This meeting may be filmed.*

Central Bedfordshire Health and Wellbeing Board

Agenda

Meeting Title:	Central Bedfordshire Health and Wellbeing Board
Date:	Wednesday, 31 October 2018
Time:	2.00 p.m.
Location:	Council Chamber, Priory House, Monks Walk, Shefford

1. **Apologies for Absence**

   Apologies for absence and notification of substitute members.

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

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

3. **Minutes**

   To approve as a correct record the Minutes of the last meeting held on 11 July 2018 and note actions taken since that meeting.

4. **Members' Interests**

   To receive from Members any declarations of interest.

5. **Public Participation**

   To receive any questions, statements or deputations from members of the public in accordance with the Public Participation Procedure as set out in Part 4G of the Council's Constitution.

JOINT HEALTH AND WELLBEING STRATEGY

Item	Subject	Lead
6	**Joint Health and Wellbeing Strategy 2018-2023**	**MS**

To receive the final draft of the Joint Health and Wellbeing Strategy 2018-2023.

7	**Improving outcomes for patients with Diabetes**	**SC/LW**

To receive presentations on improving outcomes for patients with diabetes and reducing excess weight.

OTHER BUSINESS

Item	Subject	Lead
8	**Director of Public Health Report 2018: Homelessness and Health**	**MS**

To receive the Director of Public Health Report 2018 on Homelessness and Health.

9	**Healthwatch Annual Report 2017/18**	**DB**

To receive a presentation on the Healthwatch Annual Report 2017/18.

10	**2019/20 BLMK Joint System Commissioning Intentions**	**AS**

To receive the final version of the 2019/20 Bedfordshire, Luton and Milton Keynes (BLMK) Joint System Commissioning Intentions.

11	**Update on the Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Partnership (STP) and Integrated Care System**	**RC**

To receive an update on the progress of the Sustainability and Transformation Partnership (STP) across Bedfordshire, Luton and Milton Keynes (BLMK) and the Central Bedfordshire Place Based Plan 2018/19, including the Digital Strategy and Target Architecture.

12	**Central Bedfordshire's Integration and Better Care Fund**	**JO**

To receive an update on the Integration and Transformation projects incorporating the Better Care Fund Plan and progress on improving outcomes for frail older people.

13	**Integrated Health and Care Hub Development**	**JO**

To receive a presentation on the Hub Programme work plan.

14	**Work Programme 2018/2019**	**RC**

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.

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 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
Mrs H Moulder	Acting 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
Mr A Streets	Vice Chairman of the Health and Wellbeing Board and Accountable Officer, Bedfordshire Clinical Commissioning Group

please ask for Sharon Griffin

direct line 0300 300 5066

date published 18 October 2018

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CENTRAL BEDFORDSHIRE COUNCIL

At a meeting of the **HEALTH AND WELLBEING BOARD** held in Council Chamber, Priory House, Monks Walk, Shefford on Wednesday, 11 July 2018

PRESENT

Cllr B J Spurr (Chairman)
Ms S Thompson (Vice-Chairman)

Mrs D Blackmun	Chief Executive Officer, Healthwatch Central Bedfordshire
Mr R Carr	Chief Executive
Ms H Moulder	Acting Chair, Bedfordshire Clinical Commissioning Group
Mrs J Ogley	Director of Social Care, Health and Housing
Mrs M Scott	Director of Public Health

Apologies for Absence:	Mr M Coiffait Cllr S Dixon Mrs S Harrison Cllr Ms C Hegley Mr A Streets

Others in Attendance:	Mrs E Barter
Cllr	Mrs T Stock

Officers in Attendance:	Mrs P Coker	–	Head of Service, Partnerships - Social Care, Health & Housing
	Mrs S Hobbs	–	Senior Committee Services Officer
	Ms S James	–	Public Health Senior Practitioner - Children and Young People
	Mrs C Shohet	–	Assistant Director of Public Health
	Mr M Westerby	–	Head of Public Health

HWB/18/1. **Chairman's Announcements and Communications**

The Chairman welcomed the news that the Government had agreed to increase the NHS budget by an average of 3.4% in each of the next five years. He hoped that part of this funding would be allocated to the work being carried out by public health.

The Chairman congratulated Healthwatch on receiving the Outstanding Contribution Award at the Cheering Volunteering Awards on 5 June 2018 and thanked them and their volunteers for their work.

HWB/18/2. **Election of Vice-Chairman 2018-19**

RESOLVED that the Accountable Officer, Bedfordshire Clinical Commissioning Group be elected as Vice-Chairman for 2018/19.

HWB/18/3. **Minutes**

RESOLVED that the minutes of the meeting of the Central Bedfordshire Health and Wellbeing Board held on 21 March 2018 be confirmed as a correct record and signed by the Chairman.

HWB/18/4. **Members' Interests**

None were declared.

HWB/18/5. **Public Participation**

The Chairman invited the public speaker to make his statement in accordance with the Public Participation Scheme.

Primary Care Arrangements in Leighton Buzzard

Mr Morris referred to minute number HWB/17/27 'Outline of the pilot arrangements for primary care development in Leighton Buzzard' from the meeting on 24 January 2018. He was concerned that that the provision of an Integrated Health and Social Care Hub in Leighton Buzzard was not progressing fast enough to deal with the demand of patients in the Leighton Buzzard area. Leighton Buzzard was the largest town in Central Bedfordshire and did not have a local hospital.

The Accountable Officer for the Bedfordshire Clinical Commissioning Group confirmed that work to improve health care provision in Leighton Buzzard continued. Dr Marshall was leading on this work and he would be asked to contact Mr Morris directly and an update would be provided to the Board at their next meeting on 31 October 2018. The preferred option for Leighton Buzzard was to have a virtual hub based on collaboration between three General Practices in Leighton Buzzard.

The Chairman of the West Mid Beds Locality explained that the buildings in Leighton Buzzard were being considered and how these could be put to best use to support patient needs.

HWB/18/6. **Joint Health and Wellbeing Strategy**

The Board received a presentation on the proposed vision to improve health and wellbeing and reduce inequalities now and for future generations by:

- driving change to improve mental health and wellbeing for people of all ages;
- enabling people to optimise their own health and wellbeing; and
- ensuring that growth delivers improvements in health and wellbeing for current and future residents.

The presentation explained how these priorities would make a difference to people's lives and the learning that could be taken from the Government's healthy new towns programme. It was proposed that the Board visit Bicester, as the town had been awarded Healthy New Town status in 2016 with the aim of managing the town's proposed growth in a way that helped obesity and social isolation.

There was a need to think about how to increase resilience in children by, for example, influencing Personal, Social and Health Education (PSHE) in schools. The type of accommodation where people lived also played a huge part in a person's mental health and support was needed for those with long term mental health conditions. Clinical Commissioning Groups were working on personal healthcare budgets and would liaise with the Council.

RESOLVED

1. **that the three main priorities, set out above, that make up the proposed vision for the Joint Health and Wellbeing Strategy be supported;**

2. **to organise for the Board to visit Bicester; and**

3. **the final strategy be presented to the Board on 31 October 2018.**

HWB/18/7. **School Health Education Unit Survey**

The Board considered a report that provided an overview of the findings of the School Health Education Unit (SHEU) survey. The survey was commissioned biennially to gather pupil's perception of their own health and wellbeing. The survey had been undertaken by an equal number of males and females from year groups 4, 6, 8, 10 and 12. 5,502 pupils from 36 lower and primary and 19 middle and upper schools across Central Bedfordshire took part in the survey.

The key outcomes from the results of the survey were:

- that more children were afraid to go to school due to bullying;
- 21% of older pupils had experienced physically hurtful behaviour at home;

- more pupils had a low measure of resilience with 9% of older pupils self-harming when they had a problem or felt stressed;
- 17% of older pupils had less than 6 hours sleep the night before completing the survey; and
- pupils with SEND and who were lesbian, gay, bisexual (LGB) were more likely to be bullied.

Healthwatch had appointed an assistant engagement volunteer to focus on young people and to develop more webpages to support young people. The surveys it had carried out reflected a similar outcome to the SHEU survey.

The Board agreed that resilience in young people needed to be increased and this linked to the proposed priorities in the Joint Health and Wellbeing Strategy.

RESOLVED

1. **to champion the delivery of the actions relating to improving mental health and wellbeing for children and young people which had been identified as part of the emerging Joint Health and Wellbeing Strategy; and**

2. **to report back to the Board on 23 January 2019 with an update on the actions being considered to address the results from the survey.**

HWB/18/8. **Health and Wellbeing Board Governance Membership**

The Board considered a report that set out a proposed change to the membership of the Health and Wellbeing Board. To ensure that the Board could deliver its functions, including the outcomes from the emerging Joint and Health and Wellbeing Strategy, it was proposed that the membership be expanded to include representatives from the following sectors of the system:

- Primary Care Practitioner
- Acute Care (in 2018/19 a representative of each local provider may be required)
- Mental Health
- Community Services.

RESOLVED

to support the above proposed changes to the membership of the Board, ask the Council's General Purposes Committee to recommend to Full Council the amendment of the Board's terms of reference in the Council's Constitution.

HWB/18/9. **Flu Vaccination Uptake in 2017-18 in Central Bedfordshire**

The Board considered a report that provided an overview of flu vaccination in Central Bedfordshire in 2017-18. The annual flu immunisation programme was a critical element of the system-wide approach for delivering robust and resilient health and social care services, helping to reduce unplanned hospital admissions and prevent avoidable deaths, and reduce impact on the wider economy due to increased absenteeism.

In 2018/19 there would be a change to the eligibility criteria to include an additional cohort of children in year group 5. The Clinical Commission Group's ambition was to have vaccinated those on the eligibility criteria by November 2019, but this was dependant on when the manufacturer's released the vaccination.

Maternity Services and Care Workers were also a priority to ensure those that wanted the vaccination had the opportunity to take it up.

RESOLVED

1. **that 2017/18 performance be noted;**

2. **that the proposed actions set out in the report be noted; and**

3. **that the intensification of efforts to increase take up amongst eligible groups be noted.**

HWB/18/10. **Sustainability and Transformation Plan**

The Board considered a report:-

- that provided an update on the progress of the Sustainability and Transformation Partnership (STP) across Bedfordshire, Luton and Milton Keynes (BLMK), often now referred to as an Integrated Care System or ICS;

- that set out details on the emerging collaborative approach and newly established Clinical Commissioning Group leadership structure to strengthen commissioning across BLMK;

- that reported on the publication of BLMK's Single Operating Plan and the requirement for a Central Bedfordshire Place-based implementation Plan;

- that explained the development of a Capital and Estates Strategy for BLMK, including proposals covering Central Bedfordshire; and

- that provided an update on the Integration and Transformation projects incorporating the Better Care Fund Plan and progress on improving outcomes for frail older people.

RESOLVED

1. **that the progress on the five key priorities of BLMK Integrated Care system be noted;**

2. **that the recruitment to key posts for the STP as well as the establishment of a BLMK CCG Committees in Common and new leadership structure be noted;**

3. **that the publication of BLMK's Single Operating Plan and the requirement for a Central Bedfordshire Place-based Implementation Plan be noted; and**

4. **that the update on the Better Care Fund Plan and the end of year submission to NHS England be noted.**

HWB/18/11. **Work Programme 2018/2019**

RESOLVED

that the following items/amendments be added to the work programme:-

- School Health Education Unit Survey – 23 January 2019;
- Primary Care Work in Leighton Buzzard – 31 October 2018;
- Placed Based Plan – 31 October 2018; and
- the date of the next meeting was 31 October 2018 and not the 21 October 2018.

The Chairman took the opportunity on behalf of the Board to thank Sarah Thompson, Accountable Officer for the Bedfordshire Clinical Commissioning Group for her work with the Board as this would be her last meeting.

