower than the national rate, both of which have also increased over the same time period.

HIV in Central Bedfordshire:

- The number of prevalent cases of HIV in Central Bedfordshire has risen steadily from 177 in 2011 to 221 in 2015.
- The number of people newly diagnosed with HIV infection has fallen from 36 in 2012-2014 to 30 in 2013-2015, which is lower than the national average.
- The number of late diagnoses has decreased from 17 in 2012-14 to 15 in 2013-15; however, the proportion of cases diagnosed late has increased from 47.2% to 50%.
- HIV testing coverage (the proportion of people who access genitourinary medicine services who accept an HIV test) in Central Bedfordshire improved from 74.2% to 77.6% in 2015.

Areas for focus:

- Improve the accessibility of STI and HIV screening in Central Bedfordshire, with a continued focus on increasing the coverage and detection rate for chlamydia

Respiratory Infections

The flu immunisation programme offers protection against the effects of flu to as many eligible people as possible, particularly those at greatest risk of complications including: people aged 65 years and over (including care home residents), pregnant women and those aged under 65 with long term conditions.

Seasonal flu uptake in Central Bedfordshire:

- In 2015/16, all eligible groups had small but non-significant drop in uptake compared with the previous year.
- Central Bedfordshire is the best performing local authority in the East of England for all eligible groups except those aged under 65 with long term conditions.

- Mid-programme uptake in 2016-17 shows improvement in most categories, however there is significant variation between GP practices.
- This variation is independent of practice-level deprivation, and indicates inequality in the protection of groups of vulnerable patients against seasonal influenza.

Areas for focus:

- Improve the targeted delivery of vaccination for individuals at risk from seasonal influenza and also among front-line health and social care workers.

7.0 Ageing Well

What is Ageing Well?

Ageing well is about helping older people to live active, healthy lives and limiting deterioration and illness. Ageing well should also minimise the impact of and proportion of life spent in ill health to enable people to remain in their own homes and independent for as long as possible, reducing the need for acute treatment and social care.

Social isolation

Social isolation can have damaging effects on physical health and mental wellbeing, especially with age. Conversely, the prevalence of long term conditions, physical and mental frailty can lead to social isolation as people lose confidence and face deteriorating mobility. Unsuitable housing can further isolate people within their homes.

In Central Bedfordshire:

- Over half of the population live in a rural setting, which can increase social isolation and make it harder to access local services or find opportunities for social interaction.
- Since 2010-11, the percentage of adult social care users who have as much social contact as they would like has gradually increased from 38.6% to 44.9% in 2015-16.

Areas for focus:

- Review existing council-delivered day care services to enhance their ability to combat social isolation.
- Ensure that support organisations such as the Silver Line are aware of local resources and signpost vulnerable people to these.

Dementia

Dementia is a set of progressive symptoms associated with an ongoing decline of the brain and its abilities. This includes problems with memory loss, thinking speed, mental agility, language, understanding and judgement. Under the age of 75 years, dementia mainly affects males, while over the age of 75 years females are most affected.

However, dementia is not just part of growing old. It is caused by diseases of the brain, the most common of which are Alzheimer's and vascular disease. According to the Alzheimer's Society one in three people over 65 will develop dementia, and two-thirds of people with dementia are women. The number of people with dementia is increasing because people are living longer.

In Central Bedfordshire

- In 2015, it was estimated that there were 3,000 people with dementia, including almost 300 people under the age of 65.
- Of these, 1,700 are predicted to have mild dementia, 1,000 moderate dementia, and 350 severe dementia.
- By 2030, it is estimated that there will be 5,400 people with dementia, an increase of 67%.
- It is estimated that 208 people are diagnosed with dementia via the memory assessment service in Central Bedfordshire every year.

Areas for focus:

- Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group can be a catalyst for dementia friendly communities. This could include:
- Increasing awareness of preventive measures e.g. linking dementia to existing key public health campaigns and services.
- Increasing awareness of dementia across public services and with private organisations.

Under-detection of mental illness in older people is widespread, due to the nature of the symptoms, the belief that it is an inevitable consequence of aging, and the fact that many older people live alone. Older people are at an increased risk of depression due to factors such

as retirement, social isolation, bereavement and, long-term illness and disability.

Depression in people aged 65 and over is under-diagnosed and this is particularly true of residents in care homes where symptoms of depression are present in between 20–50% of residents.

Areas for focus:

- Review equity of access to psychosocial interventions for older people, ensuing support for those individuals with long term conditions and further increase integration with physical health care.
- Development a system-wide model for liaison psychiatry in the hospital setting in order to recognise and treat mental health problems alongside physical health ones.

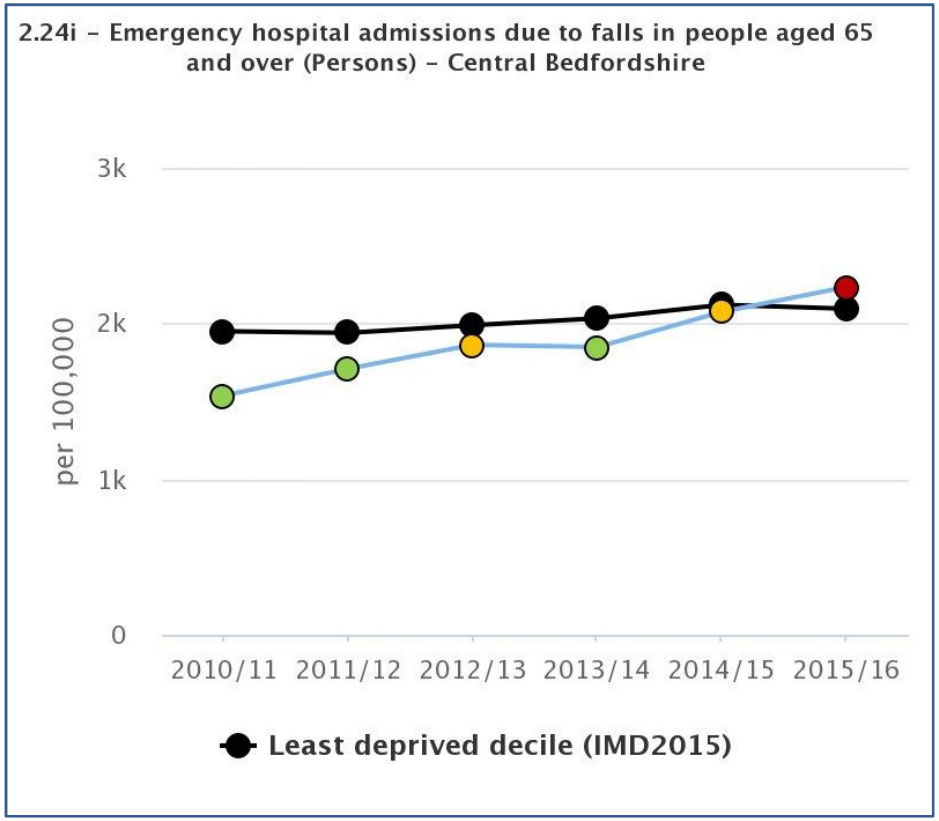
Falls and hip fractures

Falls are a major cause of disability and the leading cause of injury related mortality in people aged over 75 years, and osteoporosis increases the likelihood of serious injury. Up to 10% of falls are likely to result in serious injury, of which 5% are fractures.

A hip fracture remains the most common cause of accident related death, with an increased 1 year mortality of between 18% and 33%. One in every twelve patients will die in the first month following injury; approximately half of hip fracture patients who were previously independent will become partly dependent; and one third will become totally dependent. Approximately 20% of older people that suffer a hip fracture enter long-term care in the first year after fracture.

In Central Bedfordshire:

- In 2015, approximately 12,205 people aged 65 and over were estimated to have had a fall. It is important to note that this is the number of people that fall and not the number of falls.
- Since 2010-11 injuries due to falls in people aged 65 and over have risen. Consequently, Central Bedfordshire has fallen from being significantly better than the England average to being statistically similar.



Areas for focus:

- Ensure statutory and voluntary service providers work together to develop and implement falls and fragility fracture care pathways and initiatives that prevent, identify, assess and treat falls and fractures in a consistent and timely manner.

Excess Winter Deaths (including fuel poverty)

Excess Winter Deaths is a statistical measure which quantifies the seasonal peak in illness and death that occurs during the winter months. It can be expressed as the number of extra people who have died in comparison to the number of deaths that occur at other times of the year.

In Central Bedfordshire:

- 191 extra deaths occurred during the winter months of 2014/15 compared to the rest of the year.
- Whilst there has been a continual increase in excess winter deaths since 2010/11, this upward trend has been in line with the England average.

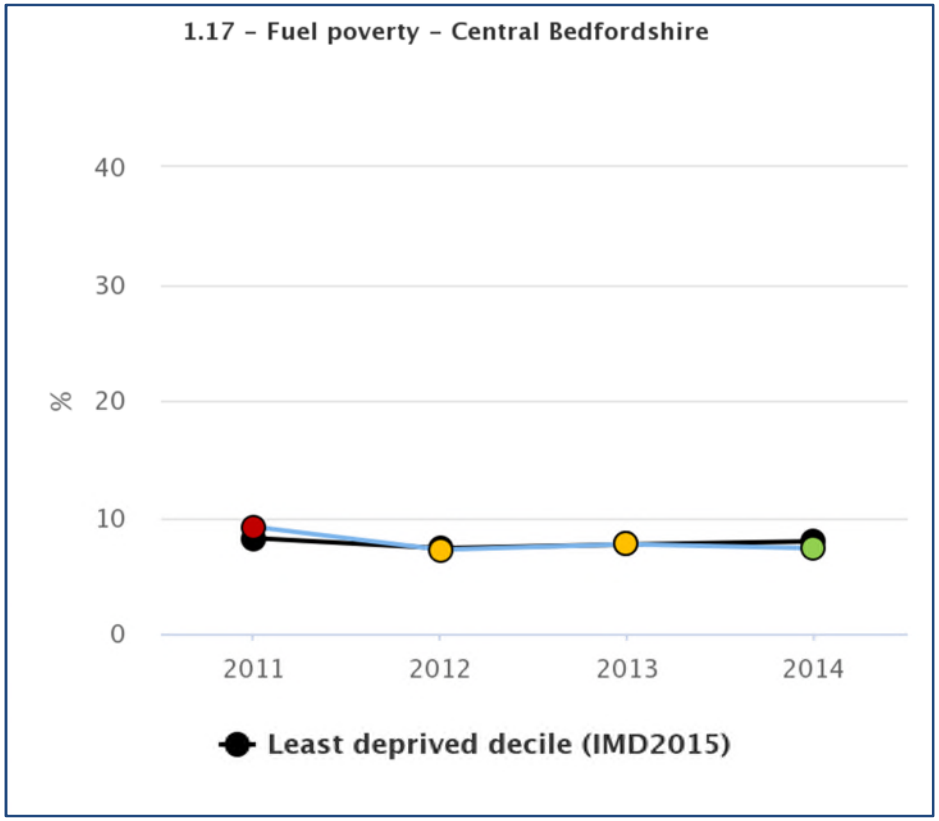
The majority of excess winter deaths in Central Bedfordshire occur in the 65 to 84 age group, but people 85 years and over are disproportionately affected.

Given that the over 65 population of Central Bedfordshire is expected to increase by 58% by 2021, it is reasonable to assume that the number of excess winter deaths will also increase substantially if action is not taken to address the root causes.

Fuel poverty is more likely to be experienced by people over pensionable age, though other risk factors include people with a disability, younger people who live alone and homelessness.

In Central Bedfordshire:

- 7.3% of households experience fuel poverty which is significantly better than its statistical neighbour.
- However, inequalities exist between the most deprived households (13%) and the least deprived.



Flu vaccination is another key preventative measure and yet in 2014/15 some 30,000 people who were eligible for the flu vaccination in Central Bedfordshire did not take up the offer.

Housing in Later Life

For an older person suitable housing can be a very significant contributor to ageing well. Homes in which older people have successfully raised a family can become a burden in later life but those who wish to move to more suitable homes (often referred to as 'downsizers') often struggle to find something suitable, especially if they are keen to stay in a particular locality in order to retain existing

social contacts. There is now good evidence that in later life unsuitable housing can contribute to physical and social isolation, the consequences of which can be an avoidable deterioration in both physical and mental health.

To address these and other issues, a range of solutions is required and during 2016 Central Bedfordshire Council published its Investment Prospectus for Meeting the Accommodation Needs of Older People which sets out for the first time the range of accommodation required in each locality in the period to 2020.

Areas for focus:

- Bring to fruition further extra care schemes in Central Bedfordshire
- Continue programme to modernise capacity in the care home sector in Central Bedfordshire

8.0 Particularly Vulnerable Groups - Adults

Some adults are more vulnerable to poor health or outcomes than others. Evidence suggests that some groups and communities such as those depicted below in Central Bedfordshire have a greater vulnerability to poor health.

The health and social care needs of vulnerable groups are often complex and require a co-ordinated and flexible response from services given such needs often overlap and can be highly specific. Hence, it is easy for clients to fall into the gaps between different services leading to unplanned care and the risk of clients revolving through the system.

But what do we mean by vulnerability?

Vulnerability is fluid, often depending on circumstances and can change through time. It is more to do with a mixture of characteristics and conditions which increases susceptibility to poorer health and difficulty accessing services. People who are vulnerable often experience multiple, complex problems and enduring disadvantage.

A more sophisticated way of tackling vulnerability is required. Focusing on the causes of vulnerability and ensuring the whole health and social care system provides equitable care focused on the individual will be the most effective ways of reducing inequalities in health.

Safeguarding Vulnerable Adults

People with care and support needs relating to physical disability, mental ill health, learning disability or needs related to substance use, and are vulnerable to abuse or neglect because of these needs. They may not always be in receipt of services from adult social care or health services, and may be more or less vulnerable to abuse or neglect at different times in their lives. The number of people subject to a safeguarding enquiry at any one time accounts for less than 2% of those known to adult social care.

In Central Bedfordshire:

- During 2015/2016, there was a sharp increase of reporting of concerns about individuals.
- During 2015/16, there were 330 safeguarding investigations compared to 238 in the previous year, an increase of 92 enquiries.
- Furthermore, 2015/16 saw a reverse in the downward trend between the number of safeguarding alerts and referrals to safeguarding investigations received since 2010/11.
- The majority of incidents continue to occur in the person's own home. The proportion of incidents in 2015/16 increased to 58% from 57% in 2013/14.
- Incidents occurring in care homes also increased by 1% during 2015/16.

The majority (85%) of safeguarding alerts and referrals received during the year continue to relate to White British people, with the majority of those at risk being female. This broadly reflects both the demography of Central Bedfordshire and the proportion of people using care services.

Areas for focus:

- Consideration should be given to the availability of counselling or other post abuse support services that can be easily accessed by people with care and support needs
- The significance of social isolation and its potential to exacerbate people's vulnerability to exploitation and abuse by other members of the community should be considered by all commissioning organisations

Adults with Learning Disabilities

Learning Disability is a life-long condition with a wide spectrum of need, which can range from mild to very complex and profound, requiring continual care and support. A person with learning disability needs may also have a 'secondary diagnosis' which can include any

combination of mental health, autism, physical disability, sensory disability, or other complex health conditions such as epilepsy, and may require continual and ongoing care and support to live with these conditions throughout their life. Some people with a learning disability may display challenging behavior which can have a negative effect on them and their families.

In Central Bedfordshire:

- There were 4,885 adults estimated to have a learning disability, approximately 1.8% of the local population in 2015, which is below the national prevalence of Learning Disabilities of 2.4% per local authority.
- However, the Learning Disabilities prevalence is expected to rise to 5,796 by 2030 an estimated increase of 2.2%.
- Approximately 70 young people are expected to transition into adult services each year.
- The number of children and young people with severe and complex conditions who are surviving into adulthood is increasing and require support when preparing for adulthood and transitioning into adult services.
- 592 people with a Learning Disability in receipt of a paid service will have had an up to date health passport and will have had an annual health check completed by their GP.

To ensure a systematic method of identifying the unmet health and social care needs of people with learning disabilities, an updated Learning Disabilities' Health Needs Assessment is being undertaken.

Areas for focus:

- Prioritise local health and care services to reshape the profile away from residential care and reliance on secondary acute services to more community based and independent living options.
- Plan for young people with learning disabilities as they move from children's services to adult services

Carers

Carers are people who spend a significant proportion of their life providing unpaid support to relatives, partners, friends or neighbours who are ill, frail, disabled or who have mental health or substance misuse problems. Carers are also parents or guardians of children with a disability, as well as elderly people.

Central Bedfordshire Council offers a number of statutory services to carers, alongside Carers in Bedfordshire who offer a number of services to adult carers (including parent carers) and sibling carers.

In Central Bedfordshire:

- There are an estimated 28,000 carers and shows that the local carer population mirrors that of the national picture with approximately 10% of people being unpaid carers.
- In 2014/15, the number of carers supported locally by Central Bedfordshire Council (1,446) and Carers in Bedfordshire (3,421) totalled 4,867.
- Only 41% of carers reported that they had the social contact they would like. Although this represents a decrease since 2012/13, it remains similar to the national average

It is also very important to recognise "hidden" carers – those that are unknown to the NHS or Social Services. GP surgeries and/or hospitals are usually the first place that carers have contact with the NHS. Work has been undertaken to highlight help for carers in GP surgeries across the locality.

With insufficient support for their own mental health and wellbeing, carers may have to stop their caring role, and this in turn will impact on health and social care services replacing the carer's role with paid carers. An area of increasing need is carers who are becoming older themselves. Older carers may be managing their own health issues and disabilities and they may also have care and support needs. This group, typically, provide more care hours per week than those in a younger age range.

More people born with disabilities and those surviving serious illnesses are living longer. This, together with an ageing population and longer life expectancies generally, is reflected in the rapidly growing number of people caring for others as well as a growth in the number of hours of unpaid care they provide

Areas for focus:

- Continue to identify hidden carers through awareness raising in the community and in GP practices.
- Support carers to consider their own health and wellbeing, to enjoy an active fulfilled life alongside their caring role and to be able to take regular breaks from caring.
- Increase information and support to enable older carers to plan for the future particularly when they are unable to care any longer

Physical Disabilities and Sensory Impairment

A disability and or a sensory impairment can significantly impact on an individual's daily living from requiring additional personal support to access issues.

The term disability covers a wide range of impairments. The World Health Organisation describes the term disability as "an umbrella term, covering impairments, activity limitations, and participation restrictions".

Physical disability in Central Bedfordshire:

- In 2015, there were an estimated 13,200 residents aged 16-64 with a moderate physical disability and 3,900 with a serious physical disability.
- These numbers are likely to increase in line with the ageing population. By 2030 these numbers are predicted to be 14,500 and 4,400 respectively.
- In 2015, an estimated 8,100 people aged 65 and over were unable to manage at least one basic activity on their own including going to the toilet and getting in and out of bed.

Sensory impairment in Central Bedfordshire:

- In 2016, an estimated 8,000 people (3.0% of the total population) were living with some degree of sight loss that had a significant impact on their daily lives, compared with 3.1% of the England population.

Hearing impairment in Central Bedfordshire:

- In 2015, approximately 19,000 people aged 65 years and over and 7,000 aged 18-64 had a moderate, severe or profound hearing impairment.

People with disabilities are more likely to experience a range of barriers including:

- Social prejudice and discrimination
- Unfair treatment at work and in the labour market
- Potential difficulties accessing services including public, commercial and leisure
- Difficulties with physical accessibility to buildings and transport

Also research suggests that people with disabilities are at an increased risk of developing other health problems such as mental health issues including depression and anxiety.

Areas for focus:

- Prioritise local health and care services to reshape the profile away from residential care and reliance on secondary acute services to more community based and independent living options.
- Work jointly with health services to reduce health inequalities for people with learning disabilities.
- Plan for young people with learning disabilities as they move from children's services to adult services.

Autistic Spectrum Disorder & Asperger's Syndrome

Autistic Spectrum Disorder or Autism is a lifelong, developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them.

In Central Bedfordshire:

- In 2015, 1,672 adults aged 18 to 64 are on the Autistic Spectrum, and set to increase by 3.9% to 1,737 by 2030.
- 139 people with Autism may also have a learning disability or mental health issue as an additional area of need.

In 2016, following an evaluation of all services available to people on the autistic spectrum through the Department of Health (DH) and Association of Directors of Adult Social Services (ADASS) Annual Autism Joint Self Assessment Framework process, key areas for improvement to our local services have been highlighted, these include:

- Improvement to the collection of data on older people with Autism, those in the BME community and women.
- Identification of unmet need particularly for people who have Autism without a learning disability or mental health issue.

To ensure a systematic method of identifying the unmet health and social care needs of people with Autism, an updated Autism Health Needs Assessment is being undertaken.

Areas for focus:

- Ensure adults with autism receive a timely diagnosis and the necessary post diagnostic support.
- Ensure the particular needs of women, the BME community and older people with Autism are taken into account.
- Ensure transition processes take into account the particular needs of young people with Autism.

Homelessness

Homelessness is not just a housing problem. It has a deep impact on health, employment opportunities, and educational achievement. For most people who become homeless their lack of accommodation is a symptom rather than a cause social exclusion. "The homeless" are not a homogenous group. In many cases, homelessness will be a phase in a person's life.

Despite this, poor access to services such as health care negatively impacts upon the health of people who have been homeless. Compared to the general population, homeless people experience poorer health outcomes. Physical health, drugs, alcohol, mental health and wellbeing have been recognised as priority health issues among people who have experienced homelessness. Such outcomes can lead to a cycle of repeat homelessness.

Statutory Homelessness in Central Bedfordshire:

- For those who meet the statutory definition of being in "priority need", the law provides a safety net so that they may not actually become roofless before accommodation has to be provided.
- Homelessness acceptances increased by 1.85% between 2014/15 and 2015/16 whilst the number of homelessness decisions fell by 3.5% during the same timeframe.
- Current indications for 2016/17 are that the number of decisions is likely to increase slightly whilst homelessness acceptances are likely to be lower than 2015/16.
- Over the past four years the number of cases where homelessness has been prevented has reduced year on year.

There is no requirement for the Local Authority to provide accommodation for those who are not in "priority need". Single people who are not vulnerable are at risk of having no accommodation and sleeping rough.

Temporary Accommodation in Central Bedfordshire:
Nationally the total number of households in temporary accommodation on 30 September 2016 was 74,630, up 9% on a

year earlier, and up 55% on the low of 48,010 on 31 December 2010. Following the national trend,

- Has seen increases since 2014/15 which mirrors the national trend.
- Increased throughout 2016 to an all time high of 101 cases by December 2016.

A strategy for purchasing good quality temporary accommodation remains a focus and has mitigated further increases. Numbers residing in temporary accommodation are anticipated to fall further with a number of purchases in the pipeline.

Rough Sleeping in Central Bedfordshire:

- Have increased from 10 in 2015 to 19 in 2016.
- Rough sleepers do not commonly die as a result of exposure or other direct effects of homelessness, they die of treatable medical problems such as HIV, respiratory disease and acute and chronic consequences of drug and alcohol dependence.
- Single rough sleepers are much more likely to die young than people who are not homeless. The average age of death of a homeless person is 47 years old and are over 9 times more likely to commit suicide that the general population.

The homeless are not a homogenous group. Their needs require different commissioning responses. People who are homeless, or at risk of homelessness, can include people with substance misuse problems, mental health issues or learning disability. Also included may be ex-offenders, those recently released from prison, older people, younger people (at risk, leaving care or teenage parents), migrants, refugees or asylum seekers and those experiencing or having experienced domestic violence. One person may fall into one or several client groups and move between groups.

Areas for focus:

- Work with Luton, Bedford Borough, & Milton Keynes to Implement the Government grant funded Rough Sleeper outreach service across the Sustainability Transformation area for 17/18 and 18/19. The funding is focused on addressing the link between rough sleeping and complex mental health issues.
- Follow enactment of the Homelessness Reduction Bill, ensure services are in place to meet the new duties for preventing and reducing homelessness, particularly for those who may not previously have been owed a rehousing duty under the current statutory provisions.

A great place to live and work

Contact us…

by telephone: 0300 300 5320
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on the web: www.centralbedfordshire.gov.uk
Write to Central Bedfordshire Council, Priory House,
Monks Walk, Chicksands, Shefford, Bedfordshire SG17 5TQ

CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of Meeting 12 July 2017

Enabling People to Stay Healthy for Longer – Reducing Excess Weight

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

Advising Officer: Celia Shohet, Assistant Director of Public Health
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Public

Purpose of this report

1. To receive an update on the actions being taken to reduce excess weight particularly in the context of reducing the prevalence of diabetes.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. **endorse and support the actions to deliver the Excess Weight Partnership Strategy (EWPS) 2016 -2020 which will help reduce the prevalence of diabetes; and**

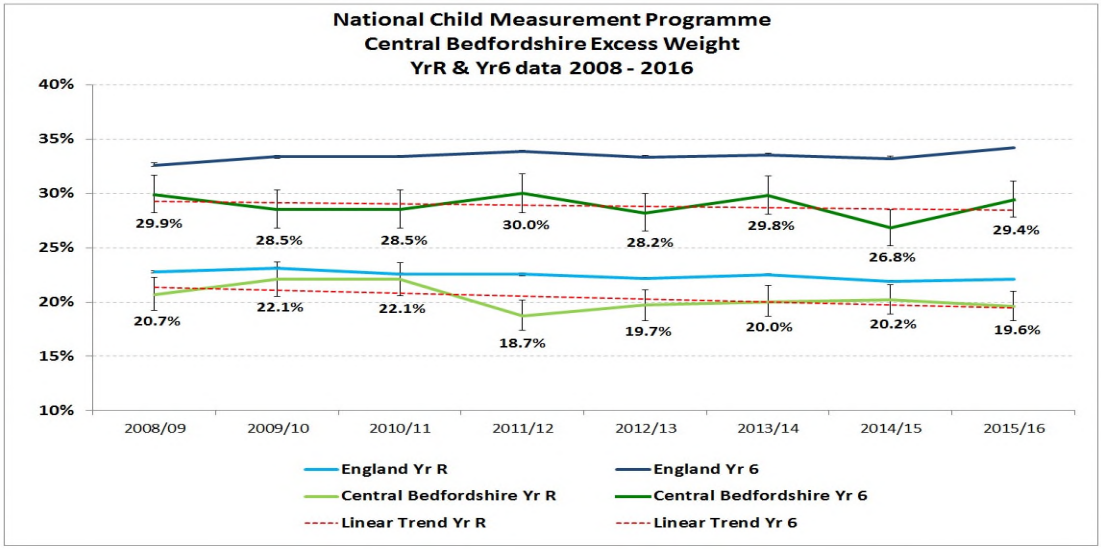
2. **provide leadership by promoting the actions outlined in the EWPS, by acting as positive role models, providing healthy workplaces for employees and by ensuring that relevant commissioned services support residents to achieve a healthy weight.**

Issues

Prevalence of Excess Weight in Adults and Children

2. The England average for excess weight in adults is **64.8%** but in Central Bedfordshire this figure is **67.1%.** Almost 1 on 4 adults (**24.2%**) are obese.

3. The trend for excess weight in children aged 4-5 remains stable, however there is a slight increase in the excess weight levels of children aged 10 – 11.



NCMP Excess Weight YrR & Yr6 2008 – 2015.

Targets for reducing excess weight

4. The target for excess weight is a 1% reduction year on year across the 4 years of the Strategy. This would mean that by 2020 the percentage for adult excess weight would be 65.1% and is currently on track to be achieved.

5. The challenging targets for excess weight in children for the school year 2016/17 is 18.8% for Year R (4 -5 year olds) and 27.3% for Year 6 (10 – 11 year olds) The data will be publicly available in December.

The relationship between excess weight and diabetes

6. 6% of Central Bedfordshire's adult population have been diagnosed with diabetes and if current trends in the size of population and levels of obesity continue the total prevalence of diabetes is expected to rise to 7.3% by 2020 and 8.3% by 2030.

7. The latest health survey for England showed that the prevalence of both diagnosed and undiagnosed diabetes rose with BMI, from 3% of normal weight adults, to 15% of obese adults.

8. Obesity is the most potent risk factor for Type 2 diabetes. It accounts for 80– 85 per cent of the overall risk of developing Type 2 diabetes.

9. There is also a strong relationship between excess weight and the management of diabetes, making it more challenging to achieve treatment targets if an individual remains overweight or obese.

Update on the Excess Weight Partnership Strategy 2016 – 2020

10. The Excess Weight Partnership Strategy has 4 priorities each has outcomes with multiple actions and initiatives that partners have identified to support a reduction in excess weight in adults and children across Central Bedfordshire.

11. Examples of some of the areas of focus over the last year are outlined below.

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

12. The planning development management team has received Health Impact Assessment (HIA) training and is working with public health to ensure that an HIA is submitted on all applications for new developments of 200+ dwellings.

13. The Transport department successfully bid, from the Department for Transport (Bedfordshire STARS project) to fund a health based sustainable travel programme, which will enable the Sustrans 'Bike It' programme to continue for another year when their contract with Public Health comes to an end in March 2018.

14. A new Healthier Options Award Scheme will start in September 2017, initially until the end of 2018. The Award will be based around a pledge system and be available to food businesses and take-aways who already have a hygiene rating of 4 or 5 stars. This will include all 6 Leisure Centres across Central Bedfordshire and the country parks and visitor centres.

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

15. The outcomes for the Bike It Officers in 2016/17 show that in the schools that are participating in Dunstable, Leighton Buzzard and Caddington area, there was an increase of 2.9% in pupils cycling and a 4% increase in pupils scooting to school regularly with a 4.6% decrease in car travel to school.

16. For those schools participating in the Sandy area, there was an increase of 3.9% in pupils cycling and a 3.8% in pupils scooting to school regularly with a 2% decrease in car travel to school.

17. The 5-19 team internet page is complete and there is an embedded link to Beezee bodies website, as well as Change4life life and health4teen boys/girls and NHS choices.
www.eput.nhs.uk/schoolnursingbeds

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

18. Leisure Services secured a small grant to fully fund a 1 year pilot programme to support an 'Oomph!' branded seated exercise project starting in May 2017. The project aims to engage staff and volunteers that already work with vulnerable older adults by providing training and on-going support to lead regular seated exercise sessions.

19. Referrals by Health Visitors to Beezee Bodies are increasing, and mothers in CBC seen antenatally by Health Visitors when weight is discussed both in Antenatal and postnatal period.

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

20. BeeZee Bodies have trained 55 staff from the 0-19 team in 'Raising the Issue of weight', giving staff the confidence to start off this discussion resulting in an increase in referrals to weight management services.

21. Making Every Contact Count (MECC) training was highlighted as a particular need for a wide range of partners. Since October the MECC programme has been delivered to staff members including those from Sustrans, Leisure Services, One Life and the 0-19 team.

22. The next meeting of the Excess Weight Implementation Group where the Action Plans will be discussed will be in September 2017.

Financial and Risk Implications

23. The implementation of the Excess Weight Strategy will be delivered through existing budgets and funding streams. There is some short term additional funding from the public health strategic reserve for a Project Officer to implement the new Healthy Options Food Award Scheme.

Governance and Delivery Implications

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

Equalities Implications

25. The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between 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

26. This has been a productive 6 months for the partners of the Implementation Group working on the actions and outcomes of the Excess Weight Partnership Strategy. The successful implementation of the strategy will help limit the rising prevalence of diabetes associated with excess weight.

27. There are still challenges around areas of maternal obesity within our local hospitals and ongoing discussions around new protocols and engagement of professionals are taking place to rectify this.

Appendices

None.

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CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of Meeting 12 July 2017

Reduce the Prevalence of Diabetes

Responsible Officer: Dr. Alvin Low
Email: alvin.low@nhs.net

Advising Officer: Dr. Sanhita Chakrabarti
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Public

Purpose of this report

1. To receive an update on the rising rates of diabetes and low proportion of people with diabetes meeting their treatment targets

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. **note the developments in improving care of patients who are diagnosed with Type 2 Diabetes across Central Bedfordshire, in particular in relation to improving achievement of NICE recommended treatment targets;**

2. **lead and influence health and social care partners to improve the early diagnosis of Diabetes though improved uptake of NHS Health Checks and promotion of Diabetes UK's 'Know your risk' tool. This is particularly required more in known population who have high risk such as BME and deprived communities; and**

3. **ensure that all partners actively implement the Excess Weight Partnership Strategy to tackle excess weight to both prevent diabetes and ensure that treatment targets are improved for those with diabetes.**

2. Diabetes is a lifelong condition that causes a person's blood sugar level to become too high.

3. There are two main types of diabetes:

- Type 1 diabetes – where the body's immune system attacks and destroys the cells that produce insulin.

- Type 2 diabetes – where the body doesn't produce enough insulin, or the body's cells don't react to insulin.

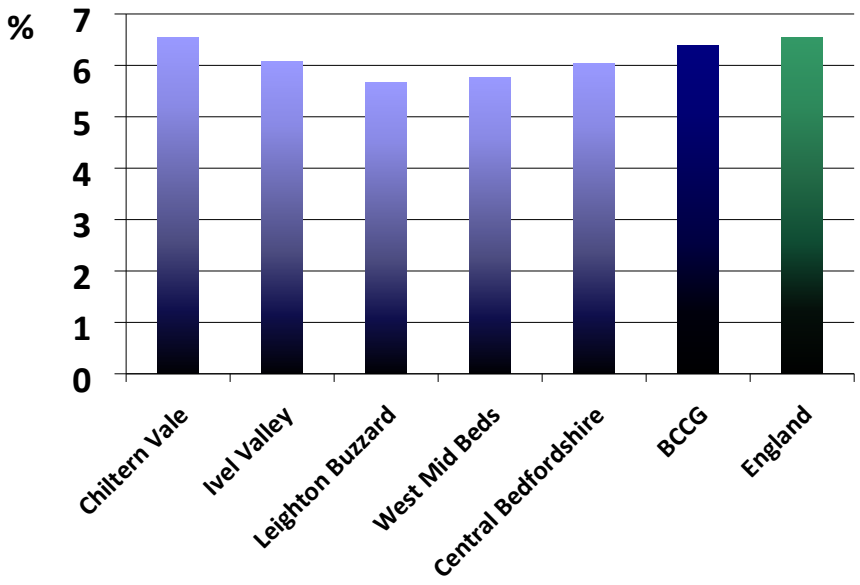
4. Type 2 diabetes is far more common than type 1. In the UK, around 90% of all adults with diabetes have type 2. Excess weight is a risk factor for Type 2 diabetes.