(Note: The meeting commenced at 2.00 p.m. and concluded at 4.00 p.m.)

Chairman ……

Dated ……..

Central Bedfordshire Health and Wellbeing Board

31 October 2018

Joint Health and Wellbeing Strategy 2018-2023

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

Advising Officer: Vicky Head, Public Health Registrar and Celia Shohet, AD Public Health
Vicky.head@bedford.gov.uk
Celia.Shohet@centralbedfordshire.gov.uk

Public

Purpose of this report

1. To present the Joint Health and Wellbeing Strategy 2018-2023 (JHWS) to the Health and Wellbeing Board for approval.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. Approve the Joint Health and Wellbeing Strategy 2018-2023.

Issues

Background

2. The Joint Health and Wellbeing Board agreed to refresh the JHWS at the Board meeting on 29th November. The decision to refresh the strategy reflected the need to keep the strategy up to date, recognising that the wider strategic context had changed and that the areas of focus needed reviewing.

Strategy development

3. The Board considered the evidence on Central Bedfordshire's health needs, as set out in the Joint Strategic Needs Assessment, and used this as the basis for a discussion on potential priorities for the strategy at a Board development session held on 21st February. The Board agreed three broad priority areas at this session: mental health and wellbeing, self care and growth.

4. Development of the mental health priority area was informed by a stakeholder workshop held on 25th April.

5. The priorities were reviewed at the Health and Wellbeing Board meeting on 11th July.

6. Engagement on the draft strategy has taken place with mental health commissioners and providers, the Council's regeneration team, the voluntary sector and Central Bedfordshire's Transformation Board.

7. The draft strategy was reviewed in detail at the Board's development session on 5th September and comments from the Board have shaped the revised draft.

8. The draft strategy identifies the following vision and priorities:

   Vision: Our vision for Central Bedfordshire is to improve health and wellbeing and reduce inequalities now and for future generations. We will do this by focussing on three priorities:

   1) Driving change to improve mental health and wellbeing for people of all ages;
   2) Enabling people to optimise their own health and wellbeing;
   3) Ensuring that growth delivers improvements in health and wellbeing for current and future residents.

Process and timeline

9. Pending agreement by the Board, the JHWS will be presented to Bedfordshire CCG Governing Body and Central Bedfordshire Council Executive.

10. Following this, the next step will be to map the agreed priorities against existing workstreams and plans to identify specific areas of focus for the Board. Leadership, governance and resourcing arrangements for new areas of work will then need to be agreed.

Financial and Risk Implications

11. The objectives of the strategy will need to be delivered within existing resources, but opportunities to obtain national or regional funding to support the aims of the strategy may be sought. If an effective Health and Wellbeing Strategy cannot be agreed, then there is a risk that partnership working to improve local health and wellbeing will stall and health gains will not be achieved.

Governance and Delivery Implications

12. The Health and Wellbeing Board has a statutory duty to produce a Joint Health and Wellbeing Strategy (Health and Social Care Act 2012).

Equalities Implications

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

14. Reducing inequalities is a core principle of the Joint Health and Wellbeing Strategy.

Implications for Work Programme

15. The JHWS will inform the Joint Health and Wellbeing Board's work programme.

Conclusion and next Steps

16. The Joint Health and Wellbeing Strategy sets out the Board's priorities. Following agreement by the Board, the Strategy will be presented to Bedfordshire CCG Governing Body and Central Bedfordshire Council Executive The next step will be to map these against existing workstreams and plans to identify areas of focus; ownership, governance arrangements and resourcing for these will then need to be agreed.

Appendices

Appendix A: Central Bedfordshire Joint Health and Wellbeing Strategy 2018-2023.

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Central Bedfordshire Health and Wellbeing Strategy

2018-2023

Foreword

I am delighted to introduce Central Bedfordshire's Health and Wellbeing Strategy for 2018-2023. This reflects a detailed analysis of the evidence contained in our Joint Strategic Needs Assessment and has been shaped by the views of the Health and Wellbeing Board, wider stakeholders and service users.

This strategy has been written at a time of change for health and care services. We know that more people are accessing care than before and work is underway in our area to improve services and safeguard their financially sustainability. The new Bedfordshire, Luton and Milton Keynes Integrated Care System (ICS), formed from 15 health and local government organisations across the area, will drive many of these changes. Local delivery will be through our Transformation Board, ensuring that the needs of Central Bedfordshire residents are understood and addressed through plans such as the Children and Young People's Plan and Better Care.

The ambition of the Health and Wellbeing Board is wider than this, however, and this strategy highlights three areas of focus for the Board, where we will drive change to meet the specific needs of local people:

- We are passionate about **mental health and wellbeing** and are committed to ensuring that the right support is available to promote good mental health for everyone. We want to make sure that anyone needing more specialist treatment is able to access appropriate services quickly and has a good experience.
- As our population gets older and more of us are living with long term health conditions, it is vital that people are empowered to **manage their health themselves**, with high quality and timely support from professionals. We know that the risk of developing many conditions can be reduced by **making healthy lifestyle choices**. We want to make sure that good quality information is easily accessible to our residents to inform their choices.
- We know that our population is changing. Central Bedfordshire has experienced significant housing growth in recent years and will continue to do so, which presents opportunities to **create health-promoting communities**. We want everybody to benefit from growth.

We are fortunate that many of Central Bedfordshire's residents enjoy good health and wellbeing but we know this is not everyone's experience. By focusing on these three priorities, we believe we can make the greatest difference to health-related quality of life for our current and future residents.

Cllr Brian Spurr
Chair of Central Bedfordshire Health and Wellbeing Board

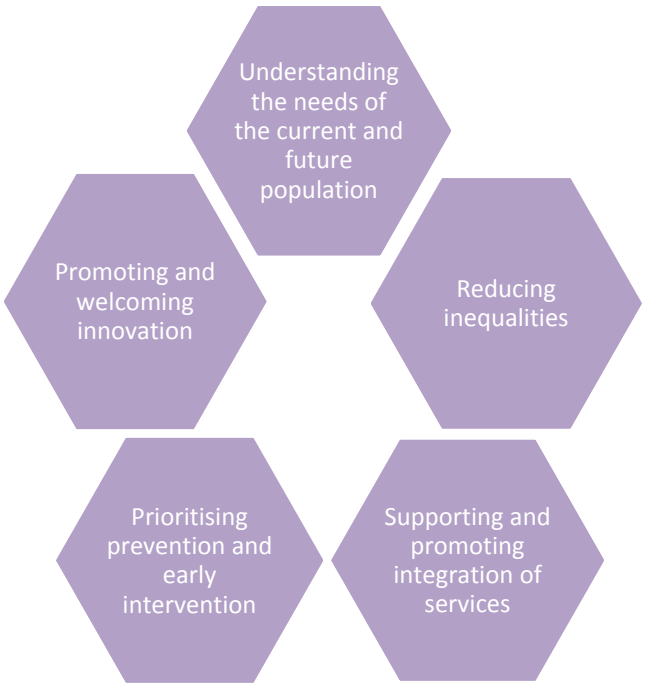
Our **vision** for **Central Bedfordshire** is to improve health and wellbeing and reduce inequalities now and for future generations. We will do this by focussing on three priorities:

Driving change to improve **mental health and wellbeing** for people of all ages

Enabling people to **optimise** their own and their familiy's health and wellbeing

Ensuring that **growth** delivers **improvements in health and wellbeing** for current and future residents

Our work on these priorities will be underpinned by five core principles:



Driving change to improve mental health and wellbeing for people of all ages

Why is this important to us?

Good mental health and resilience are fundamental to our physical health, relationships, education, training, work and to achieving our potential. Poor mental health is common; approximately one in four people will experience a mental health problem in any one year[i] and mental illness is the leading cause of long term absence from work[ii]. Three quarters of mental illnesses start before a child reaches their 18th birthday[iii]. National evidence suggests that some forms of mental ill health are becoming more common, with higher use of some services, and that people may be finding it harder to cope with their mental health problems[iv]. This is supported by local evidence from school based surveys and anecdotal evidence suggesting that there are increasing pressures on mental health services.

How will we make a difference?

To reduce the likelihood of people developing poor mental health we will:

- Disseminate evidence-based campaigns and programmes to raise awareness of mental health and promote mental wellbeing in the public sector, local businesses and commissioned services;
- Ensure that every child has the best start in life, promoting lifelong mental health and wellbeing;
- Champion an evidence-based approach to health and wellbeing in schools.

For those people who would benefit from support to improve their mental health we need to:

- Ensure that staff and members of wider community networks can recognise changes in the mental health of people they work and interact with, and can signpost them for early support;
- Ensure that children, young people and adults have timely access to an appropriate level of high quality support and care - that there is no wrong door;
- Deliver effective transitions for vulnerable children to adult services, that put the person transitioning at the heart of decision making and are underpinned by collaborative commissioning decisions;
- Champion the delivery of the suicide prevention plan;
- Ensure that help and support available takes account of the rural nature of Central Bedfordshire and is accessible either geographically or through digital platforms;
- Make the best use of community assets and promote these, for example, through social prescribing.

How will we know we've made a difference?

We will use indicators covering a range of perspectives to give us an overall picture of the direction of travel. We expect to see:

- Improvement in measures of wellbeing including: resilience in our young people, as measured by the biennial Schools Health Education Unit Survey, estimates of life satisfaction, happiness and anxiety;
- Improvements in outcomes including admissions to hospital for self-harm in young people;
- Improvements in access to services, evidenced through: improved waiting times, increased access to psychological therapies and improved experiences for those transitioning between services;
- We will also investigate local sources of data to monitor change, such as: local surveys, data held by providers and locally available process measures such as hits on mental health websites.

Enabling people to optimise their own and their family's health and wellbeing

Why is this important to us?

We know that around 40% of years lost due to ill-health, disability or early death in the UK can be attributed to behavioural risk factors such as smoking, drinking too much alcohol, lack of physical activity, poor diet and being overweight. In Central Bedfordshire, 16% of adults smoke[v], nearly two thirds are overweight or obese[vi], and nearly one third of our 10-11 year olds are overweight[vii]. By enabling our population to make positive changes to their lifestyle, we can reduce their likelihood of developing long term health conditions. We also know that, for people who do have long term conditions, equipping them with the skills to manage their condition themselves, in partnership with health professionals, can improve quality of life, slow the progression of their disease and prevent unnecessary use of healthcare resources.

How will we make a difference?

To reduce the likelihood of people developing preventable long term conditions we will:

- Support work with families to promote healthy choices for young children;
- Support schools to deliver high quality personal, health and social education (PHSE);
- Ensure that residents have access to the information, advice and infrastructure they need to optimise their own health and wellbeing;
- Work with local employers to create workplaces which promote health and wellbeing;
- Develop a detailed understanding of what would help local residents to adopt healthier lifestyles.

To ensure that those with long term conditions or with poor health have appropriate support, we need to:

- Encourage front-line staff to make every contact count by delivering brief messages and signposting people to sources of additional support and advice;
- Provide lifestyle services for those people who require additional support, particularly in the more vulnerable groups;
- Enable people to self-manage their condition with appropriate support;
- Tackle the social determinants of health e.g. social isolation, poor housing, education;
- Promote the uptake of seasonal flu vaccination.

How will we know we've made a difference?

We expect to see:

- In the long term, improvements in healthy life expectancy for men and women;
- Improvements in population-level measures for smoking prevalence, excess weight, physical activity and alcohol related admissions, with improved uptake of the seasonal flu vaccination in at-risk groups;
- Lower rates of hospital admissions for alcohol-related and smoking-attributable conditions;
- Evidence that our health services are supporting people with long term conditions better by: identifying diabetes and dementia appropriately, carrying out evidence-based care processes for specific conditions, referring more people with diabetes to structured education programmes;
- We will also investigate local sources of data to monitor change, such as: local surveys, including the Central Bedfordshire Residents' Survey and the Schools Health Education Unit survey, process measures such as hits on health advice websites and completion of assessments such as 'know your numbers', and indicators for the new Social Prescribing service.