Type 2 Diabetes Central Bedfordshire

5. In Central Bedfordshire the prevalence of diagnosed adult diabetes aged 17 years and older was 6.0% (13,993, 2015/16) which is lower than the NHS England figure (6.6%), see Figure 1. We are aware that there is a significant proportion of adults who are not diagnosed with Diabetes and present with morbidity and complications later in life.

6. The prevalence of Diabetes (percentage of adults known with Diabetes) for Central Bedfordshire is presented in the Diagram below.

Prevalence for diabetes mellitus aged 17 or over, 2015/16

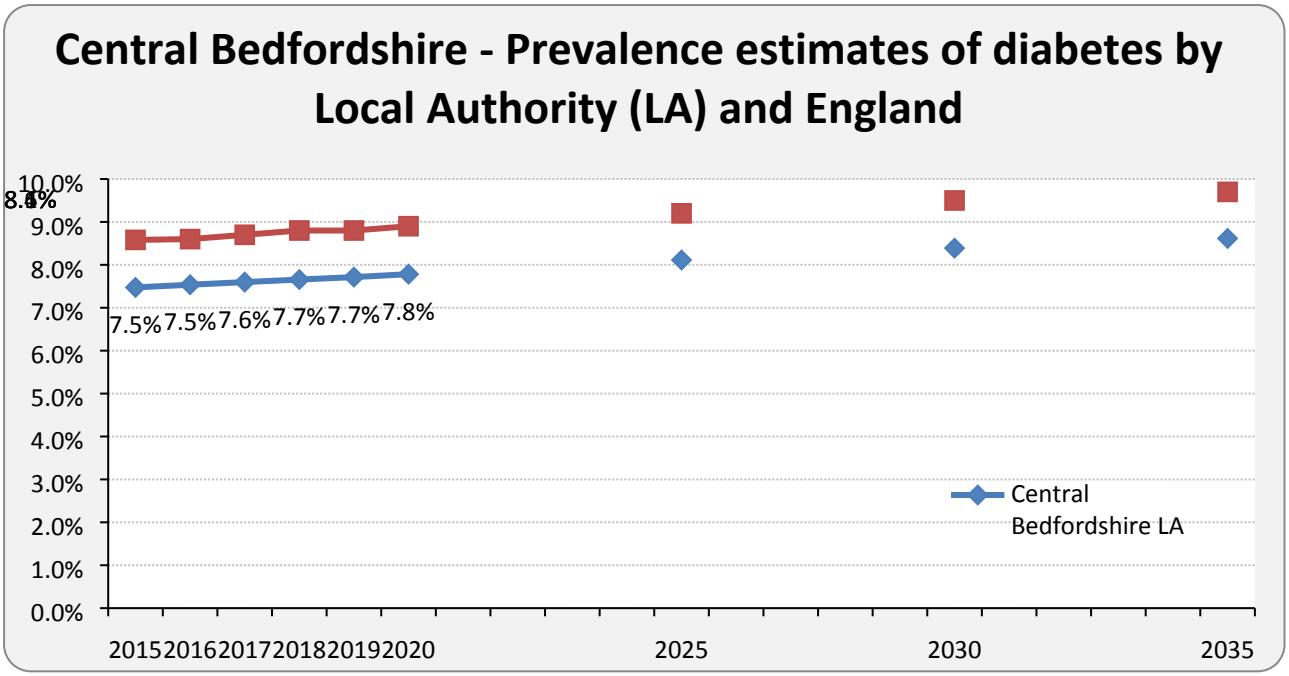


Source: QoF 2015/16

7. The above map outlines the localities served by Bedfordshire Clinical Commissioning group. Further information is available from the Bedfordshire Clinical commissioning group website. Link is: https://www.bedfordshireccg.nhs.uk/page/?id=3880

8. We are noticing an increasing trend in patients developing Diabetes. The increase in numbers of people developing Diabetes across Bedfordshire is evident from the diagram below.

9. In Central Bedfordshire 67.1% of adults have excess weight therefore we will continue to see an increase in adults developing Type 2 Diabetes unless we work across partners to halt this rise in excess weight.



Preventing Diabetes

10. Three of the main risk factors for developing type 2 diabetes are:

- Age – being over the age of 40 (over 25 for people of south Asian, Chinese, African-Caribbean or black African origin, even if born in the UK)
- Genetics – having a close relative with the condition, such as a parent, brother or sister
- Weight – being overweight or obese

11. People of south Asian and African-Caribbean origin also have an increased risk of developing complications of diabetes, such as heart disease, at a younger age than the rest of the population

12. Many cases of Type 2 diabetes are preventable and there is strong international evidence that behavioural interventions can significantly reduce the risk of developing the condition, through reducing weight, increasing physical activity and improving the diet of those at high risk.

National Diabetes Prevention Program:

13. The NHS Diabetes Prevention Programme (NHS DPP) is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale, evidence based behavioural interventions for individuals identified as being at high risk of developing Type 2 diabetes.

14. People will be identified through three primary mechanisms to be eligible for this program:

    - Those who have already been identified as having an appropriately elevated risk level (HbA1c or FPG) in the past and who have been included on a register of patients with high HbA1c* (Glycosylated Hemoglobin Test) or FPG (Fasting Plasma Glucose)

    - The NHS Health Check programme, which is currently available for individuals aged between 40 and 74. NHS Health Checks includes a diabetes filter, those identified to be at high risk through stage 1 of the filter are offered a blood test to confirm risk; and

    - Those who are identified with non-diabetic hyperglycemia (HbA1c of 42 – 47 mmol/mol (6.0 – 6.4%) or a fasting plasma glucose (FPG) of 5.5. – 6.9 mmol/ml) through opportunistic assessment as part of routine clinical care.

*Glycosylated Hemoglobin Test (Hemoglobin A1c) - A blood test can measure the amount of glycosylated hemoglobin in the blood. The glycosylated hemoglobin test shows what a person's average blood glucose level was for the 2 to 3 months before the test. This can help determine how well a person's diabetes is being controlled over time.

15. The NHS DPP behavioural intervention is underpinned by three core goals:

    - achieving a healthy weight
    - achievement of dietary recommendations
    - achievement of Chief Medical Officer physical activity recommendations.

16. The long-term aims of the NHS DPP are:

    - to reduce the incidence of Type 2 diabetes;
    - to reduce the incidence of complications associated with diabetes - Heart disease, stroke, kidney, eye and foot problems related to diabetes; and
    - over the longer term, to reduce health inequalities associated with the incidence of diabetes.

National Diabetes Prevention Program across Central Bedfordshire

17. Bedfordshire along with Luton and Milton Keynes were chosen to be on the wave 2 of the national roll out of National Diabetes Prevention Program.

18. Bedfordshire program is commencing from June 2017.

19. Practices from Ivel Valley and Chiltern Vale localities are being approached to take part in this program. Patients registered with GP practices who have high prevalence of Diabetes are being prioritised at the outset to take part in the National Diabetes Prevention Program.

Management of patients with Type 2 Diabetes:

Care Processes

All people with diabetes aged 12 years and over should receive all of the nine NICE recommended care processes and attend a structured education programme when diagnosed**.**

Nine Annual Care Processes for all people with diabetes aged 12 and over

1. HbA1c
(blood test for glucose control)
2. Blood Pressure
(measurement for cardiovascular risk)
3. Serum Cholesterol
(blood test for cardiovascular risk)
4. Serum Creatinine
(blood test for kidney function)
5. Urine Albumin/Creatinine Ratio
(urine test for kidney function)
6. Foot Risk Surveillance
(foot examination for foot ulcer risk)
7. Body Mass Index
(measurement for cardiovascular risk)
8. Smoking History
(question for cardiovascular risk)
Responsibility of NHS Diabetes Eye Screening (screening register drawn from practices)
9. Digital Retinal Screening

20. **NICE recommends treatment targets for HbA1c (glucose control), blood pressure and serum cholesterol:**

    1. **Target HbA1c** reduces the risk of all diabetic complications.

    2. **Target blood pressure** reduces the risk of vascular complications and reduces the progression of eye disease and kidney failure.

    3. **Target cholesterol** reduces the risk of vascular complications.

21. The percentage of people with Type 2 Diabetes across Bedfordshire who achieved the NICE recommended treatment targets:
(National Diabetes Audit 2015-16)

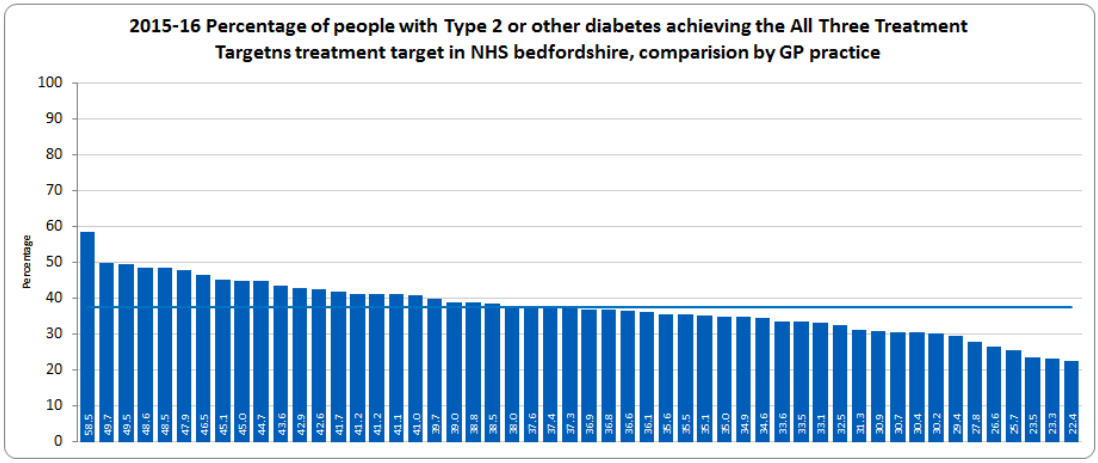
	NHS BEDFORDSHIRE CCG (06F)	ENGLAND
	Percentage completed	**Percentage completed**
HbA1c < 48 mmol/mol (6.5%)	28.1	28.2
HbA1c <= 58 mmol/mol (7.5%)	66.5	65.9
HbA1c <= 86 mmol/mol (10.0%)	94.6	93.4
Blood Pressure <= 140/80	68.5	73.7
Cholesterol < 4 mmol/L	41.6	42.3
Cholesterol < 5 mmol/L	77.1	77.2
All Three Treatment Targets	37.6	40.4

22. **<u>Detailed analysis of information published by NHS England</u>** has been combined with our local information which has suggested that there is huge variation across Bedfordshire in practices achieving the NICE treatment targets.

23. The key findings compared to the top 5 CCGs in our comparator CCG group shows:

- Lower proportion of diabetic patients receiving 9 care processes
- Lower proportion of HbA1c <64mmol/mol
- Lower percentage of patients with diabetes attending structured education.

The diagram below shows the variation of treatment targets by GP practice across Bedfordshire:



* This chart contains all GP practices that have participated in 2014-15 and 2015-16 within the selected CCG.

24. The **<u>possible causes of underachievement</u>** of the diabetes treatment targets are:

a) Lack of capacity within primary care to support patients with diabetes to develop care plans that is comprehensive and has holistic support in the form of clinical management, lifestyle interventions as well as medicine management.

b) Lack of awareness of up-to-date clinical information for practice nurses and GPs who are managing care of diabetes.

c) Lack of live and regular data available to GPs to monitor patient's progress at practice level so that call/recall can be established to target patients who are consistently non-compliant on their treatment.

d) Inadequate provision for structured education and self-empowering techniques used along with clinical management of patients with diabetes.

e) Lack of support from a trained psychologist to work with patients with diabetics who are resistant to change in lifestyle and medication compliance.

f) Lack of a population focus on diabetes and lack of targeted approach for patients from deprived communities, men and specific age groups.

g) Not enough local information about the experience of patients with diabetes who are from specific cohorts such as BME, pregnant mothers, men and children.

h) Consistent approach to annual reviews and optimisation of the treatment targets and NICE care processes in GP practices.

i) Lack of care planning for all patients with diabetes.

Plan to improve treatment targets for Diabetes for patients across Central Bedfordshire

25. We plan to increase our achievement of three treatment targets from our 2014/15 baseline of 37.4% as follows:

2017/18 40%
2018.19 44%
2019/20 47%
2020/21 50%

26. We will achieve our aim by delivering on the following plan:

a) To **commission a Locally Commissioned Service (LCS)** for our GP practices to deliver care planning process to all patients with Diabetes. Care plans requires additional effort and time within general practice to work with the patient and develop holistic plans. The locally commissioned service will incentivise for this additional work within primary care.

b) **GP Practices to develop networks** between themselves to share expertise and workforce, expected to cover a minimum of 30-50,000 patients.

c) To invest in **training of practice nurses** to undertake care planning coupled with adequate medicine management.

d) Development of **care planning templates** with quarterly dashboards for practices and CCG providing primary care colleagues with data regularly.

e) **Protected learning time sessions** with GPs and practice nurses with particular focus on case studies of patients who are struggling to optimise their control of treatment targets.

f) An **additional Diabetes Specialist Nurse will be appointed within the community based integrated diabetes service** to focus on practices where patients have poor achievement of treatment targets.

g) **Structured education (SE) -** The provision for structured education will be overhauled across Bedfordshire to support patients with Diabetes who are newly diagnosed as well as those who have been diagnosed in the past but haven't been taking advantage of the structured education. We will provide SE flexibly out of normal working hours and weekends and according to the needs of the patient. For example, patients with learning difficulty and mental health may need a separate approach to accepting SE. This will be delivered by increasing capacity within community based integrated diabetes service by employing additional Diabetes Specialist Nurses. £64K has been secured through the NHS England transformation funds (2017/18) to deliver on this important priority.

h) **A part-time psychologist** with special skills to work with patients who lack motivation will be appointed**. Bedfordshire Wellbeing Service** will work closely with GPs and integrated diabetes service to provide additional support to patients with Diabetes where required.

i) All patients with BMI over 28 will be referred to a **community weight management service.** All patients who smoke will be referred to **smoking cessation services.**

j) **Community Based Integrated Diabetes Services will be aligned to GP practices.** Focus of work for these specialised services will be to work with those practices and those patients who are particularly finding it difficult to improve their outcomes.

27. We have been fortunate to secure £170K NHS England Transformation funds (2017/18) to make further investments within our primary care and hospital services to implement the plans above.

Financial and Risk Implications

28. The following two factors can result in delay in delivering on the action plan:

- Inability to recruit to posts within local Integrated Diabetes Services to deliver added support to primary care may delay the improvement journey.

- Capacity and pressures within primary care continue to be challenging.

29. Mitigation plans are being developed by accessing Specialist Diabetes Nurses from other organisations such as National Service for Health Improvement (NHSI) to support those practices who have limited capacity and struggling with recruitment of staff.

Governance and Delivery Implications

30. Updates will be made available to the Central Bedfordshire Health and Wellbeing Board on a regular basis.

Equalities Implications

31. There is ample available evidence nationally as well as locally which clearly points to the fact that socio-economic inequalities in diabetes care do exist. Low individual Socio Economic Status and residential area deprivation are often associated with worse process indicators and worse intermediate outcomes, resulting in higher risks of microvascular and macrovascular complications. These inequalities exist across different health care systems. An evidence based, system wide approach of addressing overall care for patients with Diabetes is therefore warranted across Central Bedfordshire.

Conclusion and next Steps

32. Improving care of patients with Diabetes requires a system approach. We look forward to working in partnership across health and social care to improve outcomes for patients with Diabetes.

CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of meeting 12 July 2017

Child and Adolescent Mental Health Services (CAMHS) Local Transformation Plan

Responsible Officer: Anne Murray
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Public

Purpose of this report

1. Update on the Future in Minds Local Transformation Plan (LTP) for Children and Young People's mental health.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. note the Local Transformation Plan (LTP) which is an annually refreshed joint plan identifying how Bedfordshire and Luton are aiming to achieve the recommendations identified in Future in Minds and the Five Year Forward View for Mental Health;

2. support the refresh of the joint LTP due for submission in October 2017 to be circulated for comment in September 2017. There is an expectation this year to consider how the LTP can demonstrate joint working across the Sustainable Transformation programme (STP); and

3. this is year two of a five year work programme 2015-2020 and the board are being provided with assurance against progress of the work plan for information and update.

Progress report on work plan for the Local Transformation plan

2. The key priorities identified in the Local transformation plan are:

a) Implementation of an Eating Disorders community specialist service.(CEDS-CYP)

b) Improvement in access and waiting times to CAMHS through developing crisis and community services.

c) Skilling up the workforce and embedding the principles of goal focussed outcomes developed collaboratively with Children and Young People. Identified as CYP - IAPT (Improved access to psychological therapies).

d) Development of Early Intervention and schools support.

e) Development of Perinatal Mental Health services.

f) Development of pathways for Vulnerable groups ie Autistic spectrum disorder /challenging behaviour / complex care/ LAC.

g) Development of collaborative commissioning plans with Specialist Commissioning (NHS England) for Tier 4 beds (acute inpatient admissions for CYP with MH) and FCAMHS (Forensic pathways).

Joint Eating Disorders Specialist Community Service (Bedfordshire and Luton)

Aim

3. To increase specialist support in the community and reduce length of stay when admitted for stabilisation within an inpatient unit. By 2020 there is a requirement that 95% of CYP with an eating disorder are seen and commence treatment within four weeks.

Current Progress

4. The newly developed team working to a NICE compliant eating disorders model is now fully recruited and a draft service specification including key performance measures will be finalised by July 2017.

5. The dietician has completed training for primary care and universal services to recognise, support and signpost when CYP are at risk of developing an eating disorder or when a CYP with an eating disorder is deteriorating or relapsing.

6. The criteria for managing acutely ill CYP with rapid weight loss are being revised with the L&D to align with current guidance and will be completed by September 2017.

7. There are currently 53 children on the caseload (CBC split requested for future reports). 100% of CYP have been seen and commenced treatment within 4 weeks.

Issues/Risks

8. It has been recognised that there is a gap in service for CYP 18-25 years of age transitioning to adult hood who need additional support due to major changes in lifestyle i.e. going to university, leaving home, and starting a job therefore a pilot transitions service provided by Caraline (third sector organisation) has been implemented and will be evaluated in 6 months to review the impact of this service.

Access and Waiting Standards

Aim

9. The target is to be treating 35% of NHS funded CYP in Bedfordshire with a diagnosable mental health condition by 2020/21.

Current progress

10. The single point of access (SPOA) has been established and there were 681 new referrals to the Bedfordshire CAMHS single point of entry in Q4 which equates to approximately 56 CYP per week. (CBC data requested for future reporting).

11. This figure does not reflect CHUMS data (for low level interventions) which averages an additional 40 referrals / week.

12. A weekly panel of senior clinicians assess all new referrals into the SPOA.

13. All referrals are either signposted to other external partner's dependant on need or allocated into the most appropriate team and assigned a clinician on the same day; the clinician will offer a date for an assessment which will be included within each appointment letter and issued within 48hrs of the panel taking place.

Issues/ risks

14. Currently 25% of CYP across Bedfordshire and Luton are accessing mental health services. To achieve the 35% target by 2020 there will be a requirement for additional staff recruitment to ensure safe caseloads and to prevent increases in waiting times:

15. ELFT are currently developing a business case for the CCG to highlight additional resource requirements. Based on current numbers accessing the service and trajectories to be achieved this could potentially equate to eight additional staff by 2020.

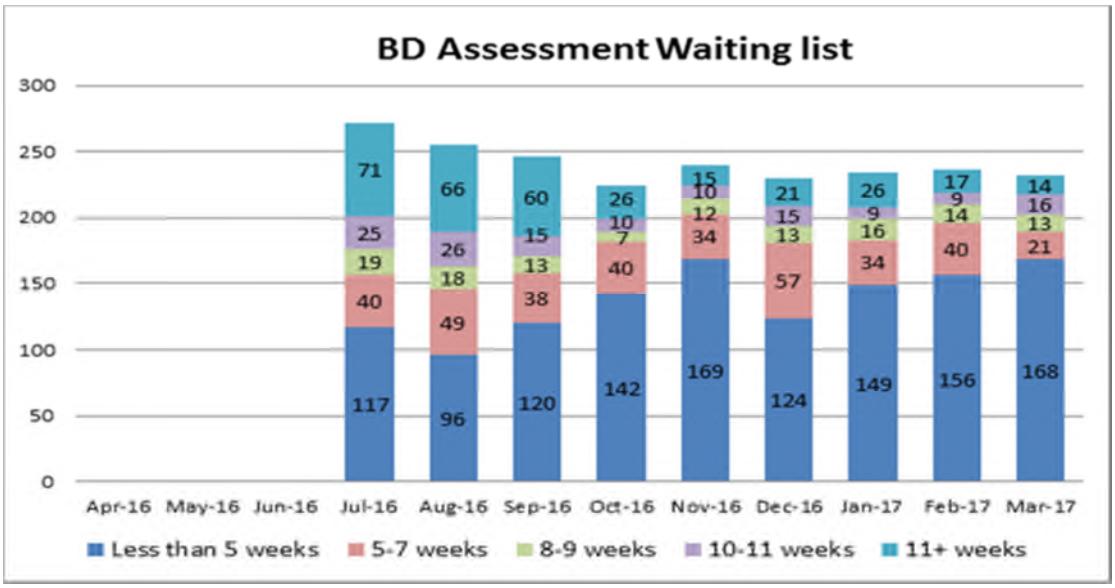
WAITING LIST INITIATIVE

16. Currently there is a specific review of mental health teams within Central Bedfordshire in order to understand the waiting times with a view to ensuring service users are offered a dedicated intervention within 2 weeks of referral.

17. The scheme has been in operation since March 2017 and aims to:

- Offer telephone call triage assessment to identify the appropriateness of treatment and intervention
- Assess the receptiveness of therapy groups as a first stage of treatment
- Assess the impact this will have on external waiting lists, assess the impact
- Assess the impact on DNAs (did not attend)
- Assess if leads to an increase in patient satisfaction.

18. The table below identifies the average waiting times for CYP for Q3 and Q4 2016/17. Q1 data is not yet available. (CBC data requested for future reports)



Crisis Service

Aim

19. To provide a 24 hour a day 7 day service for CYP in crisis.

Current progress

20. The crisis team have been fully recruited and are offering a 7 day per week service with opening hours from 8am -8pm Monday to Friday and 10am -2pm at weekends with the adult psychiatric liaison team covering the additional hours.

21. Training has been provided by ELFT to staff at the L&D hospital.

22. A CAMHS Crisis workshop was held in April 2017 to develop an agreed model of working across the county and data collection required to evaluate the impact of the service. This dashboard will be available in July 2017.

23. Requests for additional 1:1 CAMHS support when CYP in crisis are admitted to the L&D are being closely monitored to establish:

    - Reason for admission
        - For medical stabilisation
        - delay in social care finding a placement
        - Limited availability of tier 4 specialist in-patient beds commissioned by NHS England.
    - Data split by local authorities has been requested.
    - The data will be evaluated in January 2018 and the service provision reviewed.

24. Development underway to increase co-commissioning for community and in-patient care with a view to moving away from the current 4 tier inpatient model and develop services closer to home .

In patient data (Tier 4 beds)

- 6 female CBC patients -Length of stay: 21 days, 65 days, 50 days, 586 days (secure unit),42 days, 27 days.

- 2 male CBC patients-Length of stay: 64 days, 19 days.

- Placements include
    - Coburn Centre- North London
    - Priory House-Chelmsford
    - Cynet hospital - Bury
    - Huntercombe-Norfolk & maidenhead
    - Blue Bird - Enfield

Schools

Aims

25. To increase access to evidenced based interventions at the earliest point to decrease the number of young people requiring Tier 3 or tier 4 support. Improving advice and guidance to frontline family practitioners and embedding mental health professionals within Local Authority Early Help Teams and Secondary Schools.

Current progress

26. The CAMH School Programme continues to be very well received into Upper schools and Collages; the teams are covering 13 sites in Central Bedfordshire and four specialist schools in CBC.

27. ELFT have now started to explore staff wellbeing services within schools and will be holding a whole school approach conference – in collaboration with Central Beds and Beds Borough and Anna Freud.

28. Lower schools have also been included and will be covered by CHUMs. This will be implemented fully by September 2017 once the new Child Wellbeing Practitioners (CWP) have been trained.

29. The CWP is a new role under development across the country to support increase in the CAMHs workforce. The CWPs are currently being trained at master's level which is a programme supported through Health Education England to roll out early intervention principles to support are increased resilience and emotional wellbeing in school age children.

Outcomes identified

30. Develop and improve effective pathways to Mental Health support within schools.

31. Improve Mental Health Training and Knowledge of Early Help and Intervention Staff.

32. Improve Mental Health Training and Knowledge of School Staff.

33. Improved access to Mental Health Case Consultations.

34. Improved access to CAMH Assessments outside of Clinic by Early Intervention Team.

35. Schools to refer in to CAMH more appropriately.

36. To improve Children and Young People and their families' experiences of Mental Health support based outside of a clinic.

37. Decrease unmet Mental Health Needs within school population.

38. Voice of the Child is sought and implemented as part of service delivery.

39. Measurable data is currently being negotiated with providers.

Perinatal Mental Health

Aims

40. Increased investment in early year's health services and ensuring parents have access to evidence based interventions and support to strengthen attachment.

Current progress

41. Two large stakeholder events have been undertaken to develop pathways for perinatal mental health management. Pathways for Inpatient management, crisis management and community pathways have been agreed across Bedfordshire and Luton and are due for final sign off by July 2017. These pathways have already been implemented and further communications to raise awareness are planned.

42. A strategic group across BLMK has been developed to review a bid for funding to provide an additional specialist perinatal services which is due late summer. Although previously not successful support is being provided through East of England to maximise our opportunity in this bidding round.

43. Twenty Champions across CAMHS, health visiting, midwifery and social care have been trained in early interventions for infant attachment disorders and parental MH. These champions then have a programme to cascade this training across the whole workforce over the next 18 months.

44. In addition, several adult MH staff have been put forward for training in perinatal MH provided through East of England funding.

Risks

45. Continued support from local authorities to invest in funding for early support initiatives and invest strategically in mental health services from 0-5 from Oct 2015.

Children and Young People from Vulnerable Backgrounds

Aim

46. To improve access to services for CYP with complex needs.

Current progress

47. Pathways currently under development for children requiring diagnosis and management of neurodevelopmental conditions ie Autism and ADHD due for completion by September 2017.

Gaps identified are:

48. Lack of therapy support including sensory interventions. This is being addressed through procurement of new community services due to start April 2018.

49. Transforming care partnerships (TCP) now include representation from Children's services within BCCG and Central Bedfordshire to develop plans for joint agency working to support management of complex cases. This includes a capacity review across BLMK , review of accommodation in county and out of area , development of processes and protocols for transitions and community , education, treatment reviews (CETRs) for all CYP with a learning disability and/or autism at risk of admission .

50. LAC out of area protocol for access to CAMHS services has been developed by a working group supported by the strategic clinical network for east of England. Once signed off through governance processes and shared with Central Bedfordshire Children's safeguarding board this will be varied into provider contracts. Completion date due August 2017.

51. Review of forensic CAMHS pathways commenced March 2017 to understand the capacity requirements for secure estates and to develop collaborative commissioning arrangements between specialist commissioners (NHSE) , criminal justice sector and CCG's to develop early intervention services to prevent CYP with mental health , LD and/or autism entering the criminal justice system due to complex behavioral issues .

Data and standards

52. All providers are now expected to start submitting data to Unify to develop the production of the CAMHS Mental health dataset to collate key indicators, patient experience and patient outcome measures. This is in draft form for 2017/18 and will be mandated for 2018/19.

Financial and Risk Implications

53. Allocated funding

2015/16 CAMHS LTP funding allocation £795k + Schools pilot £50 K
2016/17 CAMHS LTP funding allocation £925k +Eating Disorders £227k recurrent until 2020.

54. This money has not been ring fenced by NHS England and has been base lined into Clinical Commissioning Group budgets. BCCG have committed to protecting this funding for CYP mental health transformation.

55. The trajectories identified by NHS England for access to CAMHS services will require additional investment to ensure waiting lists do not increase and caseload sizes are safe.

Governance and Delivery Implications

56. A Quarterly Future in Minds steering group has been established with representation from Bedford Borough Council, Central Bedfordshire Council, Luton Borough Council, Bedfordshire Clinical Commissioning group, Parent / Carer forum (SNAP), East London Foundation Trust and CHUMS.

57. The steering group reports to the executive board in BCCG / LCCG and the three Health and wellbeing Boards across Bedfordshire and Luton.

58. The Future in Minds steering group develops and monitors progress against the multi-agency action plan attached to the Local Transformation Plan. See Appendix 1

59. Initial proposals identify that the refresh of the LTP for this year needs to encompass the wider CYP mental health and wellbeing strategy. Guidance is awaited for the refresh of the Local transformation plan due in October 2017.

Equalities Implications

60. 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.

61. The following organisations have been consulted in preparing the local transformation plans:

Bedford Borough Council (BBC)
Bedfordshire Clinical Commissioning Group (BCCG)
East of England Strategic Clinical Network
Specialist Commissioning – NHS England
Public Health (BBC/ CBC/ LBC)
Central Bedfordshire Council (CBC)
Luton Borough Council (LBC)
Luton Clinical Commissioning group (LCCG)
Education sector
Criminal Justice Sector
South Essex Partnership trust (SEPT)
East London Foundation Trust (ELFT)
Bedford Hospital
L&D Hospital
Parent Carer forums
Children and Young People
Voluntary Sector

Implications for Work Programme

62. Future reports updating on progress against the LTP action plan to be shared with the Health and Wellbeing Board.

63. Work Plan attached in Appendix 1.

Next Steps

64. Bedfordshire and Luton are working jointly with Milton Keynes to align mental health strategies across the STP footprint to ensure the requirements align with Future in Mind, 2015 and the Five Year Forward View for Mental Health.

65. The local transformation plan and evolving action plan is scrutinised by NHSE on a quarterly basis to ensure the five year funding is being used to build capacity and resilience across the system to improve measurable outcomes for Children and Young people's mental health and emotional wellbeing.

66. The work plan supporting the LTP is a dynamic plan which is updated quarterly has been developed in partnership with parent/carers, children and young people and contributed to by all organisation stakeholders working with the local community to promote, improve and support children and young people at risk of/ with emotional wellbeing and mental health needs.

Appendices

Appendix 1 – Local Transformation Action Plan

Background Papers
Key Documents:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

https://www.england.nhs.uk/wp-content/uploads/2015/07/cyp-eating-disorders-access-waiting-time-standard-comm-guid.pdf

https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf

https://www.england.nhs.uk/mentalhealth/cyp/iapt/

http://everyonesbusiness.org.uk/wp-content/uploads/2014/06/Joint-Commissiong-Panel-perinatal-mental-health-services.pdf

http://everyonesbusiness.org.uk/wp-content/uploads/2014/06/Joint-Commissiong-Panel-perinatal-mental-health-services.pdf

https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

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NHS
Luton
Clinical Commissioning Group

Future in Minds Local Transformation Plan Reporting 2016-2020

LTP Action Plan

A Partnership Framework for LTP
Monitoring Template

Rag Status:

R/red = not achieved to time scale lead to review at mtgs, A/amber = In progress but not complete, G/green = Completed to time scale

Outcome and measurement description	5 year forward plan target/ FIM target	Quarterly Target and performance	Lead	Completion By:	Rag Status	Evidence/Commentary
Overarching themes – Karlene Allen/Sharafat Ali						
To develop a communication and engagement plan Action: To set up a task and finish group			Sarah Frisby (HO Comms and Engagement) Luton rep	TBA		Steering group to establish aims of a communication and engagement plan, and to identify group members and lead person.
Development across STP footprint			BCCG Karlene Allen/LCCG Sharafat Ali/MKCG TBA	2017/18		Discussions started around STP prevention plan and clinical service plans, linking in with Local Maternity Plan across the STP. STP 5 year forward view templates being completed CYP MH now on strategy agenda.

Link in with CQUIN schemes	National requirement		Bernie Harrison Luton rep	2017/18 scheme		Transitions cquin (ELFT) developed and monitored quarterly. BHT A&E data collection cquin
Refresh of LTP	National requirement		Sarah James Luton rep	October 2017		Submission to NHSE by (TBC) Guidance awaited
Co-ordinated ways of working.	Development of collaborative commissioning arrangements		Specialist commissioning	March 2017		Tier 4 review completed FCAMHS- Secure estates review in consultation. Guidance held up due to purdah.
Workforce development			CCG's/all providers / HEE	Ongoing		Strategy to be developed. Elements captured in LTP
Integrated services being developed across seamless pathways.			All providers			How will this be measured to be discussed further at next FIM meeting Patient experience measures
Person centred approach with engagement from CYP and their families involved in decision making.			All providers			How will this be measured to be discussed further at next FIM meeting Patient experience measures
Reduction in health inequalities						How will this be measured to be discussed further at next FIM meeting

Reduction in CAMH waiting times	5 weeks		ELFT Bedfordshire ELFT Luton update required	2020		Waiting times reduced from 16 weeks to 8-12 weeks dependent on area. Needs monitoring as service demands growing as a result of expectations for improved access to services and large caseloads. Business case being developed to review demand and capacity.
Improving access to any NHS funded CAMH service. CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service <u>Data collection</u> Number of new children and young people aged 0-18 receiving treatment from NHS funded community services in the reporting periods	At least 30% receive treatment (2017/18 target) 35%.target by 2020 National requirement		CCG / ELFT	2020 /21		Link with MH SIG (BCCG)

Total number of individual children and young people aged 0-18 receiving treatment by NHS funded community services						
Improved patient experience and **service users will remain at the heart of continuing service delivery and developments.** <u>Data collection</u> Service user experience and views shape future service improvements : GPs Tier 4 ELFT Caraline Acute Trusts 0-19 Teams Street Triage	Requirement to ensure this is in every provider contracts		Karlene Allen/ Bernie Harrison/ Luton rep	TBC		Monitored quarterly through provider contracts for ELFT , Street triage , 0-19 teams , Caraline . GPs / acute trusts to be developed ELFT Stakeholder service user events held quarterly to obtain ongoing feedback.