Ensuring that growth delivers improvements in health and wellbeing for current and future residents

Why is this important to us?

We want Central Bedfordshire to be a great place to live. Our Local Plan aims to deliver 43,000 new homes between 2015 and 2035. This will ensure that there is sufficient housing to meet our population's needs and promote economic development. Development on this scale presents opportunities to improve health and wellbeing for the whole population, by creating places that promote health, by improving access to affordable housing, and by providing appropriate housing for people with specific health and mobility needs. It will also be a challenge, however, and we need to make sure everybody benefits equally from development, and that we plan well to make sure there are enough and appropriate services in place to support the growing and changing population.

How will we make a difference?

- We will engage with our communities to improve our understanding of people's experiences of recent local growth. We will use this deeper understanding, along with evidence from elsewhere in the country, to identify specific changes or interventions to create 'healthy places' that promote health and wellbeing in areas experiencing growth.
- We will work with agencies involved in the planning and delivery of growth to ensure that health and wellbeing are 'hard-wired' into new developments, including access to good quality green space, health and care facilities, infrastructure to support walking and cycling and design to link new homes into existing communities.
- We will ensure that voluntary and statutory services, particularly in areas affected by growth, are sensitive to changes in local communities, signpost residents appropriately and play an active role in minimising social isolation.
- We will consider how development provides opportunities for technology-enabled care to support people to live safely and independently in their own homes for as long as possible, self-manage long term conditions and have remote access to specialist care when needed.

How will we know we've made a difference?

We are realistic that it will be difficult to demonstrate change in this area. Many of the challenges we are addressing are hard to measure and any change will be slow to achieve. We will use the following measures as a barometer to help us judge whether we are moving in the right direction:

- We will undertake a bespoke survey of residents in new communities to establish a baseline understanding of people's experiences. We will consider repeating this in the future to measure change.
- Trends in published indicators including proportions of people using the natural environment for health and exercise, educational attainment and aspirations, social cohesion and voter turnout;
- Access to housing in terms of affordability, family homelessness and statutory homelessness;
- Referrals to the social prescribing service and/or attendance at community groups in specific areas.

[i] McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E., & Jenkins, R. (2009). Adult psychiatric morbidity in England, 2007: results of a household survey. The NHS Information Centre for health and social care.
[ii] Centre for Business Innovation. www.cbi.org.uk/media/.../cbi-pfizer_absence___workplace_health_2013.pdf
[iii] Dunedin Multidisciplinary Health & Development Research Unit. Welcome to the Dunedin Multidisciplinary Health and Development Research Unit (DMHDRU). http://dunedinstudy.otago.ac.nz/
[iv] McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016). Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014. Leeds: NHS digital.
[v] Annual Population Survey 2017
[vi] Active Lives Survey, Sport England, 2016/17
[vii] NHS Digital, National Child Measurement Programme, 2016/17

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NHS
Bedfordshire
Clinical Commissioning Group

Improving outcomes for patients with Diabetes 2017-2021

Dr. Sanhita Chakrabarti
Diabetes Clinical Lead
Bedfordshire Clinical Commissioning Group

Diabetes Case for Change

NHS
Bedfordshire
Clinical Commissioning Group

- Rising number of people with diabetes
  - 8.0% (29,744) - 2015
  - Forecast to rise to 9.2% (42,680) by 2035
- High prevalence of obesity - a key contributor to the development of Type 2 diabetes
- Lack of personalised care planning with patients as part of their Diabetes Annual Review
- Some variation of care across practices
- High rate of activity and expenditure on unplanned Diabetes admissions
- High rate of amputations and admissions for people with foot care problems

NHS
Bedfordshire
Clinical Commissioning Group

NDA - Diabetes Care Processes and Treatment targets

Type 1	2015/16	2016/17
% Received NICE Care Processes	51.6%	47.4%
% Achieved Nice treatment targets	19.8%	20.1%

Type 2	2015/16	2016/17
% Received NICE Care Processes	65.5%	43.2%
% Achieved Nice treatment targets	37.6%	38.1%

Our transformation plan to improve care for patients with pre-Diabetes 2017-2021

NHS Bedfordshire Clinical Commissioning Group

Issue	Solution
A rising number of patients with pre-diabetes	**NHS Diabetes Prevention Programme (Healthier You)** A joint initiative from Public Health England, NHS England and Diabetes UK. Long term intervention - 13 group sessions, spread across a minimum of 9 months. Participants aim to make positive changes to their lifestyle to achieve 3 key goals: • Weight loss • Achievement of dietary recommendations • Achievement of physical activity recommendations The programme commenced in May 2018.

NHS Diabetes Prevention Programme

NHS Bedfordshire Clinical Commissioning Group

- Original referral targets for BCCG were:

2017/18	2018/19	Total
800	940	**1740**

Up to July 2018 :

- 32% of the referrals attended the Initial Assessment
- 92 people have attended 6 months session
- There is on an average of 3.4 kgs weight loss noticed in the 6 months in these patients.

BLMK Sustainability & Transformation Plan

Our transformation plan to improve care for patients with pre-Diabetes 2017-2021

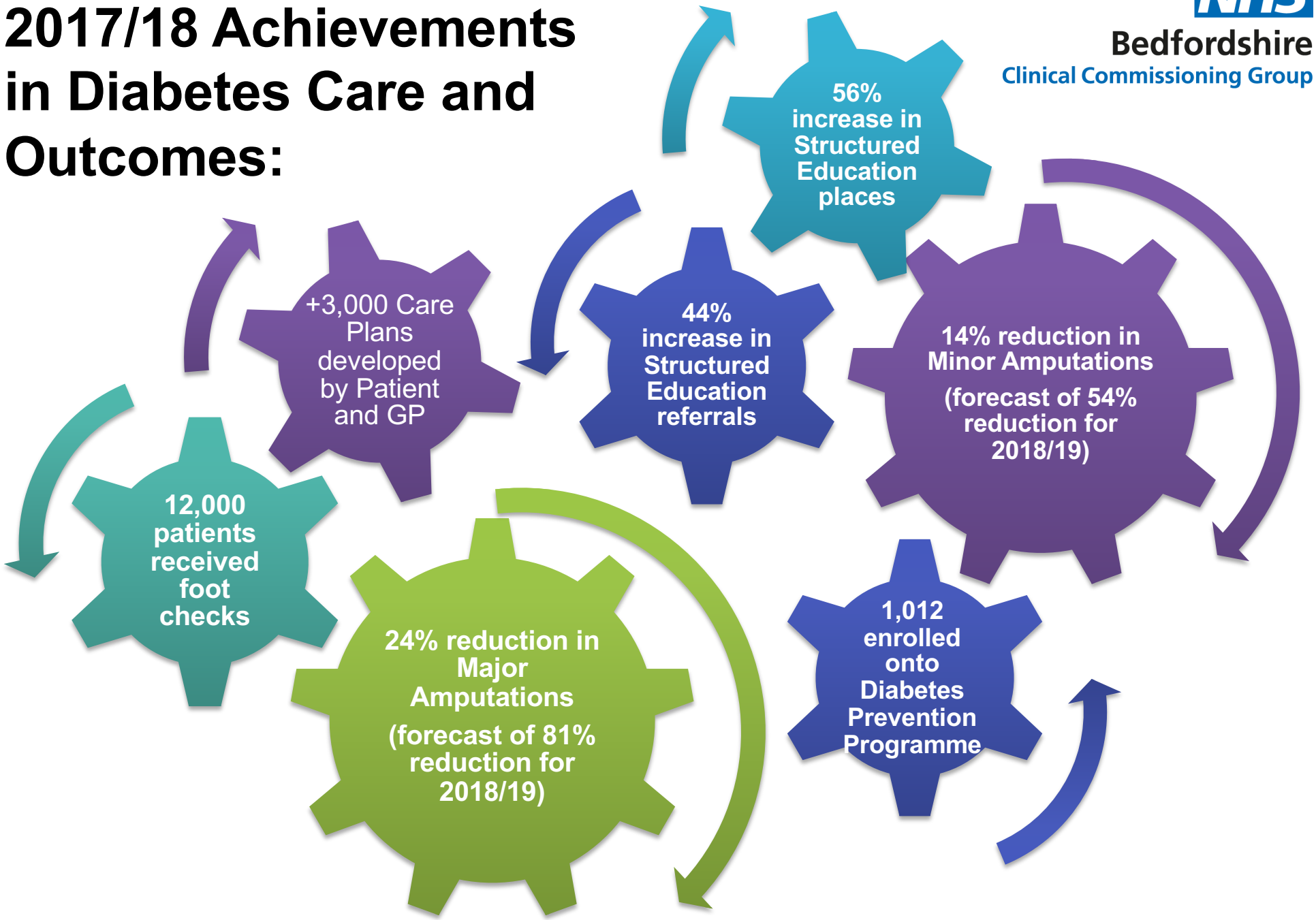
NHS Bedfordshire Clinical Commissioning Group

Issue	Solution
Patients not achieving NICE recommended treatment targets (HbA1c, cholesterol and blood pressure).	**Diabetes Treatment & Care Programme** Personalised Care Planning for patients diagnosed with Diabetes supporting improved understanding and management of Diabetes, supported by specialist nurses.
Lack of access to structured education.	Increasing access, availability and uptake to specialised Diabetes Structured Education.
High number of admissions to hospital with diabetic foot disease and high number of amputations.	Improved access to community foot protection team and hospital multi-disciplinary foot team

Transformation Plan supported by investment programme including 2-year NHS England funding.
of 2017/18 £564,000 to 2018/19 £814,000

2017/18 Achievements in Diabetes Care and Outcomes:

NHS
Bedfordshire
Clinical Commissioning Group



Bedfordshire Diabetes Improvement Network

NHS
Bedfordshire
Clinical Commissioning Group

The Transformation Plan has been led by the **The Diabetes Network 'Team'** which includes all of the following key stakeholders:

- Bedfordshire CCG
- Bedford Hospital NHS Trust
- Luton & Dunstable Hospital University Hospital NHS Trust
- East London Foundation Trust
- Bedford Borough Council
- Central Bedfordshire Council
- Diabetes UK
- Health Watch
- Patients

Together, we are confident of continued improvement for our patients as we continue to expand and improve the programme in 2018-19 and beyond.

NHS
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Clinical Commissioning Group

What our patients are saying …

‘I would like to let you know about my satisfaction over the consultation and personal care plan I have received from my GP in dealing with my Diabetes.

I have had a personal care plan and support from my GP and I must say that the difference it has made is huge. This is very much different to the traditional treatment and talks I have been having over the years with different GP’s and makes me feel that my GP very much understands my personal treatment needs and it is no longer a generic discussion. This has restored my faith back in the NHS’

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Bedfordshire
Clinical Commissioning Group

What our GPs are saying…..

‘The pathway is fully supported by the new gold standard comprehensive template. Its ability to meticulously complete a comprehensive annual assessment has hugely reassured both us as clinicians and our patients.

I also gladly receive the prominence which has been given to the lifestyle measures section (with embedded patient information) as this is an integral part of the management process.

Finally I would like to thank Dr Ponnala, GP clinical lead, and his team for introducing the new diabetic care planning pathway.’