Theme 1 Eating disorders Lead – Karlene Allen/Sarah James/ LBC (TBC)						
Identification of model for Joint Beds and Luton specialist CEDS-CYP service			CCG's / ELFT	2015		Specialist Service commissioned across Bedfordshire and Luton
Recruitment to specialist service			ELFT (Bedfordshire and Luton)	April 2016		Service available. June 2017 -Vacancy for dietician post remains outstanding. Recruitment attempts x3.
Development of Service specification for contract			CCG's/ ELFT / Caraline (Bedfordshire and Luton)	July 2017		
Development of measures of success			Task and finish group Luton rep required	August 2017		
Development of eating disorders pathway for early intervention through to crisis support			Task and finish group	December 2017		
Evaluation of eating disorder service and sustainability			Task and finish group	October 2018		Not started yet.
Rapid Access to specialist support			Monitored through ELFT contracts	September 2017		Baselines established. Quarterly MH assurance returns to NHSE commenced. Add to quality schedule for 2018/19 contract

Reduction of length of time from referral to assessment Data collection Percentage CYP receiving treatment within 1 week from first contact with a designated healthcare professional for urgent cases Percentage CYP receiving treatment within 4 weeks from first contact with a designated healthcare professional for routine cases	80% target 2017/18(TBC) 80% target 2017/18(TBC)					
Reduction in numbers CYP –ED admitted to acute setting Data Collection Numbers admitted Length of stay	30% reduction 2017/18					

Reduction in Number of CYP-ED admitted to Tier 4 <u>Data collection</u> Decrease in Numbers admitted Decrease in Length of stay Increase in Discharge planning in place on admission Numbers accessing NICE compliant interventions ie family therapy	50% reduction 2018/19 85% 2019/20 85% 2020/21 100% NICE compliant					
Children and young people accessing the CEDS-CYP care pathway should show measurable improvements in the presentation of their eating disorder symptoms			ELFT / CARALINE	September 2017		ED Team to define success measure

Increased awareness across our communities of children, young people and families, agencies and communities of the presentation and prevalence of eating disorders. Data collection Training evaluation shows increased awareness post training.			ELFT	TBA		
Patients feel supported through transition to adult services(Bedfordshire service)			Caraline / BCCG	September 2017		Caraline spec developed. Outcome measures currently being identified. One year pilot. Evaluation to be completed by May 2018 Caraline to define success measure

Theme 2: Perinatal mental health Lead Karlene Allen(BCCG) /Seana Perkins(BBC/BCCG) /Sanhita Chakrabathi (BCCG) /Loraine Rossati(LCCG) / Stephanie Cash(LBC) / Lousley Wayland (MK) / Hannah Pugliese (MK) / ELFT / CNWL						
Development of pathways for : **Inpatient** **Community service** **Crisis**			BCCG / LCCG Seana Perkins / Stephanie Cash	September 2017		2 x stakeholder work groups undertaken to refine and agree pathways
Development of specialist service perinatal bid			BLMK reps / ELFT / CNWL	September 2017		Meeting date to plan 3rd July 2017
Reduction in attachment difficulties resulting in stronger emotional resilience and better mental health outcomes in the longer term			Barbara Rooney / EPUT	October 2017		Work in progress Confirm Luton position Barbara Rooney to define success measure currently reported by 0-5 HV team (Exception reporting to LTP Steering Group) Sarah Wilson to define measurement tool
Parents feeling better supported <u>Data collection</u> Increased Numbers of pregnant mothers receiving rapid access to adult IAPT services.	At least 25% of people with common MH conditions access psychological therapies each year. Maintain		Gina Manning/ ELFT	2020-21		ELFT have met access targets for 2016-17 and have planned trajectories for 2017-18. *We are not presently able to specifically determine access of crisis care for our perinatal population.*

Increased Numbers of fathers with mental health problems receiving rapid access to IAPT. Improved Service user experience of IAPT service exception reporting to LTP Steering Group	waiting time and recovery performance Increase access rate by: 16.8% (2017/18), 19% (2018/19), 22% (2019/20), 25% (2020/21).					
Reduction in perinatal mental health crisis Exception reporting to LTP Steering Group via contract monitoring	24-hour mental health teams at the Core 24 standard, covering five times more A&Es by March 2019, than now. The service will be available in more than a quarter of acute hospitals by March 2018 and nearly half by	.	Rachel Volpe	April 2018		There is currently a skeleton 24/7 mental health liaison team in BHT provided by ELFT. Additional resource has been contracted in 2017-18 to expand this provision and is currently being recruited to. The aim is for this to be in place July-August 2017. This is part of our stepped approach, to the further expansion in April 2018 (with the realisation of transformational funds) to a specialist mental health teams in BHT that will be 'Core 24' compliant. We are currently reviewing crisis care for adults in Bedfordshire. This encompasses: MH Street triage pilot, Inpatient provision, access, primary liaison, places of safety and scoping of crisis cafés, sanctuary models and suicide prevention. *We are not presently able to specifically determine access of crisis care for our perinatal population.*

	March 2019, compared to under 10% today. All Acute trusts to have core 24 psychiatric liaison service by 2020					
Effectiveness of interventions monitored through use of outcome monitoring <u>Data collection</u> Continue to report outcomes through KPi reporting of number of mothers assessed and number of babies/children assessed at usual milestones ie. 8			Barbara Rooney/EPUT	TBA		BR to define target via contract monitoring

weeks, 9 months and 2½ years. Continue to report number of early interventions and attendance at these within the HV service for mothers with identified depression Exception reporting to LTP Steering Group						
Sustain model of learning over the next years through the use of the champions facilitating training thereafter. **All current and future staff to attend training to ensure competence and confidence.**	Ratio of 1 champion per 5 staff 400 HV and MW staff trained 2017/18 target		Providers	2017-2020		Embedded document of cascade training. Jacky Syme to provide Bedfordshire champions training completed. Luton position?

Data collection Increased Numbers of health visitors trained. Increased Number of champions trained						
Theme 3: Crisis Services lead Karlene Allen/Sarah James						
Develop and improve effective pathways to manage CYP in crisis						Service in place and fully recruited to Success measure to be developed by ELFT
Crisis stakeholder event to define outcomes / KPIs and data collection across the whole system.			Providers / BCCG / LBC / ADS	April 2018		Data collection tool in draft format. Data collection July 2017-January 2018 Evaluation February 2018 Crisis stakeholder event to be held early spring 2018 to feedback and review pathway .
Align with crisis concordat work plan	All Acute trusts to have core 24 psychiatric liaison service by 2020.		Karlene Allen / Rachel Volpe	April 2018		Crisis Care development work for both C&Y and adults will be aligned with commissioning priorities and with the revised Crisis Care concordat plan for Bedfordshire & Luton.

						Please also see **Reduction in perinatal mental health crisis & To improve Children and Young People and their families' experiences of an out of Hours CAMHS crisis service in Luton & Bedfordshire.**
Develop and improve CAMHS out of hours access to advice and assessment <u>Data collection</u> Increase Number of CYP seen out of office hours in the community Increased Numbers of MH patients seen and assessed within 2 hours of presentation at A+E	75% 2017/18(TBC)		Sarah James	July 2017 – January 2018		Establish baselines
Decrease unmet Mental Health needs out of hours Reduced Numbers attending A+E			Sarah James	July 2017 – Jan 2018		Establish baselines

Reduce the number of presentations of young people in crisis Reduction in Numbers of repeat presentations	25% reduction 2017/18(TBC)		Sarah James/ BHT+L&D	July 2017 – Jan 2018		
To improve Children and Young People and their families' experiences of an out of Hours CAMHS crisis service in Luton & Bedfordshire.			Sarah James / ELFT	July 2017-jan2018		Success measure to be defined
Prevent unnecessary inpatient admissions <u>Data collection</u> Reduced Numbers admitted to acute ward (split by BHT and L&D) Reduction in numbers admitted to Tier 4	75% reduction 2017/18(TBC)		Sarah James / Claire Oliffe	July2017-Jan2018		Emergency admissions admitted to acute ward : Bedford Hospital -184 (15/16)and 186 (2016/17) L&D- 100 (2016/17)and 94 (16/17) Link to : • Adult MH Crisis care pathway development • Street triage • Suicide prevention work streams • Transitions works treams

Appropriateness of Reason for admission Increase in CYP with Discharge plan in place Reduction in Length of stay Increase in CYP with a crisis care plan in place						
Theme 4: Early Intervention lead: Chris Morris Bedford Borough Council , Ben Pearson Central Bedfordshire Council						
Increased access to mental health support Families and YP report Improved experience of accessing Mental Health Support – Exception reporting via CHUMS contract Qualitative data collection via survey			Chris Morris / ben Pearson / Sarah James	March 2018 (TBA)		Trajectories / baselines and projections being developed by ELFT after Quarter 4 1. Meeting needed with Nikki Scott, CAMH Participation Lead to look at holding focus groups and feedback events with young people.(time frames) 2.Joined up working already taking place between CAMH Participation Lead and Bedford Borough Council (Central Beds update) Engagement and Development Team led to a CAMH / Early Help Activity Day for Service Users from Early Help and CAMH to come together and give feedback

Increase in number of Case Consultations with CAMH School Team Increase in number of Case Consultations with CHUMS School Team						3.Need to create a questionnaire to send out to service users to gather feedback(time frames) Oversight Committee now in place to hold quarterly reviews of data and performance. This committee will offer both support and challenge to the project to ensure we are meeting trajectories and baselines
Improved family based support Increase in number of Children's Services Staff trained in Mental Health and Wellbeing Increase in number of Mental Health Assessments completed outside of clinic by an Early Intervention CAMH Clinician			Chris Morris / Ben Pearson / Sarah James	March 2018 (TBC)		Training Strategy agreed. The Early Intervention and Schools Team are now creating training packages around 12 different areas of Mental Health. This will then form one coherent training offer across the service to enable a collective and strong voice of Early Help / Schools team. This will also enable the team to clearly see where gaps lie and make future plans to fill this(time frames) Oversight Committee now in place to hold quarterly reviews of data and performance. This committee will offer both support and challenge to the project to ensure we are meeting trajectories and baselines

Increased awareness across our communities of children, young people and families, agencies and communities of the presentation and mental health disorders. <u>Data collection (TBA)</u> Wider range of referral sources into SPOE? Increased number of professionals trained? More appropriate referrals into SPOE – increased number of successful referrals? Increase in number of 'Tier 2' referrals showing earlier identification of issues?				Chris Morris / Ben Pearson / Sarah James		Measure of success for community? Mapping taking place of Tier 2 provision is taking place already and CAMH are reviewing their Tier 2 funding / contract at present?

Joining up services locally through collaborative commissioning approaches between CCGs, local authorities and other partners enabling all areas to accelerate service transformation. Data collection (TBA) Measure of success? Range of services and provisions for CYP on offer? Number of joined up approaches?			Chris Morris / Ben Pearson / Sarah James	Time frames TBA		Oversight Committee for the Early Intervention and Schools Project consists of representatives from both BBC and CBC Public Health and Early Help Services, EPUT, Chums and ELFT. This joining up of services has enabled us to ensure the services are embedded effectively and swiftly within schools and LA services. This approach has also allowed us to explore other collaborative and joint commissioned approaches to further enhance the current offer. This has also led to the creation of a 'Team Around the School' approach where the Early Help Link, CAMH Worker and School Nurse for the school meet with the school to ensure a holistic approach is being taken to Young Peoples mental health and wellbeing Bedford Borough Council funding £15K towards the embedded CAMH worker Building on the framework developed as part of the FIM Transformation Plan, service transformation has been accelerated through further recruitment of an additional school worker, through the funding of a Peer Mentoring Pilot within schools, enhancing our Tier 2 offer through utilising the training on offer via CYP IAPT to train current frontline staff within Childrens Services. ELFT and Bedford Borough Council have joined up in recruiting a CYP IAPT Parenting Trainee; ELFT have recruited this worker to work with parents of children with conduct and mental health concerns and Bedford Borough Council agreed to be part of her training by joining her up with the parenting coordinator to develop confidence and the

						practical resources to deliver parenting groups. This has proved extremely successful and beneficial to both services. Bedford Borough exploring a bid to enhance the 0-5 Infant Mental Health Offer by recruiting 2 workers to train in 0-5 Infant Mental Health IAPT training through Anna Freud. Exploring this being a collaboration with ELFT, EPUT and BBC Public Health
Training provided to school staff Increase in number of School staff trained in Mental Health and Wellbeing Increase in number of Children's Services Staff trained in Mental Health and Wellbeing	Targets TBA		Leads to be identified	Time frames TBA		Oversight Committee now in place to hold quarterly reviews of data and performance. This committee will offer both support and challenge to the project to ensure we are meeting trajectories and baselines One coherent training offer across the service to enable a collective and strong voice of Early Help / Schools team.

Theme 5 Vulnerable Groups Lead – specialist commissioning / BCCG / LCCG –LBC / MK CCG						
Alignment with LD transforming Care plans to enable Children and young people with LD to live in the community and not be admitted to inpatient settings.			Karlene Allen(BCCG) BBC/ CBC leads to be confirmed	March 2018		BLMK TCP draft plans submitted June 2017.
Alignment to the SEND agenda. **Data collection TBA**			Julie Cronin	March 2018		EHCP processes currently under review.
Close working relationships and information sharing between education, health, social care, and youth justice sector.			Karlene Allen / Liz Clarke / Yvonne Carey	December 2018		Evaluation of YOS pathways to be defined. BCCG funded additional support to YOS team. First meeting held 17.05.16
SARC pathways to be reviewed for access to MH/ Trauma based interventions.			Specialist commissioning / BCCG	March 2018		First meeting held with provider 21.06.17 Review of NICE guidance in progress Business case to be developed.

MASH pathways to be evaluated for access to MH pathways				TBC		Align with work already in progress.
LAC/ CAMHS out of area protocol to be embedded			Karlene allen / Teresa Mcdonald .	October 2017		Regional group designed protocol –finalised May 2017. To be circulated to LSCB's June 2017 Contract variations to be negotiated by October 2017
Development of neurodevelopmental pathways			Karlene allen / Michelle Williams / ELFT/ EPUT/ CCS	March 2018		Task and finish groups established Bedford and Luton
Theme 6: EIP Lead Rachel Volpe						
% of people receiving treatment in 2 weeks	60% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral 50% (2017/18) 53% (2018/19), 56% (2019/20), 60% (2020/21)		Rachel Volpe	2020-21		EIP service is meeting its targets to date.

Specialist EIP service in line with NICE recommendations Data collection to be agreed	35% receiving early treatment are in employment compared with 12% in traditional care Reduced likelihood of an individual receiving compulsory treatment from 44% to 23% during first two months of psychosis Reduced suicide risk from 15% to 1% Reduced numbers detained under mental health act Referral to treatment time	See above	Rachel Volpe/ Karlene Allen /ELFT	2020-21		Audit of compliance is being developed.

Theme 7 – CYP IAPT Lead –Providers						
Upskill/ develop workforce in CYP IAPT interventions Increased Number of staff trained in CYP IAPT			Graeme Lamb Russell Hurn/ Chris Morris / Ben Pearson	2015-2020		?? no of Staff across CAMHS teams undertaken training to date. 4 CWP's employed by CHUMS . Bedford Borough Council have joined the CYP IAPT collaborative and currently have 4 of its workforce being trained to deliver CBT interventions for mild to moderate anxiety and depression. Embedded Early Intervention Worker within CBC is supervising two IAPT Trainees . Embedded Early Intervention Worker within BBC is undertaking IAPT Parenting Supervisor Training and is supervising the embedded CAMH Parenting IAPT Trainee Future opportunities being explored
Roll out of CYP IAPT principles across all agencies with routine outcomes monitoring established.			ELFT / CHUMS	2015-2020		Review of good practice related to embedding I-Thrive

Increased workforce using IAPT Principles Increased Numbers of staff trained exception reporting via contract monitoring	95% by 2020(TBA)			2015-2020		.

CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of meeting 12 July 2017

Emotional Health, Wellbeing and Resilience in Children and Young People and their Families

Responsible Officer: Sue Harrison, Anne Murray, Muriel Scott

Advising Officer: Sanhita Chakrabarti
Email: Sanhita.chakrabarti@bedfordshireccg.nhs.uk

Public

Purpose of this report

1. To update Health & Wellbeing Board on a partnership approach in addressing emotional health, wellbeing and resilience in children and young people and their families.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

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1. **receive update on a draft partnership action plan to improve emotional health and wellbeing of children and young people across Central Bedfordshire; and**

2. **support commissioners across health and social care to identify the opportunities to embed and mainstream emotional wellbeing into commissioning for health and social care for children and young people.**

2. **Our ambition** for children and young people across Central Bedfordshire is to make sure they are feeling good, feeling that their life is going well, and feeling able to get on with their daily lives.

3. **Positive mental health** is central in achieving best possible health outcomes for adults as well as children and young people. "*There is no health without mental health*". It is now well understood that positive mental health or mental wellbeing is more than simply the absence of mental illness. Mental wellbeing means that an *individual is able to realise his or her own abilities, cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.*

4. **Resilience** is described as the capacity to bounce back from adverse experiences, and succeed despite adversity. Adversity can be defined as a lack of positive circumstances or opportunities, partly brought about by physical, mental or social losses or deprivation, or the experience of trauma.

5. Resilience is the opposite of vulnerability.

What do we know?

Below are some facts that describe the state of emotional wellbeing of Children and Young People in Central Bedfordshire. These are published facts and may only give us an estimate.

6. The overall youth index (combining young people's happiness and confidence) score was **71** across the UK. **A decrease on last year's** index of 72 (Princes Trust Youth Index 2015).

7. An estimated **3,225** children in Central Bedfordshire aged 5-16 years and **1,640** 16-19 year olds have a mental health disorder. (CHIMAT)

8. The national What About YOUth (WAY) survey 2014/15, 47.6 using the Warwick-Edinburgh Mental Well-being Scale (14 statements covering a range of feelings and attitudes towards life)

   – Score of 47.6 nationally,
   – **47.1** for CBC - **lower than England** average but same as East of England (max of 70 is good).