Dr Roshan Jayalath, Bedfordshire GP

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Clinical Commissioning Group

Questions

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Excess Weight Overview and Update

Laura Waller
Senior Public Health Officer for Excess Weight
Laura.waller@bedford.gov.uk

Excess Weight- Adults

In 2016/17 64% of adults in Central Bedfordshire were estimated to be overweight or obese which was similar to the England average but worse than statistical neighbours

Rate of admissions directly attributed to obesity- better than national average

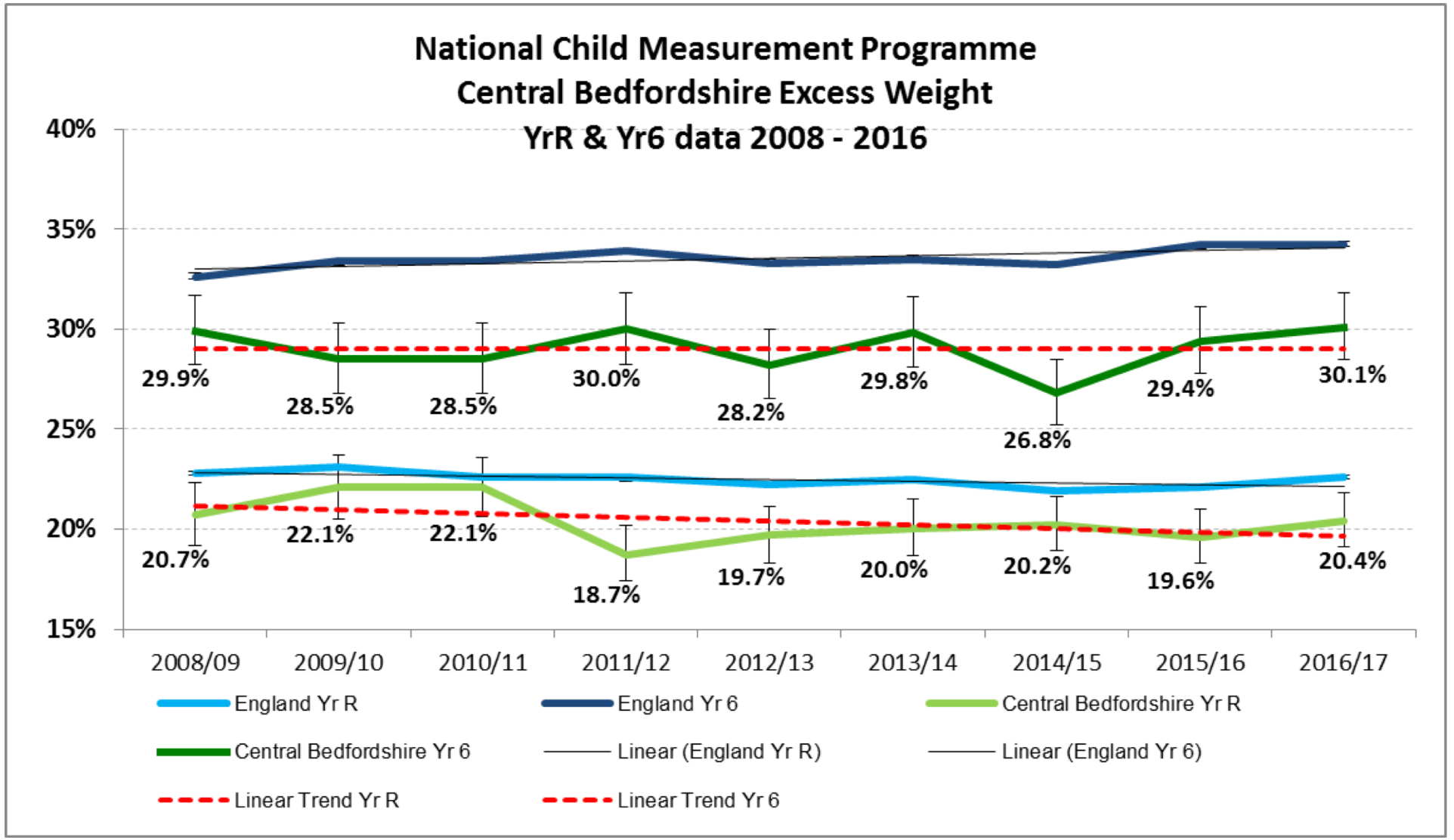
Rate of admissions where obesity was a factor- **better** than national average

Children and Young People

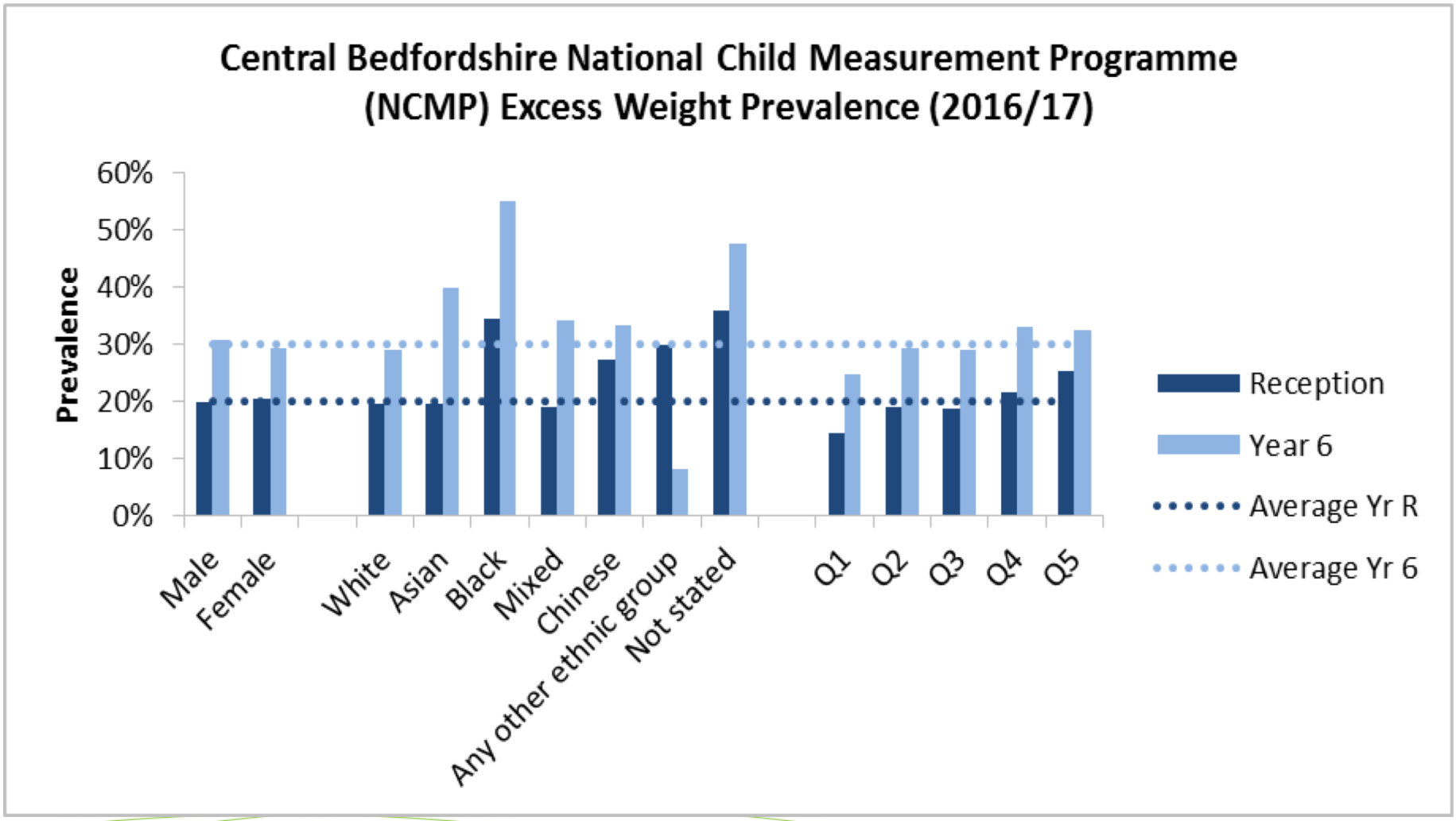
The National Child Measurement Programme (NCMP) records the height and weight of children in reception (aged 4–5 years) and year 6 (aged 10–11 years) in state-maintained schools in England.

- 20.4% of 4-5 year olds are overweight or obese
- 30.1% of 10-11 year olds are overweight or obese
- This is **lower than the national average** and **similar to the regional average**