9. In 2014/15, **52%** CBC children surveyed were bullied in last couple of months (Eng 55%, East of England 56.4%).

10. School Nursing Service is reporting that nearly **50%** of the young people attending drop-ins are presenting issues around emotional wellbeing and anxiety. (2015/16)

    Findings from the SHEU survey 2015/16 amongst school children across Central Bedfordshire are:

11. 75% of younger pupils responded that they are 'quite a lot' or 'a lot' happy with their life at the moment (the most positive answer in online surveys was labelled 'very much').

12. 70% of older males and 50% of older females responded that they feel at least 'quite' happy with their life at the moment.

13. At least 1 in 10 children and young people report sometimes being so worried that they find it hard to concentrate on anything.

14. Resilience is the capacity to bounce back when faced with adversity; however, over a third of Year 8, 10 and 12 pupils have low resilience scores.

15. Children and young people mostly turn to family and friends for support; however, a significant minority say they would not have any support for a range of issues.

Why do we need to address emotional wellbeing and resilience for children and young people across Central Bedfordshire? (SEE ATTACHED POWERPOINT SLIDE No 1)

16. Improving the emotional wellbeing of children and young people through promotion, prevention and early intervention has the potential to contribute to far-reaching improvements in physical health and wellbeing, a better quality of life, higher educational attainment, economic wellbeing and reduction in crime and anti-social behaviour. Investing time and resources now in improving mental wellbeing has the potential to achieve these outcomes and rebalance investment.

17. There are four drivers for promoting positive mental health and emotional wellbeing: the economic case, the equalities case, the ethical case, and the evidence case.

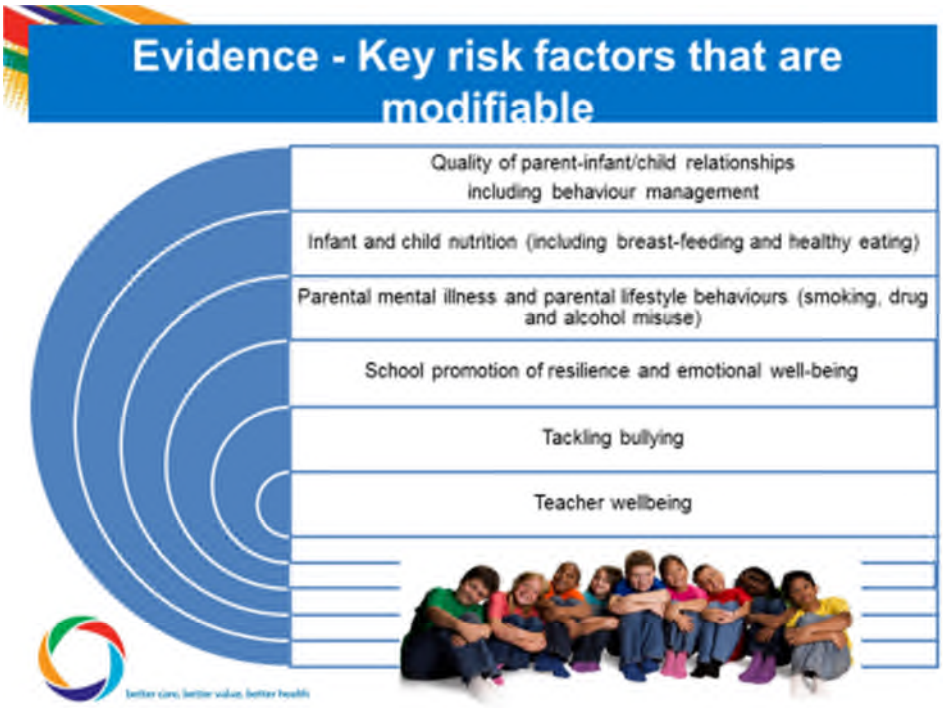
18. **The economic case**: promoting positive mental health and emotional wellbeing along with illness prevention will reduce costs for the NHS and local authorities over the next two to five years. With health and local authority colleagues commissioning well evidenced programmes strategically there is a good likelihood this will lead to lower demand on primary care, hospital and community services, and will achieve improvements in overall population health.

19. **The ethical case**: everyone has the right to the best physical and mental health that society can afford, to enable them to enjoy their capabilities to the full and contribute to society. Focussing on holistic wellbeing, and emphasising strengths and abilities (rather than deficits) offers a positive alternative to the illness and disability focus of much health and social care provision.

20. **The equalities case**: reducing health inequalities using the evidence that mental wellbeing can play, is critical to promoting positive mental health and wellbeing and to reducing the impact of 'prior discrimination' amongst minority groups.

21. **The evidence case**: there is very good evidence that 1) mental health status impacts on a broad range of health and social outcomes and 2) a range of interventions can promote mental wellbeing and prevent poor mental health. The partnership action plan has been derived from the best available evidence.

What is the evidence around modifiable risk factors that impact on emotional and mental wellbeing in children and young people?



Partnership action plan to improve emotional wellbeing and resilience in Children and young people across Central Bedfordshire 2017-2019 (Attached document)

22. Partners from Central Bedfordshire Council Children's Trust Board met five times between September 2016 and January 2017 to consider available published evidence on effective interventions, evidence from existing services for children and young people who are striving to improve emotional wellbeing and children across Central Bedfordshire. The partnership group then used this evidence to develop plans to work together and further improve the lives of children across several developmental stages in their life.

23. The objective of the partnership action plan is to build on community resilience within children, young people and their families and in turn improve the emotional wellbeing and resilience.

24. The action plan was developed with the input from services commissioned by Bedfordshire Clinical Commissioning Group, Central Bedfordshire Children Services, Public Health, Schools, children and their families, Early years services and provision, CAMHS service, adult services to support transitions, youth services, leisure services and the voluntary sector.

25. The Draft action plan takes an approach to:

- Improving access to professional support when our children are feeling vulnerable.
- Increasing expertise in all front line staff, who work with children to detect early signs of emotional distress.
- Building resilience in the community, including parents.

26. A major aspect of the partnership action plan is to support schools in developing a **whole school systems approach** to improve emotional wellbeing for our children and young people. The evidence around this is comprehensive. The aim is to do this through the work with clusters of schools as part of CBC Children's services transformation program.

27. NHS England funding was sought and training workshop was commissioned from Anna Freud Centre for school heads and governors around whole school systems approach. This took place in April 2017.

The principles of whole school system approach is outlined below:
(SEE ATTACHED POWERPOINT SLIDE)
Public Health England and Children's and Young People's Mental Health Coalition
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414908/Final_EHWB_draft_20_03_15.pdf

- Leadership, management and managing change
- Policy development
- Curriculum planning and resourcing
- Teaching and learning
- School culture and environment
- Giving pupils a voice
- Provision of pupils' support services
- Staff professional development, health and welfare
- Partnerships with parents, carers and local communities
- Assessing, reporting and recording achievements

How will we measure success?

28. The attached draft action plan outlines some short term process measures with time lines on the several initiatives that have been identified by the partnership group.

29. This draft action plan will be managed through the children's services transformation program within Central Bedfordshire Council.

30. In the long term outcomes will be measured in improved survey data from SHEU survey.

31. Other quantitative and qualitative parameters measured through the various commissioned services in health and social care for children across Central Bedfordshire Council will show an impact.

Financial and Risk Implications

32. Investment in this action plan will deliver significant financial benefits across the system as is established from published evidence.

33. Noted benefits will be improved achievement in children as they access education and less access to specialist health services and particularly mental health services.

34. Economic benefit is investing in early intervention in improving emotional wellbeing and resilience in children delivers is estimated as nearly £8 for every £1 invested.

Governance and Delivery Implications

35. The delivery of the action plan will report to the Central Bedfordshire Council Children's Leadership team.

36. Delivery of the action plan will be managed by Central Bedfordshire Council, Children's Transformation Board.

Equalities Implications

37. This partnership action plan will aim to address health inequalities in tackling emotional wellbeing and resilience by using a 'needs based' and targeted approach where required.

Conclusion and next Steps

38. Request Health and wellbeing board to support this ongoing partnership approach across health and social care for children and young people.

39. Updates will be delivered to the Central Bedfordshire extended leadership team on a regular basis.

Improving emotional health and wellbeing of Children and Young People across Central Bedfordshire Councils - action plan 2017- 2019

Sponsor – Sue Harrison (DCS CBC), Muriel Scott (DPH CBC), Anne Murray (Director of Commissioning of children's services BCCG), CBC Extended leadership team for CYP

Responsible Officers – Sanhita Chakrabarti (Clinical Lead Bedfordshire CCG CYP), Celia Shohet (Assistant Director Public Health), Gerard Jones (CBC – Post to add), Leo Jones (CBC – post to add), Karlene Allen (BCCG Head of Children's Commissioning)

Organisational and partnership groups responsible for delivery – Bedfordshire and Luton wide Future in Mind Steering Group, CBC Children's Transformation Board, BCCG CYP operational group

Assurance – CBC Extended Leadership Team, CBC Health and Wellbeing Board, BCCG executive team

	Recommendation	**Responsible Officer/Manager**	**Lead project officer(s) and support officers**	**Success criteria**	**Timescale**	**Finance Required**
	Promoting mental health and wellbeing as everyone's business					
1	National 'Time to Change' stigma campaign pledge to be adopted locally (and to include local campaign)	Karen Aspinall (CBC)	Jim Brock	Number of organisations signed up	1st reporting - Q3/Q4 (2017/18) reporting	Resource to disseminate material
2	Increase uptake of services from Bedfordshire adult wellbeing service and single point of access for CAMHS. Promote Bedfordshire adult wellbeing service to businesses	**Gina Manning (LEAD)** (BCCG) Karlene Allen (BCCG) Sandra Harrild	Sandra Harrild Sarah James Ben Pearson Anna Flecknoe	IAPT data	1st reporting - Q3 (2017/18) reporting	

		Celia Webb (ELFT)				
3	Council and partners to make mental health awareness training mandatory for all staff (making mental health and wellbeing everybody's business)	**Muriel Scott (CBC) Sue Harrison(CBC) (LEADS)**	Debbie Crawford Sarah James CBC LD rep Anna Flecknoe/ Freena Tailor	Numbers of staff trained Numbers of partners delivering training to staff Evaluation of training data	1st update – Q4 (2017/18)reporting	'Mental Health First Aid' type training for key staff Front line Children's social care Housing and Job Centres
4	GP awareness training and development of pathways through PLZs	Sanhita Chakrabarti (BCCG)	Sanhita Chakrabarti GP Locality managers	Number of GPs trained. Evaluation of training data	1st update – Q4 (2017/18) reporting	
	Developing Practice					
5	Analysis of maternal wellbeing scores obtained through universal screening need to inform future targeting of services to improve emotional wellbeing within the family.	**Celia Shohet/Barbara Rooney (LEADS)** Gerard Jones (CBC)	Jacky Syme (EPUT)	Review taken place and ongoing Review has informed targeting of provision	Annual audit report for ongoing reporting 1st Update – Q4 – 2017/18	Commission Review with CLARHC/Public Health
6	Family mental health and parenting issues to be included as part of 2.5 year integrated review. Analysis of this universal information to target intervention for the family. Review use of Social and emotional scores already collected as part of this review. Questions we need to answer: 1. What is the intervention that takes place as part of these reviews?	**Celia Shohet/Barbara Rooney (LEADS)** Gerard Jones (CBC)	Jacky Syme (EPUT)	Parental MH included at 2 ½ year review of children Number of adults/families identified	Annual audit report for ongoing reporting 1st update Q4 – 2017/18	Commission Review with CLARHC? University of Bedfordshire/Public Health

	2. How are we linking with parenting programs?					
7	To identify and utilise an assessment tool such as Edinburgh wellbeing scale for Year R and Year 6 health reviews	Celia Shohet/Barbara Rooney (CBC)	Kerry Dufraisse	Assessment tool agreed. Tool used at Year R health assessment. Tool used at Yr 6 health assessment. Numbers of children needing follow up interventions/ care	Annual audit report Going forward Update – 2017/18 Q3/Q4	
8	Review impact and outcomes of current parenting programme outcomes Question that needs answering? 1. Are we getting the best out of our commissioned parenting programs in improving overall wellbeing of our families and children's? We need to compare to national best practice and published evidence.	Gerard Jones (CBC)	Sue Tyler/Fiona Side	Outcome measures developed for Parenting programmes Data on evaluation of programme outcomes	1st report – Q4 reporting 2017/18	Commission Review with CLARHC?/Univ of Bedfordshire
	Promoting a whole school approach to mental health and wellbeing					
9	All schools adopt a Whole School Approach to mental health and wellbeing 8 principles as recommended by Public Health England and Children's and Young People's	**Leo Jones (LEAD)**/ Jackie Edwards (CBC)	Jackie Edwards Sarah James Ben Pearson	WSA focus group formed Feedback on	1st reports - Q3 (2017/18)	Commissioning of specialist provider to

	Mental Health Coalition – https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414908/Final_EHWB_draft_20_03_15.pdf a) Leadership, management and managing change b) Policy development c) Curriculum planning and resourcing d) Teaching and learning e) School culture and environment f) Giving pupils a voice g) Provision of pupils' support services h) Staff professional development, health and welfare i) Partnerships with parents, carers and local communities j) Assessing, reporting and recording achievements In addition schools to have a policy and code of practice for **tackling bullying**, which is owned, understood and implemented by all members of the school Community. This includes specific interventions on Cyberbullying. Parent training, curriculum support for PA, the arts and culture.		School imp rep Anna Flecknoe /Freena Tailor Katolo Curtis	workshops - 3 key actions followed up. Local WSA toolkit developed CAMH School project baseline data obtained Project measures reported Behaviour management project implemented Number schools adopting WSA	reporting	support schools adopt a Whole school Approach training Funding for workshops to support school clusters in reviewing and further developing policy and code of practice for **tackling Bullying particularly Cyber - bullying**, which is owned, understood and implemented by all members of the school community and includes contact with parents and carers.

10	PSHE Network development to widen its remit to support WSA to health and wellbeing	**Celia Shohet/Barbara Rooney (LEAD)** Leo Jones (CBC)	Sarah James	Developments to network- in response to focus group feedback. Gov metric data reported Online resource list developed for MHW and presented to Cluster groups		
	Working with Primary Care					
11	Working with clinicians across primary care • Appoint a 'champion' in the practice for young people's health • Let young people register with a GP • Help young people make appointments • Involve young people in patient participation groups • Education on emotional wellbeing assessment as part of non – specific symptom presentation by children and their families • Use of RCGP_Adolescent Health Group developed leaflets on the topic of young patients visiting the GP on their own	**Sanhita Chakrabarti (LEAD)** Roshan Jayalath (BCCG)	Roshan Jayalath	Survey using 'You're welcome' standards across GP practices Developing young people's champions within localities and GP practices	Q4 (2017/18) – 1st update	
	Working around transition of children across different systems					

12.	1. School transition: toolkit development – Best practice from Beds schools and wider research. Clinical input and when to seek clinical support. 2. Transitions for SEND – Transitions as part of the EHCP process. Individual transition plans. Support at the point of transition embedded in plans 3. Supporting CYP with learning and physical disabilities in to Adults service – Existing Preparing for Adulthood (PfA) work, ages 14 to 25. 4. Starting school (Early Years) – Existing policy. Review, communicate.	**Claire Olliffe (BCCG) (LEAD)** Leo Jones (CBC)	Julie Cronin (BCCG) Ken Harvey (CBC) Claire Olliffe (BCCG) Jackie Edwards (CBC)	Pre and post measures. Before and after transition feedback introduced within school set up Reviewed and agencies aware	Q4 (2017/18) – 1st update and reporting structure	
	Supporting parents and carers					
13	• Sign post parents and carers via schools and other parents forums to online resources • Workshops for parents and carers who are identified to have children where resilience and emotional wellbeing is an issue • Support parent's emotional wellbeing with Bedfordshire wellbeing service – as described above https://www.bedfordshirewellbeingservice.nhs.uk/	**Kirsty Green – Participation Manager** **SNAP (CBC) (LEAD)** Ken Harvey (CBC) Julie Cronin (BCCG)	Hazel Dean- (EPUT) Sandra Harrild – (ELFT)		1st report – Q4 2017/18	
	Engagement of children and young people					
14	Implementation of recommendations made in a recent report from a survey of young people conducted by CBC Youth Parliament : • Developing Peer Support Network amongst	Peter Fraser Youth Parliament (CBC)	Lisa Wright Simon Bailey	Survey report communicated with partners Positive	1st update with action plan and reporting	

	children and young people • Parent Support and network for parents • Develop Mental Health Minimum Standards / Charter • Develop Wellbeing Groups – Step up Step Down Early Help • Develop Male "Break the stigma" Campaign			network feedback Views result in actions and are fed into the policy process	by – Q4 2017/18 reporting	
15	**Emotional resilience in children with SEND, LAC and Children in contact with YOS**	Work in progress Due to be completed by October 2017				