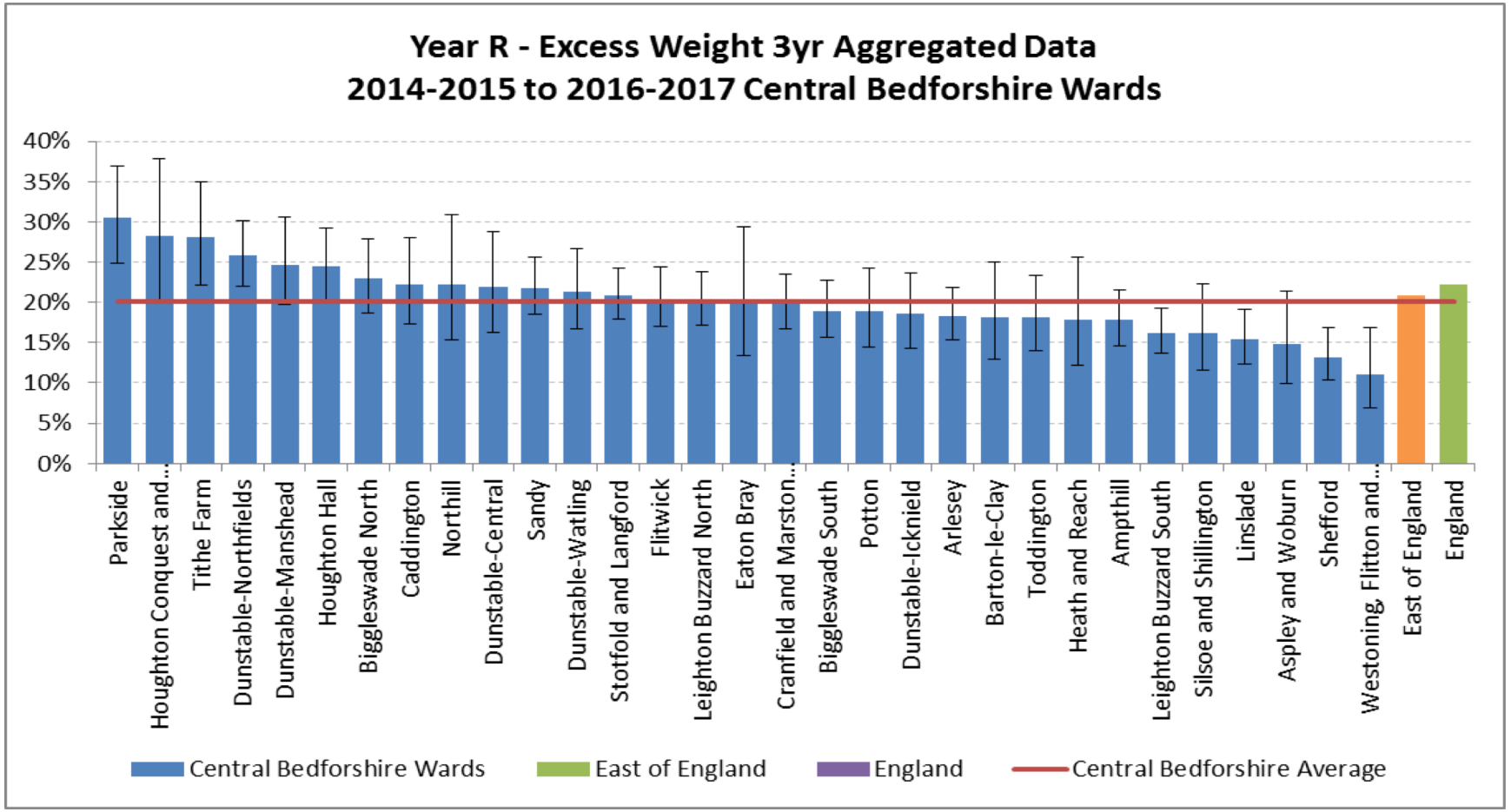
Trends in Excess Weight 2008-2017



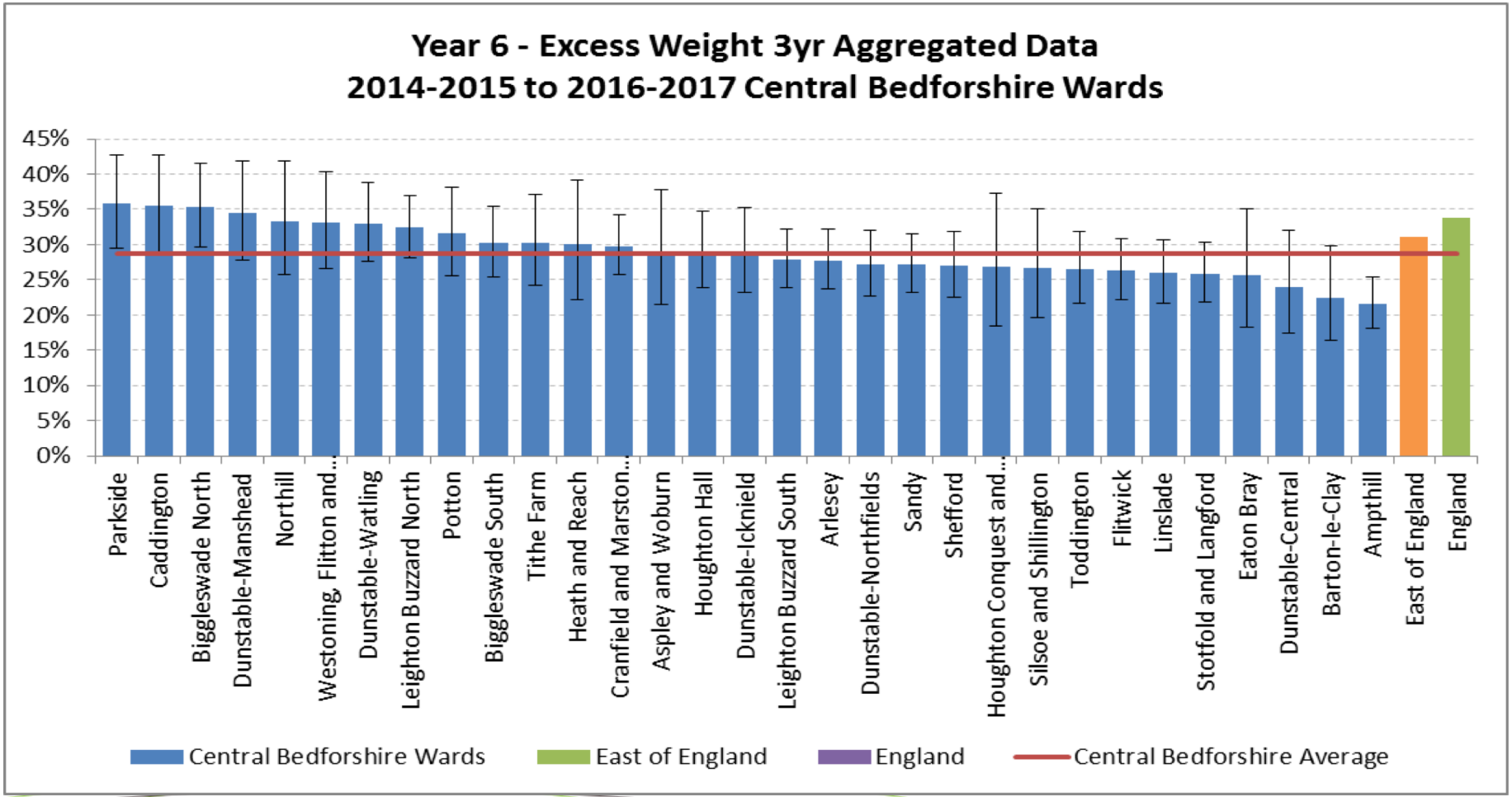
Inequalities in Excess Weight



Excess Weight by Ward- age 4-5



Excess Weight by Ward- age 10-11



Excess Weight Work

Tackling obesity is everyone's business- there is no single group or individual that can do this alone.

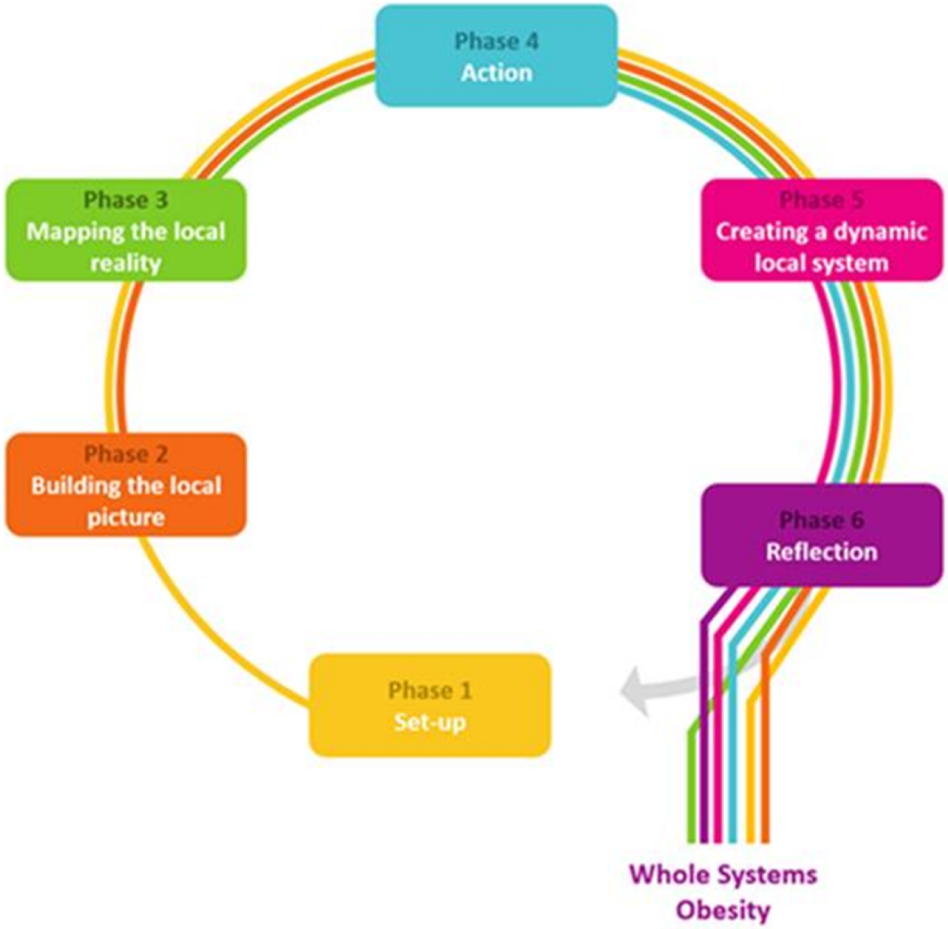
Current Excess Weight Partnership Strategy has four key aims

1. **Creating positive environments which actively promote and encourage a healthy weight.**
2. **Giving all children and families the best start in life and supporting them in achieving a healthy weight and lifestyle.**
3. **Empowering adults and older people to attain and maintain a healthy weight.**
4. **Enabling practitioners working in Central Bedfordshire to have a meaningful discussion about weight in a confident and effective manner.**

PHE Whole Systems Approach to Excess Weight

PHE have developed a 'Whole Systems Approach' toolkit

- Route map with 6 phases
- The early phases focus on preparation
- Followed by collective working
- Finally, taking actions forward as a group
- A set of systems behaviours underpins the whole approach



Excess Weight work continued

- Feedback regarding the action plan linked to the strategy- supportive but needed to be more effective
- Combine previous good work with the PHE toolkit to identify some key local priorities that are achievable, not ‘work as usual’ and will really begin to make a difference

Weight Management Service Procurement

- Funded until 2022 with an option to extend until 2024 - overall budget has been reduced (Public Health Grant reduced)
- More specific referral criteria for adults- will focus on low income and co-morbidities
- The service will have a prevention element in schools, early years and primary care
- Maternal Obesity review and action plan- healthy lifestyles programme for pregnant women
- Whilst beneficial, the service has a limited reach and therefore limited impact on population level obesity rates.

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Central Bedfordshire Health and Wellbeing Board

31 October 2018

Director of Public Health Report, 2018: Homelessness and Health

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

Advising Officers: James McGowan, Public Health Registrar
James.McGowan@centralbedfordshire.gov.uk

Rob Couch, Public Health Evidence and Intelligence Team
Rob.couch@bedford.gov.uk

Public

Purpose of this report

1. The purpose of the Director of Public Health Report: Homelessness and Health is to present evidence and make recommendations to improve the health and wellbeing of those without safe and stable housing in Central Bedfordshire

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. To consider the report and if satisfied, endorse the recommendations set out in the full report which in summary are to:
    - Improve awareness of the Homelessness Reduction Act and its implications for partner organisations, especially regarding the duty to refer
    - Improve the identification, assessment, recording and sharing of housing vulnerability, including little understood groups such as the hidden homeless
    - Improve understanding of the overlap between mental health, other vulnerabilities and housing
    - Improve signposting and access to local services that can address the root causes of homelessness
    - Improve consistent healthcare access for homeless individuals, from primary care through to acute care
    - Incorporate health and wider outcomes into evaluations of homelessness initiatives

Issues

2. The Director of Public Health report is an independent report focused on improving the health of the people of Central Bedfordshire. This report is on the important topic of homelessness and health. It aims to highlight issues, present evidence and make recommendations to address the key public health challenge of homelessness, to better prevent homelessness and improve the health of homeless people.

3. Ill health can be both a cause and consequence of homelessness and being homeless is associated with extremely poor health outcomes relative to those of the general population, with average life expectancy of rough sleepers being 48 years for men and 43 years for women. Homeless people are more likely to have poor physical and mental health, and people with physical and mental health problems are more vulnerable to becoming homeless. As with other risks to public health, prevention and early intervention can keep people housed appropriately, stopping the escalation of issues that can lead to losing stable accommodation and worsening health.

4. The report draws on national and local evidence to describe key challenges for homeless people, focusing on the health impacts of homelessness for a number of vulnerable groups including:

    - Homelessness in children, young people and their families,
    - Hidden homeless
    - Homelessness and complex health needs including the relationship between homelessness and mental health, substance misuse, offending and in veterans

5. The report highlights a small number of targeted areas for focus that collectively aim to improve health and prevent homelessness among vulnerable groups, and to improve health outcomes for homeless people. The recommendations are intended to be achievable, evidence-based and with potential to positively impact population health.

Financial and Risk Implications

6. Failure to implement the recommendations could lead to missed opportunities to improve the health and wellbeing of those without safe and stable housing.

7. There are no new resource implications, and the recommendations can be achieved within existing resources. The Report cites a number of ways in which local organisations can work more effectively together to ensure that the needs of homeless people are met more effectively. By working together to identify people at risk of homelessness and improving the health and wellbeing of those who are

homeless we can reduce the impact of ill health and poor social outcomes in this vulnerable population and reduce avoidable pressures on public services.

Equalities Implications

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

9. The report explores the relationship between homelessness and health for a range of groups who are particularly vulnerable to homelessness and highlights the action that should be taken to improve outcomes for these vulnerable groups.

Implications for Work Programme

10. A progress report should be presented to the Board in one year's time.

Conclusion and next Steps

11. The Director of Public Health's vision for Central Bedfordshire is that local partners strengthen their collaboration and collective leadership in order to:

- Better identify the overlapping vulnerabilities that put people at risk of homelessness and its health impacts, to enable better prevention and early intervention.
- Improve health and mitigate risks to health among people who experience homelessness, including people living in temporary accommodation and rough sleepers.
- Reduce health inequalities among vulnerable populations who experience homelessness.

Appendices

Appendix A: Executive Summary of the Director of Public Health Report, 2018

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Director of Public Health Report 2018

Appendix A

Central Bedfordshire

great lifestyles

Homelessness and health: improving the health and wellbeing of those without safe and stable housing in Central Bedfordshire

Draft Executive Summary

A great place to live and work.

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Contents

Summary

The annual Director of Public Health report is an independent report focused on improving the health of the people of Central Bedfordshire and this year the report focuses on the important topic of homelessness and health. It aims to highlight issues, present evidence and make recommendations to address the public health challenges of homelessness, in order to better prevent homelessness and improve the health of homeless people.

Ill health can be both a cause and consequence of homelessness. Being homeless is associated with extremely poor health outcomes relative to the general population. In 2012 the average age of death of homeless people was 47 years for men and 43 years for women, compared to 77 years for the general population (74 for men, 80 for women). Homeless people are more likely to have poor physical and mental health, and people with physical and mental health problems are more vulnerable to becoming homeless.

As with other risks to public health, prevention and early intervention can keep people housed appropriately, preventing the escalation of health and social issues that can lead to the loss stable accommodation and worsening health.

The root causes of homelessness

Several factors have driven the recent rise in homelessness in England, impacting the vulnerability of individuals and families to homelessness and the wider societal conditions that give rise to homelessness. The important drivers of homelessness in England include:

Health, social and behavioural risk factors

A range of health, social and behavioural risk factors put individuals and families are greater risk of insecure housing and homelessness and are the focus of this report. They include:

- Complex and overlapping needs.
- Substance misuse, including misuse of drugs and alcohol.
- Mental ill health.
- Offending behaviour.

Socioeconomic risk factors

A range of economic and social risk factors put individuals and families at greater risk of insecure housing and homelessness, including:

- Relationship breakdown (including domestic abuse)
- Growing relative poverty and social inequalities – a combination of income inequality, inflation and stagnant wages puts additional pressure on the affordability of housing for many households.
- Problematic household debt – a growing issue nationally that is exerting significant pressure on household budgets and affordability of everyday living.

The supply of affordable housing.

- Alongside an overall shortage of housing in England, there is strong evidence that long term underinvestment in affordable housing has increased vulnerability to homelessness nationally and undermined protections for the homeless population (Downie et al., 2018).
- Since 2009/10, there has been a decline in the overall supply of affordable housing options in the UK housing market, including the availability of affordable social rented housing, shared ownership properties and affordable home ownership options.

The impact of welfare reform.

- Reductions in housing-related welfare payments associated with the introduction of universal credit have resulted in an increasing proportion of accommodation options becoming unaffordable for individuals and families.
- A related and well-documented issue has been the impact of the late payment of benefits on the affordability of housing, combined with the rising cost of temporary/transitional accommodation.

The costs of homelessness

Research shows that early intervention and prevention can have a big impact on reducing the financial cost of homelessness to society and taxpayers.

Economic costs

- In 2012 the cost of homelessness in England was reported to be up to £1 billion per year (Department for Communities and Local Government, 2012).
- One study reported that the cost of a single person rough sleeping in the UK for 1 year was £20,128 (Pleace, 2015). This includes costs incurred by NHS services responding to the health impacts of homelessness, including A&E departments and mental health services.
- In 2015-16, local authorities in England spent £1,148 million on homelessness services. The single largest component was spending on temporary accommodation which increased by 39% in real terms between 2010/11 and 2015/16 from £606 million to £845 million (National Audit Office, 2017).
- Research shows that early intervention and prevention can have a big impact on reducing the financial cost of homelessness to society and taxpayers.

Impact on public services

- Homelessness costs an average of £4,298 per person to the NHS, £2,099 per person to mental health services and £11,991 per person for offenders (Pleace and Culhane, 2016).
- In Scotland, homeless people use NHS services 24% more than the general population (Scottish Government, 2018).
- Research shows that homelessness increases reoffending by about 20% (Scottish Government, 2018).

Homelessness in England and Central Bedfordshire

Homelessness in England is a much bigger problem than that captured by statutory homelessness statistics.

- Rough sleepers represent the 'tip of the iceberg' of homelessness and are the most visible group affected. However, a much larger group include people living in temporary accommodation, the 'hidden homeless' (including those known as 'sofa surfers') and people without access to safe and secure housing.
- In England, there is strong evidence that homelessness has increased significantly in recent years. Between 2010/11 and 2016/17 rough sleeping increased by 134% and the number of households in temporary accommodation increased from 48,240 to 77,230.

In Central Bedfordshire rates of homelessness have largely remained below national statutory homeless measures due to its relative affluence and substantial investment in tenancy sustainment, supported housing and homelessness prevention. However, several measures of homelessness have increased since 2010/11. Rough sleeping has increased significantly since 2010/11 but then reduced more recently (2017/18), helped by the interventions of the Rough-sleeper partnership. Since 2015 the number of households in temporary accommodation has risen, though rates of family homelessness and overall statutory homelessness since 2011-12 have experienced less fluctuation and remain markedly below national levels.

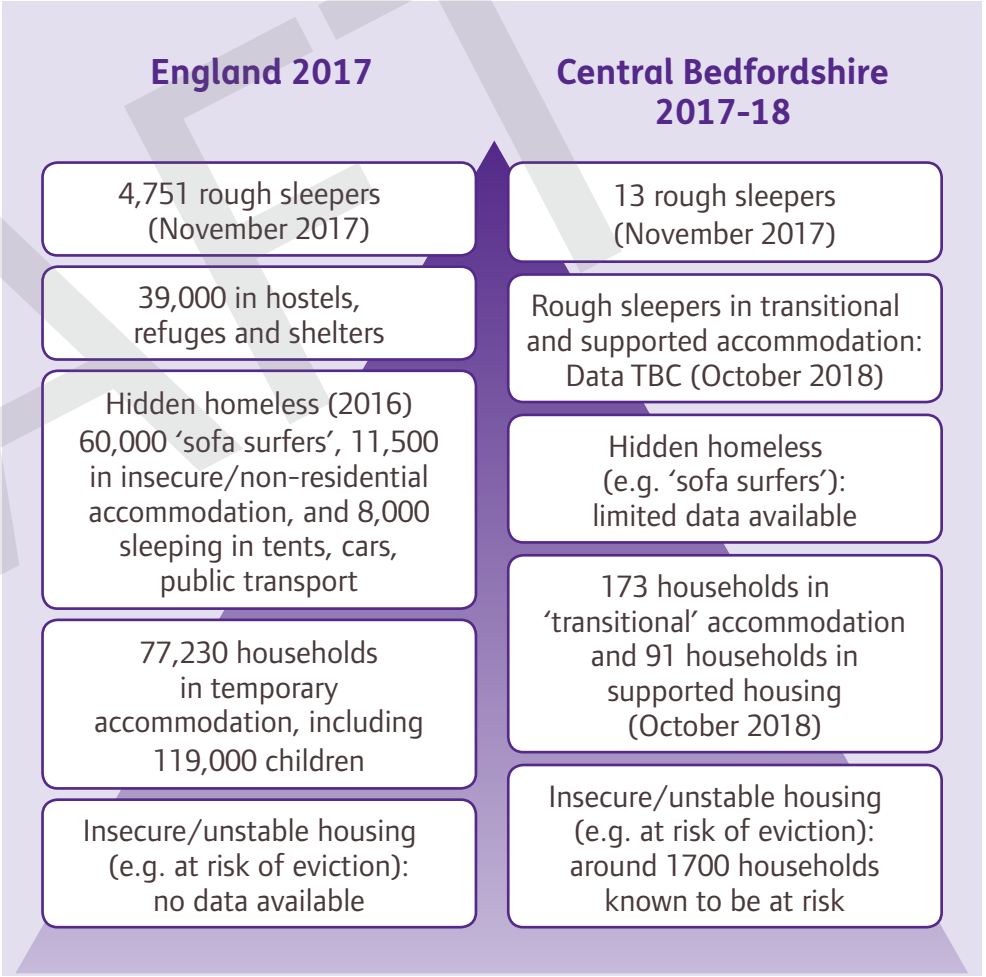

Figure: The pyramid of homelessness in England and Central Bedfordshire

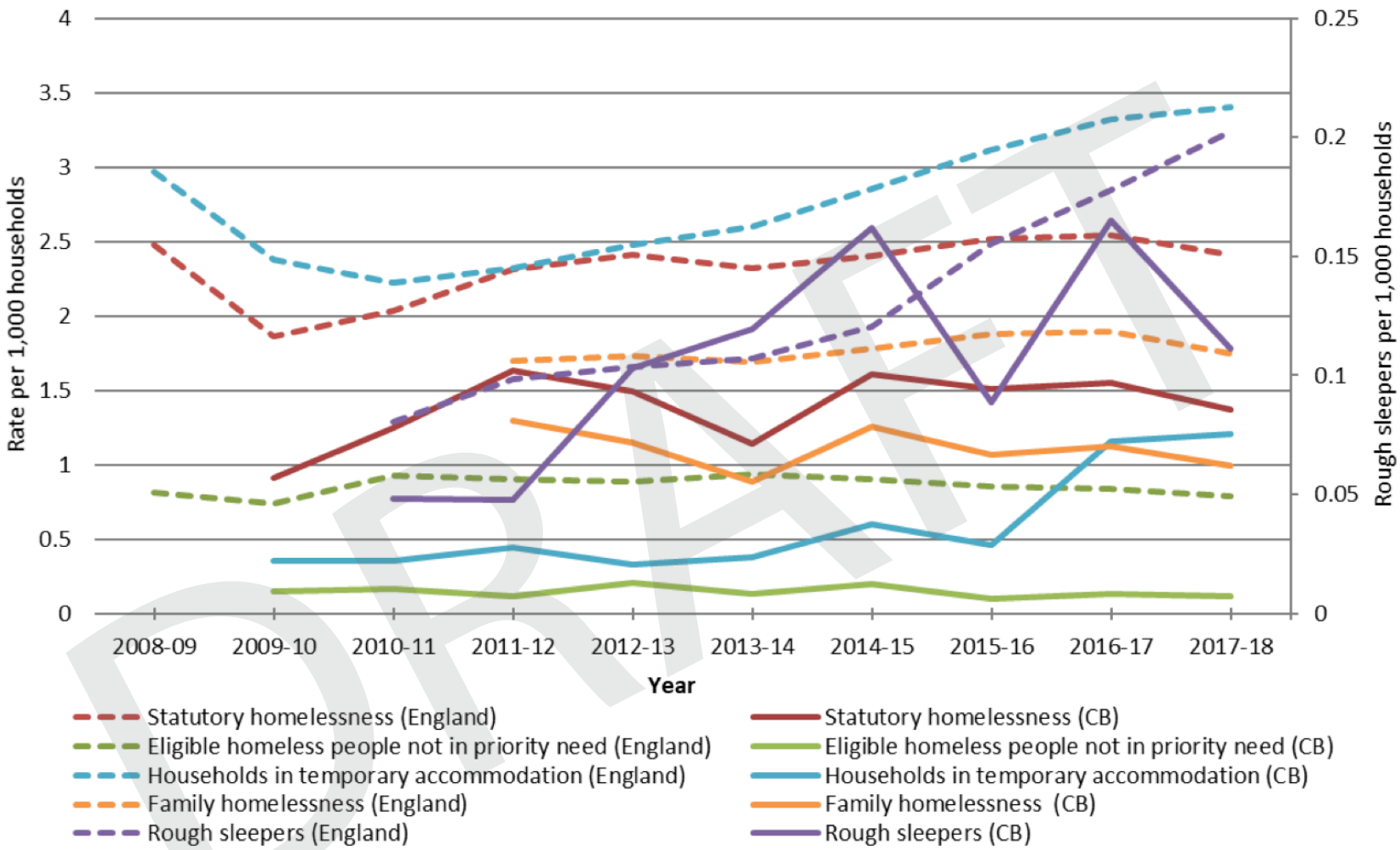

Figure: Snapshot of current national homelessness and recent trends in England and Central Bedfordshire
(Source: Ministry of Housing, Communities & Local Government)

Homelessness Reduction Act (2017)

This report comes during the implementation of the Homelessness Reduction Act (HRA) in England. This means that historical trends and current levels of homelessness are presented with reference to measures of 'statutory homelessness' collated by national government, including households in temporary accommodation and family homelessness.