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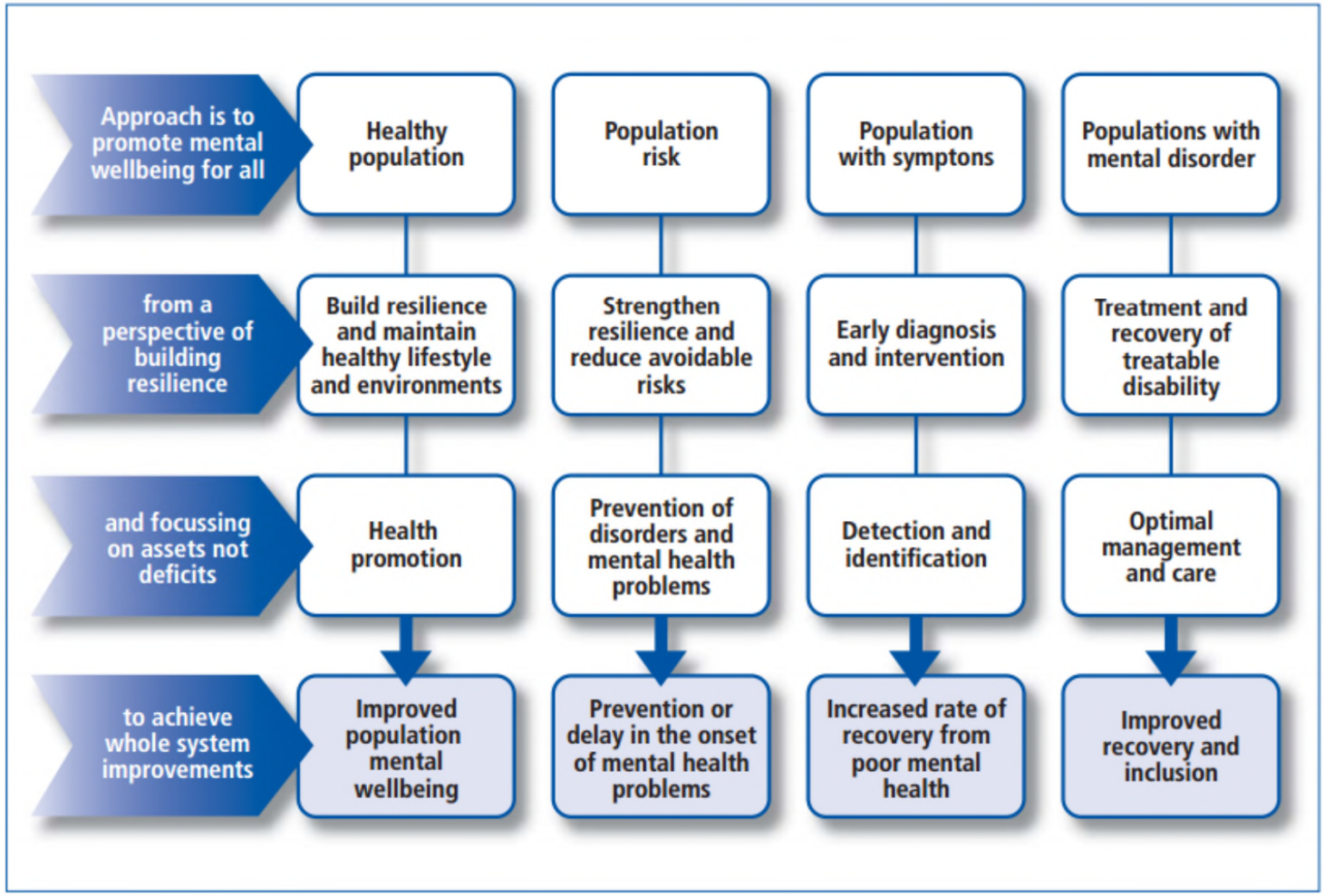
Accompanying slides- Emotional wellbeing and resilience in CYP

Sanhita Chakrabarti

better care, better value, better health

Opportunities for Mental Health Promotion: a population perspective

•UCLAN (2010) Commissioning Mental Wellbeing for All: A toolkit for commissioners. University of Central Lancashire. Commissioned by the National Mental Health Development Unit (NMHDU).



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Clinical Commissioning Group

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Clinical Commissioning Group

Eight Principles

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CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of meeting 12 July 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 action identified for the Health and Wellbeing Board outlined on each scorecard.**

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

3. The scorecard includes the key measures providing an indication of progress against target, direction of travel and a comparison with benchmarks.

4. 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.

5. The scorecards now contain the successes, challenges and suggested actions for the Board rather than outlining them separately in the covering report.

Financial and Risk Implications

6. There no financial implications directly associated with the scorecard

Governance and Delivery Implications

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

Equalities Implications

8. The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Implications for Work Programme

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

10. 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

11. 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	Statistical neighbour/ deprivation decile
Proportion in need accessing psychological therapies	Mar 17	↑	12.97 %	15.00 %	▲	n/a	n/a
CAMHs waiting for intervention for more than 18 weeks	Dec 16	→	0 %	0 %	★	n/a	n/a
Hospital admissions for mental health 0-17 years	Dec 15	n/a	73.4		n/a	87.4	n/a
Hospital admissions for self-harm 0-18 years (CBC Population)	Mar 17	↓	25		n/a	n/a	n/a
Emotional wellbeing of looked after children	Sep 16	↑	13.4	13.0	●	n/a	14.6
Recovery rates for those completing psychological therapies	Mar 17	↑	54.7 %	50.0 %	★	48.4 %	n/a
Premature mortality (<75 years) in adults with serious mental illness	Dec 13	n/a	1,232		n/a	1,319	n/a
Proportion of adults in contact with secondary mental health services in paid employment	Sep 15		6.5 %	13.2 %	▲	5.8 %	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

Successes:
The performance of recovery rates for those completing psychological therapies has improved and achieved the 50% threshold in March 2017.

CAMHS have successfully recruited 1.00wte CAMHS Mental Health Practitioner to support the Central Bedfordshire Emotional Behaviour team (CEBT) to target the external waiting list with a view to reducing the current wait for assessment in the team.

Challenges:
The target for the proportion in need accessing psychological therapies indicator has been re-negotiated to a year end recovery target of 13.2% as opposed to the original target of 15%.

Health and Wellbeing Board Action:
To consider appropriate action following the presentation from ELFT as discussed under item 10.

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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	Statistical neighbour/ deprivation decile
Smoking at the time of delivery (L&D deliveries only)	Sep 16	↓	17.1 %	15.0 %	▲	n/a	n/a
Breastfeeding rate 6-8 weeks	Dec 16	→	47.8 %	50.0 %	●	n/a	47.0 %
Early access to antenatal care (all L&D deliveries)	Mar 17	↓	80.0 %	90.0 %	▲	n/a	n/a
Mothers who receive a maternal mood review by the time the infant is 8 weeks	Mar 17	↓	85.9 %	90.0 %	●	n/a	n/a
Successful completions (opiates) of clients who live with children under 18	Mar 17	↑	13.4 %	12.8 %	★	7.7 %	n/a
Successful completions (alcohol) of clients who live with children under 18	Mar 17	↓	35.4 %	37.7 %	●	43.1 %	n/a
No. of Domestic Abuse incidents reported	Mar 17	↓	742		n/a	n/a	n/a
Children who received an integrated 2-2.5 year review	Mar 17	↑	74.1 %	90.0 %	▲	n/a	n/a
Number of disadvantaged 2 year olds placed in early education/childcare	Mar 17	↓	614	645	●	n/a	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 %	71.6 %
Childhood Excess Weight: Reception Year Children (4-5 years)	Jul 16	↑	19.6 %	18.8 %	●	22.1 %	n/a
Teenage pregnancy	Dec 15	↑	18.6	17.7	●	22.8	13.6

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

Successes:
The latest data relating to giving every child the best start in life shows improvements in:

- The successful completion of clients (opiates) who live with children under 18.
- The number of children who received an integrated 2-2.5 year review.

Challenges:
The following indicators show a decline from the previous quarter:

- Early access to antenatal care. This has been raised with the BCCG to explore concerns and to request for data to be split between Luton and Central Bedfordshire.
- The successful completion of clients (alcohol) who live with children under 18 has fallen from 39.1% previous quarter to 35.4% and now below target. This will be raised at P2R's next performance meeting.
- The number of disadvantaged 2 year olds placed in education/childcare. However 95% of disadvantaged 2 year olds are in early education/childcare settings in the Spring Term 2017.
- The percentage of mothers who receive a maternal mood review by the time the infant is 8 weeks. The reduction is caused by short-term capacity issues in the 0-19 team and a failure of some acute trusts to pass on information in a timely way which is being actively addressed.

Health and Wellbeing Board Action:
To continue to monitor the direction of travel and actions for those indicators which remain under target.

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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	Statistical neighbour/ deprivation decile
Smoking prevalence 18+	Dec 16	↑	10.3 %		n/a	15.5 %	11.8 %
Adult Excess Weight	Jul 15	↑	67.1 %	68.1 %	★	64.8 %	62.6 %
Percentage of adults classified as inactive	Jan 17	→	22.7 %	23.6 %	★	28.7 %	23.6 %
Health Checks Delivered % of Target	May 17	↑	86.2 %	100.0 %	▲	n/a	n/a
Recorded diabetes	Nov 15	n/a	6.0 %	5.3 %	▲	6.4 %	5.3 %
% people with diabetes meeting all 3 treatment targets (blood sugar, blood pressure & cholesterol)	Feb 16	↑	37.6 %		n/a	40.4 %	n/a
Premature mortality	Dec 15	↑	280	272	●	335	241
Premature mortality for cardiovascular disease	Dec 15	↓	63.8	57.7	▲	74.6	57.7
Premature mortality for respiratory disease	Dec 15	↓	25.2	23.5	●	33.1	23.5
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

Data for most of the indicators related to enabling people stay healthy longer are reported annually however plans are in place and being monitored to ensure performance of these indicators do not worsen.

Successes:
The number of health checks delivered (% of target) has increased throughout the year and particularly the final quarter, the year end figure of 87.5% compares well with the previous year which was 70% of target. This is due to a number of factors, including intensive/detailed support for providers, clarity of contracting arrangements and improved, more convenient 'single point of care' blood testing for patients.

Health and Wellbeing Board Action:
To continue to promote health checks to residents in order to enable the early identification and prevention of people at higher risk of developing cardiovascular disease, including diabetes.

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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	Statistical neighbour/ deprivation decile
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	Mar 17	↓	2,630	2,309	▲	n/a	n/a
Permanent Admissions of Older People (65+) to residential & nursing care homes (BCF 2) QUARTERLY	Mar 17	↓	375	485	★	n/a	n/a
Proportion of 65 + still at home 91 days after discharge from hospital	Dec 16	↑	91.8 %	95.5 %	●	n/a	n/a
Emergency hospital admissions due to falls (65+) per 100,000	Mar 16	↓	2,235	1,771	▲	n/a	n/a
Dementia diagnosis rate (65+)	Mar 17	↑	61.22 %	66.72 %	●	67.70 %	n/a
Social isolation-Adult carers who have as much contact as they would like	Mar 14	↓	41.0 %	41.6 %	●	38.0 %	n/a
Delayed Transfers of Care (days) from hospital per 100,000 population	Mar 17	↑	627	423	▲	n/a	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

Successes:
The rate for delayed transfers of care shows an improvement in performance. There were 538 days spent in acute care because of delayed transfers (435 NHS, 90 Social Care & 13 both NHS and Social Care) during March 2017.

Permanent admissions of older people to residential and nursing care homes show a decrease from previous quarter but are performing well against the target.

Challenges:
Delayed discharges remain challenging across the Health sector with per 100,000 population performance during Q4 2016/17 behind target - 627.3 vs 423.3 target.

The target for non elective admissions into hospital remains challenging and is below the BCF target. A review of non elective admissions has been carried out and includes those areas with higher rates of emergency admissions, such as paediatrics and people with long term conditions.

Dementia diagnoses rate (65+) shows a slight increase from previous month but still remain below target. East London Foundation Trust (ELFT) continue to support low referring GP surgeries as part of the CQUIN and are offering training to those identified. Dementia education seminars for patients and carers will take place throughout the summer. This is to encourage patients to come forward who are worried about their memory and to promote the range of post diagnostic support services in place for people.

Health and Wellbeing Board Action:
To continue to provide support and oversight of the Better Care Plan including the development of integrated care.

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	**Better Care Fund Plan 2017/18 - 2018/19**
Meeting Date:	12 July 2017
Responsible Officer(s)	Julie Ogley, Director of Social Care, Health & Housing Donna Derby, Director Commissioning - Bedfordshire Clinical Commissioning Group
Presented by:	Julie Ogley, Director of Social Care, Health & Housing Donna Derby, Director Commissioning - Bedfordshire Clinical Commissioning Group

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Recommendations **The Health and Wellbeing Board is asked to:**

1. **note the latest policy framework in respect of Better Care Fund plan for 2017/19 and progress made on developing the plan;**
2. **note the end of year progress against the 2016/17 Better Care Fund Plan (BCF); and**
3. **note that Quarter 4 BCF monitoring template was submitted to NHS England 31 May 2017.**

Purpose of Report	
1.	To provide an update on the development of the Better Care Fund (BCF) Plan for 2017-19.
2.	To advise the Health and Wellbeing Board on planned use of the additional social care grant, the Improved Better Care Fund, as set out in Appendix 3.
3.	To update the Health and Wellbeing Board on the delivery of the BCF Plan 2016/17 and to note the Quarter 4 BCF monitoring template that was submitted to NHS England 31 May 2017.

Background	
1.	The Integration and Better Care Fund Policy Framework for the two year 2017-19 BCF was published in March 2017. The Policy Framework for the Fund covers two financial years to align with the NHS operational plan timetables and to give areas the opportunity to plan more strategically.

	It remains unclear however when the planning guidance will be published.
2.	The policy framework sets out the story of integration of health, social care and other public services. It provides an overview of related policy initiatives and legislation, as well as the Government's proposals for going beyond the BCF towards further integration by 2020.
3.	The 2017/19 BCF Plan should build on the 2016/17 plan and is a key mechanism for the delivery of integration. There is also a requirement for partners to develop, and the HWB approve: • An agreed narrative including details of how national conditions will be addressed. • Confirmed funding contributions from each partner organisation. • A spending plan which sets out funding of each of the BCF schemes. • A plan detailing how health and social care integration will be achieved by 2020. • Quarterly plan figures to meet the national metrics. • Engagement with stakeholders in formation of the plan. • Progress a new nationally produced 'High Impact of Change' Model template.
4.	In 2017-18, the total BCF will be increased to a mandated minimum of £5.128 billion and £5.617 billion in 2018-19. The local flexibility to pool more than the mandatory sum remains. The main change to the Framework from last year is inclusion of significant amounts of local authority social care grant funding. Some of this was announced at the 2015 Spending Review, with an additional £2 billion over three years announced at Spring Budget 2017.
5.	As well as completing a national planning template, Health and Wellbeing Boards are required to submit a narrative plan that outlines the local vision and approach to integration, the case for change and demonstrate alignment with local strategic vision for the STP and the GP Forward View.
6.	The narrative plan should also include a detailed expenditure plan setting out the initiatives and projects that will be funded via the BCF pooled fund and the arrangements for the Improved Better Care Fund (iBCF).
7.	The BCF 2017-19 Policy Framework sets out four key national conditions for the two year plan: 1. Plans to be jointly agreed 2. The NHS contribution to adult social care is maintained in line with inflation 3. Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care 4. Managing Transfers of Care (a new condition to ensure people's care transfers smoothly between services and settings).

8.	Beyond these, areas have flexibility in how the Fund is spent over health, care and housing schemes or services but need to agree how this spending will improve performance in the following four metrics: 1. Delayed transfers of care, 2. Non-elective admissions (general and acute), 3. Admissions to residential and care homes and 4. Effectiveness of reablement.
9.	Whilst awaiting publication of the technical guidance and confirmation of the BCF allocations and ring fenced sums, health and social care colleagues have been working to consider the areas of focus for the next plan.
10.	The 2017/19 BCF plan should build on the 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.
11.	In light of this, the guiding principles set out in the BLMK STP Plan and the GPFV will continue to be reflected in the new plan and are as follows: • Prevention and early intervention • Care Closer to home • Improving out of hospital services • Securing integrated outcomes for people across physical, social and mental health.
12.	A place based approach to integration is being considered by partners. Equally an Integration Plan will be importantly influenced by the findings of the Overview and Scrutiny Enquiry into Integration in Central Bedfordshire. A report on the findings will be presented at the Executive meeting in June.
13.	Agreement will be sought on the overarching schemes identified within the Plan. These schemes will contain a number of projects which will help to meet the national conditions as well as deliver outcomes against the national metrics and build on both strategic and operational integration initiatives already underway. • Multidisciplinary Approaches delivering integrated services and improving pathways across all parts of health and social care. • Care Homes – including incorporating key elements of the Vanguard Enhanced Health Care in Care homes (EHCH) framework • Assistive Technology and Housing Adaptations (to include DFGs) • Improving Out of Hospital services – including an integrated reablement service, discharge to assess and home care services.