The report also presents information on wider homelessness in England and Central Bedfordshire, building on definitions provided by Crisis and in the context of the HRA, which seeks to lower the threshold of vulnerability qualifying individuals and families to assistance from local authorities.

The HRA aims to encourage local authorities to focus on prevention and early intervention, improve the quality of advice and assistance provided, improve protection for single homeless people and promote joined up services. It amends existing homelessness protection in five important ways:

1. Improved advice and information about homelessness and the prevention of homelessness.
2. Extension of the defined period of "threatened with homelessness".
3. New duties to prevent and relieve homelessness for all eligible people, regardless of priority need and intentionality.
4. Introduction of assessments and personalised housing plans.
5. Duty of public bodies to refer service users who may be homeless or threatened with homelessness to a local housing authority.

By lowering the threshold for support the new duties place additional pressure on local authorities in terms of advice, assessment and the provision of temporary accommodation.

The complex relationship between homelessness and health

Homelessness among children, young people and their families

- Children who have lived in temporary accommodation for more than a year are over three times more likely than non-homeless children to develop mental health problems such as anxiety and depression, and 33% experience self-harm (PHE, 2018).
- Homeless children and young people experience more bullying and social isolation and have lower educational attainment due to a disrupted school life, absenteeism and overcrowded home environments.
- Homeless children are exposed to more adverse childhood experiences, including all forms of abuse, neglect and exposure to domestic violence.
- Homeless children are more likely to suffer from health problems associated with overcrowded home environments, including accidents and respiratory infections.

Hidden homelessness

- Hidden homeless are those who may be considered homeless, but whose situation is not visible on the street or in official statistics. This includes sofa surfing, inappropriate or non-residential housing. More widely this can also include overcrowded households, sharing households and concealed households (family units or single adults living within other households). Estimates include 60,000 sofa surfers (Bramley, 2017) and 2.32 million concealed households (Fitzpatrick et al., 2018) in England.
- The majority of single homeless people are hidden: in one study, 62% of homeless surveyed were 'hidden' homeless at the time of interview, and 92% had experienced hidden homelessness in the past (Crisis, 2011).
- A UK survey of about 2000 16-25-year olds found that 35% had experience of sofa surfing, of which 20% had sofa surfed in the last year (Clark, 2016).
- The hidden homeless are more likely to find it difficult to practice healthy behaviours and find themselves in high risk or vulnerable situations.

Homelessness and complex needs

- Homelessness commonly overlaps with a wide range of vulnerabilities that impact health, particularly (JRF, 2011):
  - Mental health problems
  - Substance misuse
  - Offending behaviour
- Homeless people with complex needs experience special barriers to accessing services. In one survey 32% of hostel residents had complex needs; 66% of respondents had experienced difficulties in accessing mental health services; 36% reported difficulties accessing drug services; and 33% reported difficulties accessing alcohol services (Homeless Link, 2017).

Homelessness and mental health

- Homelessness and mental health often interact. For example, homelessness may exacerbate a pre-existing mental health problem, and mental ill health is a risk factor for sustained homelessness, making it more difficult for vulnerable people to find and maintain secure and stable housing (MIND, 2017).
- The prevalence of common mental health problems is over twice as high among the homeless compared with the general population, and prevalence of psychosis is up to fifteen times higher (NHS England, 2016).
- Over the life course, 72% of the homeless population are affected by a significant mental health problem, compared to 30% of the population as a whole (Homeless Link, 2018).
- In a survey of 900 homeless people, Homeless Link found that 49% had experienced depression and over 40% had experienced anxiety (NHS Confederation, 2012).

Homelessness and substance misuse

- Misuse of drugs and alcohol is highly prevalent among the homeless population; two thirds of homeless people cite drug or alcohol use as a reason for first becoming homeless, and those who use drugs are seven times more likely to be homeless (Crisis, 2018).
- Drug and alcohol misuse are particularly common causes of death amongst the homeless population, accounting for over a third of all deaths (Thomas, 2012).
- Homeless people are between seven and nine times more likely to die from alcohol-related diseases than the general population, and twenty times more likely to die from a drug-related cause (Thomas, 2012).

Homelessness among ex-offenders

- Offending and homelessness are closely interrelated; an estimated 20-33% of rough sleepers and the 'hidden homeless' having previously spent time in prison (Crisis, 2011; Greater London Authority, 2016).
- 13% of females and 15% of males on short term sentences are released with no fixed abode (HM Inspectorate of Probation and HM Inspectorate of Prisons, 2016).
- There is a greatly increased risk of death in the period post release from prison. It is particularly marked in the weeks immediately post release (especially for females) and is often associated with drug misuse.

Homelessness among veterans

- In 2014 it was estimated that the proportion of veterans sleeping rough ranged from 3% to 6% (Forces in Mind Trust, 2014).
- In 2015-16 there were an estimated 452 homeless veterans in England, of whom 142 were UK nationals (Murphy, 2016).
- For many veterans, pre-existing vulnerabilities such as poor educational attainment, relationship breakdown, mental ill health, family unemployment, domestic abuse or substance misuse may be exacerbated by transitioning out of military service, increasing their risk of future homelessness (RBL, 2010).

Current work to reduce homelessness in Central Bedfordshire

There has been considerable work in Central Bedfordshire to reduce homelessness and especially rough sleeping over the last few years. Central Bedfordshire Council's ongoing strategic priorities reflect this work and the need to work more in partnership both to prevent people becoming homeless and to provide a joined up response when people do become homeless. However, further work is needed to prevent and address the health impact of homelessness and to understand and address the wider forms of homelessness and their impact on health and wellbeing.

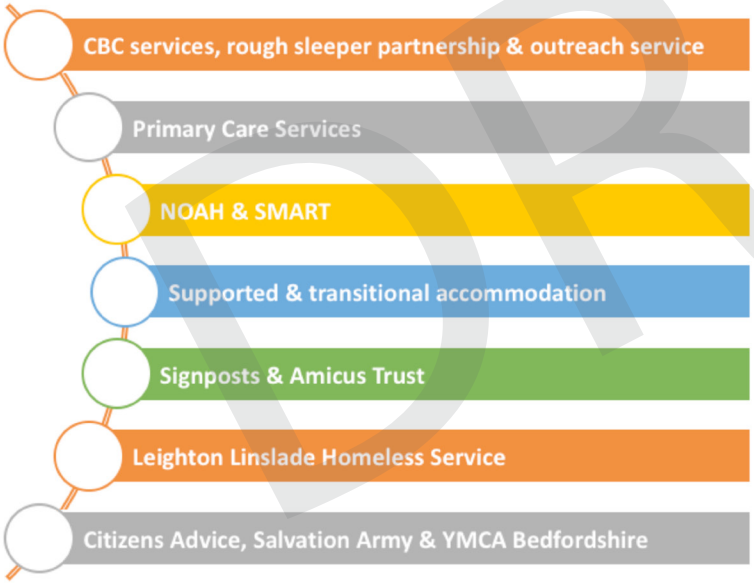

Figure: Examples of homelessness services available in Central Bedfordshire

Recommendations: How can we work together to reduce rough sleeping, better prevent homelessness and improve the health of homeless people in Central Bedfordshire?

1. Improve awareness of the Homelessness Reduction Act 2017 and its implications for partner organisations, especially regarding the duty to refer

- To improve awareness among public authorities in Central Bedfordshire of the new duty to refer and consider whether there should be wider implementation than the listed public authorities, e.g. in primary care.
- To achieve commitment to the aims of the HRA (with a focus upon improved referral routes and advice offer), building upon the Duty to Refer portal already established by CBC and aligned to the Care Act 2014.
- To develop a CBC Rough-sleeping strategy to be adopted by CBC Health and Wellbeing Board and CBC Executive by August 2019. This will help strengthen partnerships e.g. with Housing Associations and a further enhanced housing advice offer.

2. Improve the identification, assessment, recording and sharing of housing vulnerability, including little understood groups such as the hidden homeless

To improve system-wide understanding of homelessness, its impact and the current response, Central Bedfordshire Council should build on existing good practice by expanding its multi-professional approach to housing need, identification and assessment through:

- Building on existing work to capture information on the hidden homeless and wider homeless groups.
- Consideration of developing a single assessment process for vulnerable households (Care Act 2014 compliant), to identify at first assessment (using pre-agreed criteria) those at risk of deteriorating health and wellbeing. The impact on health and wellbeing will then be evaluated.
- Determining how public sector bodies and commissioned services should routinely record housing status, housing vulnerability and the duty to refer during initial assessments, and proactively address risk factors for homelessness.
- Developing and encouraging long-term housing approaches for vulnerable people (e.g. strengthen existing work with hospital discharge teams, prison/ offender management services and the veteran housing advice service).

3. Improve understanding of the overlap between mental health, other vulnerabilities and housing

- Improve mental health literacy by providing mental health awareness and intervention training for all frontline staff involved in homelessness prevention.
- Increase homelessness awareness within mental health and substance misuse services and ensure that care providers support individuals to obtain safe and stable housing.
- This improved partnership approach could include formal review meetings to learn from cases and transform services where required, including those relating to children leaving care and children in transitional accommodation.

4. Improve signposting and access to local services that can address the root causes of homelessness

- Improve system-wide knowledge regarding local services to maximise effectiveness and prevent duplication
- To improve signposting from primary care to local services, Central Bedfordshire Council should work with GP practices to build and launch a 'resource pack' for primary care professionals.
- Increase signposting to advisory services (e.g. homelessness and debt advisory services) in health settings including primary care, mental health and drug and alcohol services, linking with existing work on GP signposting and social prescribing.

5. Improve consistent healthcare access for homeless individuals, from primary care through to acute care

Increase the proportion of the homeless population registered with a GP practice (including children and families in temporary accommodation). Approaches to improve registration could include:

- Development of a shared strategy to improve registration of homeless patients across all GP practices in Central Bedfordshire.
- Education and training for GP practices to clarify rights and responsibilities in relation to registration of homeless patients.
- Introducing the 'My Right to Healthcare' card in Central Bedfordshire

6. Incorporate health and wider outcomes into evaluations of homelessness initiatives

- Measure the impact on health, wellbeing and socio-economic outcomes within any evaluation of homelessness initiatives e.g. the Rough Sleeper Outreach Service.