	New Grant for Adult Social Care (Improved Better Care Funding)
14.	The Chancellor's Budget in March 2017 announced £2bn additional non-recurrent funding for social care, of which Central Bedfordshire can expect £1.810M in 2017/18, followed by £1.956M in 2018/19 and £1.3M in 2019/20. This additional funding is required to be pooled through the BCF and should be spent on unmet social care need. The conditions also stipulate that the additional funding for adult social services paid directly to local authorities does not replace, and cannot be offset against, the NHS minimum contribution to adult social care.
15.	The new improved BCF grant will be paid directly to local authorities from the Department for Communities and Local Government. The grant will be included in the BCF however can only be used for the purposes of meeting social care needs, reducing pressures on the NHS and ensuring that the local social care provider market is supported.
16.	While the additional funding will need to be pooled within the BCF and principles agreed as part of the overall plan, plans for investment of this element of the fund will need to be agreed by Council.
17.	The Council can use the money to drive forward the strategy for Central Bedfordshire which is to implement a community based model for health & social care that focusses on the whole population. It will enable the population to access health and social care closer to home, via health and social care hubs, and also focusing activity on reducing the delays of transfers from hospital (DToC) but also addressing the real challenges of reducing admission into hospital. This would include: • investment in additional social care resources to support timely discharge from hospital, • complex care management and support to care homes, • voluntary sector investment to build capacity in the community • adult social care market sustainability • expanding the use of assistive technology • increasing community bed capacity
18.	The investment will also look at the importance of Housing as, nationally and locally, there is a strong focus on the relationship between housing, adult social care and health. The Council will need to focus on the whole system not just ASC or health.
19.	The use of the money will come under national scrutiny and as such both DCLG and NHSE will be seeking quarterly evidence of the success of the deployment of the money.

	A more detailed breakdown of the proposed use of the grant is set out in Appendix 3.
	Progress on BCF Plan 2016/17
20.	In this second year of BCF plans, there is demonstrable evidence of the impact on the health and care system. Key projects such as multidisciplinary working in our localities and relationships with care providers, particularly Care Homes. Local partnerships are strengthened and there is greater collaboration across services to deliver integrated outcomes for people.
21.	The Q4 and End of Year return submitted to NHS England was made on 31st May 2017 and the following outturn on performance against the six metrics were reported: **Non elective admissions:** no improvement against BCF Target. • Reducing non-elective admissions remains a challenge. We are continuing to review the reasons for the increasing figures and have recently undertaken a Public Health led review which will help to ensure that local plans are focused to deliver improvements. **Delayed transfers of care**: on track for improved performance but not to meet full target. • The additional community beds commissioned to support timely discharge from hospital are having some impact. A discharge to assess model is being developed. The Council has increased capacity within the hospital social work team to provide greater oversight and timely support to coordinated discharge from hospital and reduce DTOCs. **Emergency admissions due to falls:** on track for improved performance but not to meet full target. • There is a more joined up and collaborative approach to improve the falls pathway. Delivery of falls awareness and training to care homes have had a real positive impact and non-elective admission for falls showed an 8% reduction in 16/17 against a rising trend in NELs overall. **Patient satisfaction**: on track for improved performance but not to meet full target. • This was based on last quarter – as latest data not available. **Permanent admissions to care homes**: on track to meet full target • Use of residential care has reduced and is below the BCF Target.

	Reablement, patients/customers still at home 91 days after discharge: on track for improved performance but not to meet full target • There have been some marginal improvements in the proportion of people at home 91 days after discharge from hospital. Further work is continuing to ensure more people who can benefit from the rehab/reablement receive support and to promote independence and wellbeing. A Summary of Highlights and successes and the Year End Feedback on the BCF 2016/17 Plan are attached as Appendix 1 and 2.
	Financial Performance
22.	Financial performance of the fund is in line with the BCF Plan. There is however an underspend of £1.258M comprising our 2015/16 brought forward capital grant and 2016/17 increased Disabled Facilities Grant - we have made minor use of both capital grants during 2016/17 and propose to carry forward £1.214M. We also have a revenue reserve of £0.044M which we plan to use in 2017/18.
23.	The focus of the DFG capital grant will be on expanding the use of Assistive technology to promote independence, self management and continue to reduce reliance on institutional forms of care.

Reasons for the Action Proposed	
24.	The Better Care Fund Planning Guidance requires that Plans are signed off by Health and Wellbeing Boards and by the constituent Council and Clinical Commissioning Group.
25.	The Health and Wellbeing Board (HWB) has a statutory duty to promote integration and is seen as a valuable forum for stakeholders to come together to review performance of the BCF and consider opportunities for transforming health and social care. The expectation is that HWBs will continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners.
26.	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.
27.	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
28.	The timetable for the BCF submission will be tight and likely to be before the next scheduled meeting of the Health and Wellbeing Board.
29.	Whilst awaiting publication of the technical guidance and confirmation of the BCF allocations and ring fenced sums, health and social care colleagues will continue to progress planning for the BCF Plan aligned with an Out of Hospital Strategy.
30.	The Health and Wellbeing Board has given the delegated authority to officers developed and submit the initial plan on behalf of the Health and Wellbeing Board. This initial plan and any future iteration will be brought to the Board for approval, where possible.
31.	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.

Issues	
Governance & Delivery	
32.	Delivery of the Better Care Fund Plan is a key mechanism by which the Health and Wellbeing Board is able to fulfil its statutory duty to promote integration of health and social care.
33.	Progress on the Better Care Fund Plan will be reported to the Health and Wellbeing Board and delivery will be through agreed Joint Commissioning Board and governing boards for partners. The Health and Wellbeing Board will provide overall assurance and sign off performance monitoring returns.
34.	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 Health and Wellbeing Board.
Financial	
35.	This section will be updated once the actual allocations for the 2017/19 plan are established.
36.	The current Better Care Fund created a pooled fund of £20.543M in 2016/17 to support the delivery of integrated care. This was made of up of contribution of £5.258M from Central Bedfordshire Council and £15.275M from Bedfordshire Clinical Commissioning Group. An amount of £4.977M was assigned out of the CCG minimum allocation for the protection of social care services. The BCF pool also included the Council's Disabled Facilities Grant of £3.417M.

Public Sector Equality Duty (PSED)	
37.	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.
38.	Are there any risks issues relating Public Sector Equality Duty **No**

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

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

Appendix 1 – Highlights and Success
Appendix 2 – BCF Successes
Appendix 3 - Improved Better Care Fund

Appendix 1

Highlights and Successes:

MDT working:
Caring Together MDT meetings: Proactive care and risk stratification approach is continuing. The Luton and Dunstable Hospital Consultant Geriatrician is providing input into the meetings and supporting case management.

A 'place based' multidisciplinary approach in Ivel Valley with staff from community, mental health and social care is progressing. This multidisciplinary approach is being led by senior operational managers, who are now meeting on monthly basis. A staff directory has been produced. This test bed for a place based team is being supported by Health Education East who has provided important insights into the experiential learning from this way of working. Work is also on going to facilitate interim co-location of the team at the Biggleswade Hospital site. Plans are underway to roll out this approach across Central Bedfordshire from July 2017. This place based focus aligns with the STP vision and work packages for primary, community and social care priority.

End of Life: 2016/17 saw the review of EoL and palliative services across the health and social care pathway and a revised care model developed. There is greater integrated working, increased capacity and a more proactive approach to care management. An integrated care pathway is now being developed. Advanced Care Plans training has continued. Work with the Ambulance service has seen as reduction in the number of conveyances to hospitals with more calls to the PEPS Service. Up to 12 Care Homes in Central Bedfordshire have appointed an EoL Champion to work with professionals.

Delayed Transfers of Care: Additional investment and realignment of staff to support early and coordinated discharge from all hospitals used by Central Bedfordshire residents. Closer working with all acute trusts to improve understanding of patient flows is underway. Social care related reasons for delayed transfers of care reduced and is one of the best performers in the Eastern Region. Additional intermediate care beds have been made available.

Stroke Early Supported Discharge: ESD service went live in March and referrals have been received from the Luton & Dunstable, Bedford and Lister Hospitals. The stroke tracker developed by the team to be able to monitor impact of the service on length of stay and access to community stroke rehabilitation showed that in the first month of the service there were 19 referrals for Central Bedfordshire residents and all referrals were seen within 24 hours .

Supportive Technology: Disabled Facilities Grants - Developing a policy for more flexible use of resource to support early discharge from hospital and promote independence through wider use of assistive technology.

Falls: Business case approved for fracture liaison service to commence in April 2017 at Bedford Hospital. Individual care home providers are purchasing equipment to help get people up safely following the ISTUMBLE seminar.

The assessment against the enhanced care in care homes framework has been completed and priorities identified. Community nursing service specifications have been updated and include nursing homes having access to community nurses, contract variation is in discussion.

General Integration:

- The Social Care, Health and Housing Overview and Scrutiny Committee concluded its enquiry on the local approach to integration and integrated health and care hubs. A report is due to go to the Council's Executive in June 2017.

- The outcome of the LGA Peer Review into Reablement and Rehabilitation which took place in Q3 will be taken forward in an action plan which will form part of the 2017/19 BCF Plan.

- Successful funding bids: Following the success of the ETTF fund allocation for Integrated Health and Care Hubs in Dunstable and Biggleswade, we have also received funding from the One Public Estate to develop scoping documents and outline business cases for Hubs in Leighton Buzzard, West Mid Beds and requirements for Houghton Regis. On going discussions with NHS Property Services to secure the Biggleswade Hospital Site asset are critical to meet the ambition for the Ivel Valley Hub. Locality based integrated health and care hubs are a key part of the STP vision for out of hospital services and key also for the implementation of the GP Forward View.

Challenges and concerns:

- Challenge of working with several acute trusts, particularly in relation to DTOC and engagement in A&E delivery Boards where Central Bedfordshire residents are in minority.
- Recruiting and retaining sufficient care workers, particularly in the domiciliary care sector.
- Information and shared records to facilitate timely transfers of care and joint care planning.

Potential actions and support:

- Engagement with stakeholders for fracture liaison service
- Review into novel uses of DFG to facilitate early discharge and promote independence as well as expand use of assistive technology.
- Improvements in DTOC performance due to additional resources and capacity for early supported discharge.
- Development of integrated care pathways for Falls, stroke ESD and End of Life Care

- Developing multidisciplinary place based teams across Central Bedfordshire.
- Move to integrated health and social care offer to improve patient flow and reduce hand offs between professional groups.

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Year End Feedback on the Better Care Fund in 2016-17

Selected Health and Well Being Board:	Central Bedfordshire

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	There has been closer working between Council and health colleagues to deliver greater collaboration and joint working across the system. More partnership approaches is also emerging in light of the STP and the development of 'place based' Transformation Boards. However there are still al challenges for delivering what remains an ambitious Central Bedfordshire BCF Plan, particularly in relation to reducing unplanned admissions to hospitals. Multidisciplinary approaches with place based teams are being developed with an initial test bed in one of our localities and plan to roll out this appraoch across the rest of Central Bedfordshire later this year.
2. Our BCF schemes were implemented as planned in 2016/17	Neither agree nor disagree	Overall. there has been important progress our scheme areas such as multidisciplinary working and key areas such as falls, end of life care, and reduction in permanent admissions to care homes. Elements of the falls pathway improvement plan have progresed, some timescales have been revised. The Urgent Home Care and Falls Response Service has been providing a service to care homes in Central Bedfordshire since Nov 2016. Falls Champions are present in 31/34 care homes in CBC , 34/35 in Bedford. The Falls champions meet quarterly for education and peer support, these have been well attended throughout the year and included sessions on: Medicines Management, Dementia, Sensory Impairment, Getting up safely with and without equipment.
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality	Agree	We continued to build on multidisciplinary working to deliver integrated outcomes to people with long term conditions, frail elderly and those patients most at risk of admission who would benefit from a more joined up response. The Caring Together pilot across two GP Practices in two localities, Chiltern Vale and West Mid Beds is continuing. Mulitdisciplinary place based teams are being developed across our localities. Additional investment to support timely and an improved co-ordinated discharge from hospital with ongoing community care is in place.
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions	Disagree	Delivery remains challenging. A number of additional projects were mobilised to mitigate the challenge of reducing non elective admissions. Whilst some of the BCF projects, such as falls, end of life care and support to care homes have helped to reduce NELs, the numbers are still rising. A Public Health Review of non-elective admissions has been undertaken.
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care	Agree	Overall the number of delays due to social care reduced. Supported early discharge planning and coordination through joint working has delivered improvements and use of intermediate care beds in the community is having an impact.
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Agree	The measure for most part of the year reported only on the Council's reablement service and did not include outcomes data in relation to rehabilitation/intermediate care provided through Community Health Services. Information is now available to provide a complete picture of the effectiveness of rehabilitation and reablement. Following an LGA led Peer Review of Rehab and reablement across Bedfordshire, there is widespread agreement to establish a more integrated approach and work has begun to deliver this.
7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Strongly Agree	This measure is on track to meet target. There is greater scrutiny of packages of care to ensure that appropriate alternatives are explored. There is a greater focus on reablement and promoting independence which is enabling people to return to their own homes and that residential and nursing placements are apprpriate. Step up and step down beds are being used to provide bed based rehabilitation. The Council is also investing in Independent living accomodation with Care for people.

Part 2: Successes and Challenges

Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

8. What have been your greatest successes in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **successes**	Response category:
Success 1	Delivery of key BCF Projects. Engagement with key delivery partners to deliver improved outcomes. Establishing falls champions in 94% of care homes, focus on prevention and the positve impact on the number of falls in some care homes. Early supported discharge for stroke patients is now live and has seen in reduction in lenght of stay in hospital as a result.	3. Collaborative working relationships
Success 2	Partnership working with Community Health Services provided has improved significantly and a joint associate director post has been established. There is wider engagement across the council and the recognition of this approach to secure improved outcomes for people through timely and appropriate access to better coordinated care and support in their localities. Recently, a Council's Overview and Scrutiny panel carried out an enquiry into Integration and delivery approaches for Central Bedfordshire. A report on the outcome of the Enquiry will be tabled at the Council's Executive later this year.	2. Shared leadership and governance
Success 3	Central Bedfordshire Health and Care System have a shared vision for integration. There is a clear focus on a locality approach with development of locality integrated care hubs. We secured both One Public Estate and ETTF funds to progress the plans for Integrated Health and Care Hubs.	1. Shared vision and commitment

9. What have been your greatest challenges in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	Data sharing and timely access to information for heatlh and care services dellivery across a wide range of provider organisations and different sytems remains a challenge. Securing a shared care record across remains a key focus.	7. Digital interoperability and sharing data
Challenge 2	Ensuring that system responses reflect the wider patient flows and footprint of Central Bedfordshire residents, beyond the three acute hospitals in the STP footprint. Ensuring engagement with A&E Boards for example.	6. Delivering services across interfaces
Challenge 3	Developing integrated care pathways across the systems to deliver improved outcomes as well as ensuring better use of resources.	5. Evidencing impact and measuring success

Footnotes:
Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):
1. Shared vision and commitment

2. Shared leadership and governance
3. Collaborative working relationships
4. Integrated workforce planning
5. Evidencing impact and measuring success
6. Delivering services across interfaces
7. Digital interoperability and sharing data
8. Joint contracts and payment mechanisms
9. Sharing risks and benefits
10. Managing change
Other

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Appendix 3

iBCF proposed allocation

The new investment in 2017/18 is to be used in the following areas:

- investment in additional social care and housing resources to support timely discharge from hospital,
  - 4 additional social workers to support timely discharge (£170k)
  - 8 additional carers in the Urgent Home Falls Response service (£197k)
  - 4 Housing Options officers (£170k)
- complex care management and support to care homes (£125k)
- voluntary sector investment to build capacity in the community (£100k)
- adult social care market sustainability
  - Care Provider Trusted Assessors (£99k)
  - Investment in CBC Care Association (£100k)
- expanding the use of assistive technology (£150K)
- increasing community capacity (£333k)
- Integrated Operations and Commissioning (£281k)
- Programme Support (£87k)

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CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of Meeting 12 July 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)
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.	18 October 2017	Julie Ogley, Director of Social Care, Health and Housing, CBC Contact Officer: Patricia Coker, Head of Partnership and Performance, 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
Pharmaceutical Needs Assessment Update	To receive an update on the Pharmaceutical Needs Assessment.	18 October 2017	Matthew Tait, Chief Accountable Officer, BCCG Contact Officer: Karen McCormack-Morgan NHS Health Checks - Public Health Practitioner, BCCG
Bedford Borough and Central Bedfordshire Annual Safeguarding Adults Report	To receive the annual report from the Bedford Borough and Central Bedfordshire Safeguarding Adults Board.	18 October 2017	Julie Ogley, Director of Social Care, Health and Housing, CBC Contact Officer: Emily White, Principal Social Worker, Head of Quality Improvement and Safeguarding, CBC

Health and Wellbeing Board
Work Programme 2017/18

Issue for Decision	Description	Indicative Meeting Date	Lead Director and contact officer(s)
Moving Forward as an Accelerated Accountable Care System	To provide an update on the STP.	18 October 2017	Julie Ogley, Director of Social Care, Health and Housing, CBC Contact Officer: Patricia Coker, Head of Partnership and Performance, CBC
Children and Young People's Plan	To approve the Children and Young People's Plan 2017 - 2019.	18 October 2017	Sue Harrison, Director of Children's Services, CBC Contact Officer: Amanda Coleman, Partnerships and Performance Officer
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
Local Safeguarding Children Board Annual Report - 2016/2017	To receive the annual report from the Local Safeguarding Children Board.	24 January 2018	Sue Harrison, Director of Children Services, CBC Contact Officer: Phillipa Scott, Strategic Safeguarding Partnership Manager, CBC

Health and Wellbeing Board
Work Programme 2017/18

Issue for Decision	Description	Indicative Meeting Date	Lead Director and contact officer(s)
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
Pharmaceutical Needs Assessment	To approve the Pharmaceutical Needs Assessment.	21 March 2018	Matthew Tait, Chief Accountable Officer, BCCG Contact Officer: Karen McCormack-Morgan NHS Health Checks - Public Health Practitioner, BCCG
To be Timetabled			
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
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

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