Central Bedfordshire in contact

Central Bedfordshire

great lifestyles

Find out more

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healthwatch
Central Bedfordshire

HWCB Annual Report 2017/18

Diana Blackmun, HWCB CEO

31st October 2018

healthwatch
Central Bedfordshire

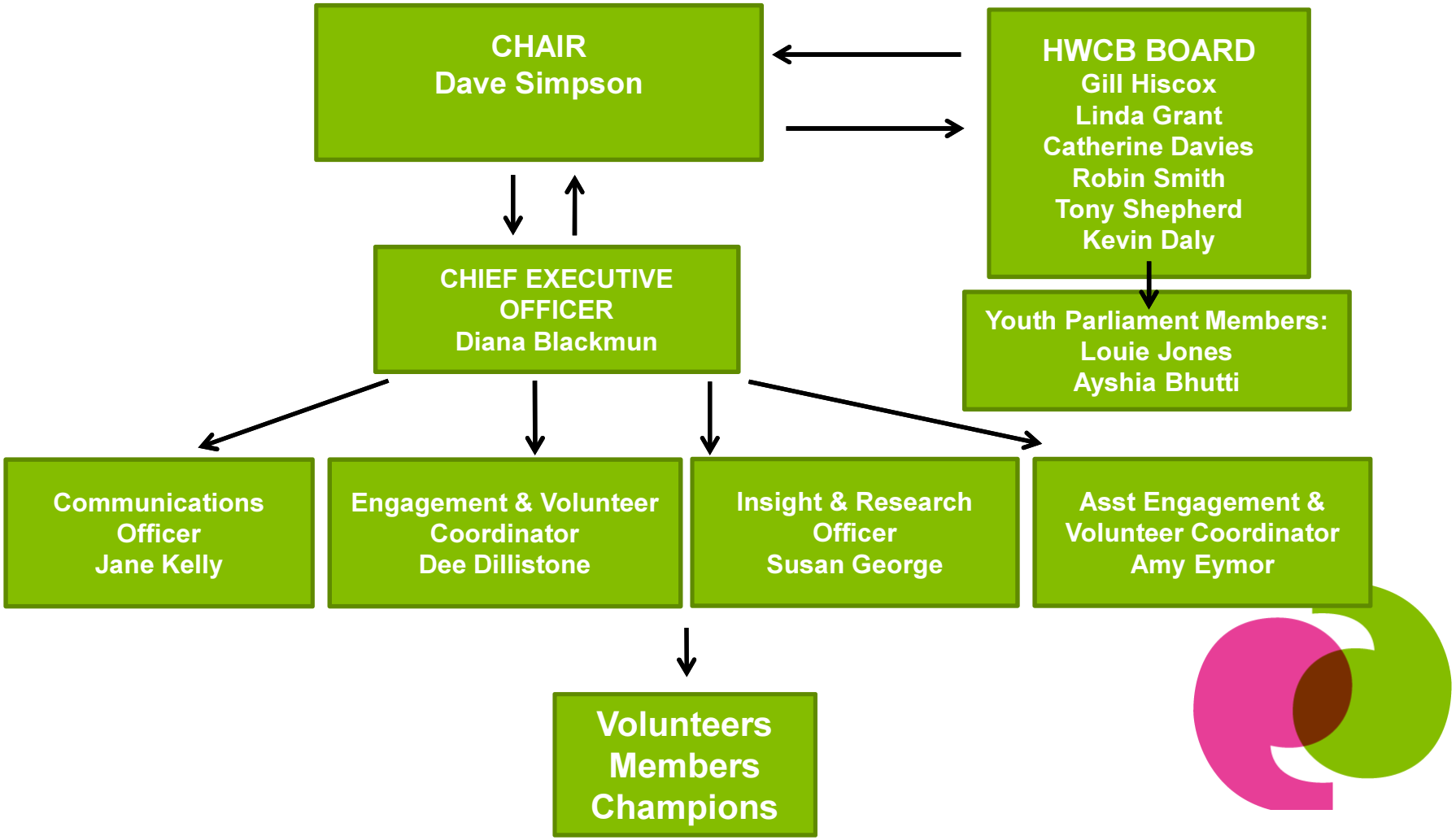
Key Function

Healthwatch is the independent consumer champion created to gather and represent the views of the public. We play a vital role at both national and local level to make sure that your experiences of health and social care are taken into account by the service providers.

HWCB - Structure

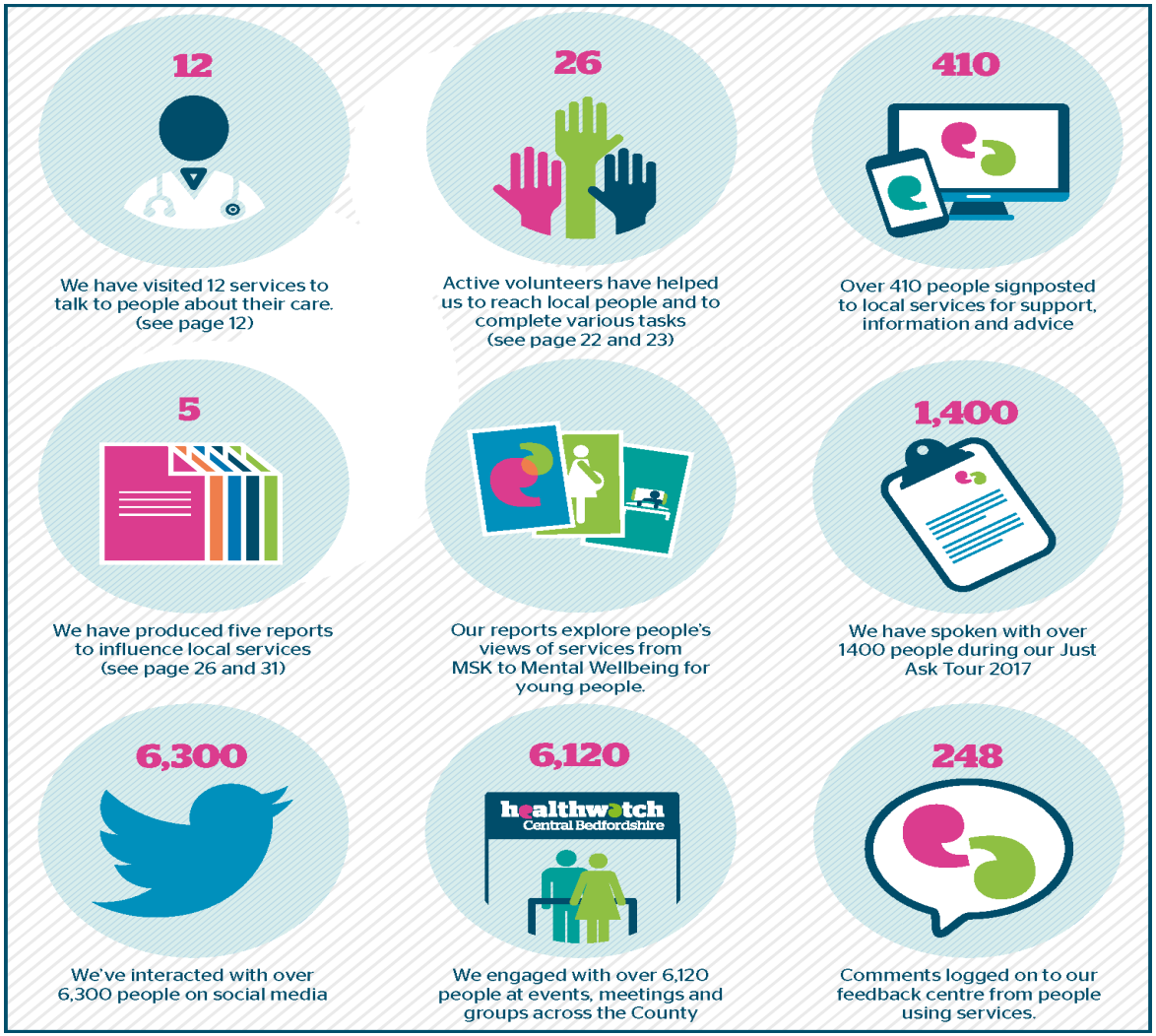
healthwatch Central Bedfordshire

Company Limited by Guarantee & a Registered Charity



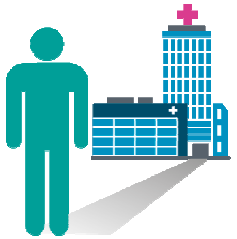
Highlights 2017/18

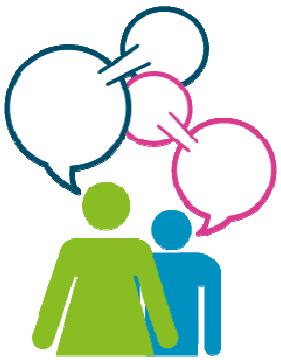
healthwatch Central Bedfordshire



Activities 2017/18

- Website - feedback centre
- Outreach project, Just Ask
- Listening Events
- Hidden Voices
- Surveys / Questionnaires / Reports
- Signposting service
- Projects and Events
- Robust Enter & View programme
- Festival for Older People
- Young Healthwatch
- Mock CQC Inspections
- Filming
- Procurement Panels representing Patient/User voice
- Committees & Boards





healthwatch Central Bedfordshire

What are people telling us?

- **Mental Health:** Inadequate support following crisis care; self-harming considered a 'coping strategy' by many young people.
- **Young People:** find it difficult to approach healthcare professionals; lack confidence to express their feelings; place a large emphasis on the importance of feeling 'listened to'.
- **Acute Trusts:** dissatisfaction with treatment, lack of care and understanding shown to relatives particularly following a bereavement.
- **Deaf Services:** Limited support provided during hospital stay leading to poor quality of care.
- **GP Surgeries:** lack of consistency in service provision, long waiting times for appointments.
- **Transport:** Non-Emergency Patient Transport Service & affordable transport to hospital/healthcare appointments.
- **Carers:** Find it challenging to access the information they need, particularly how to access respite care.
- **Domiciliary Care:** difficulty in securing a local agency to provide care in a rural location, inconsistency of carers.
- **Residential Care:** CQC report rated a home as 'inadequate', HWCB conducted an independent review. Concerns raised during serving of meals.

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What did we do with the information?

- **Met with ELFT staff** to discuss feedback about MH services and discussed how HWCB can support the CMH Teams to ensure the voice of the service user is heard and acted upon.

- **Worked with Young HW** to develop a supportive tool for young people to use on their first independent visits with a healthcare professional which includes a body map. Available to download on Young HW website.

- **Worked with PALs at the Acute Trusts** to highlight patient dissatisfaction with the way their complaint was managed and wrote directly to CEO to highlight relatives concerns. Hospital acknowledged that learning is identified and action taken to prevent re-occurrence.

- **Highlighted the concerns of deaf patients to local acute trust** and community services with recommendations for improvement and developed a survey of deaf patients experience to include young people, in collaboration with a local support group.

- **Worked with GP Practices & the BCCG** to highlight patient concerns and to help educate patients to access a healthcare professional other than a GP.

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What did we do with the information?

- **Worked with service user of NEPTS to develop a snapshot survey** to gather evidence from a wider sample of patients. Report highlighted a poor quality service for both patients, Carers and staff. Strong actions recommended to urgently improve the service.

- **Invited Carers** across Central Beds to talk about their experiences, the challenges they face and their ideas for how they can be better supported, on film, which was shown to HWB Board and BCCG Governing Body with suggested actions.

- **Worked with CBC** to design a postal questionnaire to give current users the opportunity to shape the way in which domiciliary care services are provided in the future.

- **Representatives spent a day at residential care home** talking with residents, families and staff. Promotion of privacy, dignity and respect for residents clearly in evidence. HWCB report highlighted a concern which was immediately addressed. Feedback given at Provider Performance Meeting.

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Working in the Local Community

- **Falls Prevention Report:** Survey to find out what level of awareness and understanding exists amongst the population of Central Beds about the best ways to prevent falls and whether people have the willingness to 'future proof' their homes in advance of need and eliminate risk through good planning.

- **BLMK Snapshot Survey:** Worked with HW colleagues from Beds, Luton and MK, to determine local people's understanding of the STP; whether they were aware of Plans for their area and if so, how involved they are and how to achieve good communication.

- **Musculoskeletal (MSK) Survey**: Giving local people the opportunity to have their say about the quality of service and to shape the way services are delivered in the future.

- **Young People's Mental Wellbeing Project:** Worked with a group of young people to develop a mental health survey to gather feedback about their knowledge and understanding of mental health.

- **Newsletters / Ebulletins / Website** - Providing up to date information about health and social care services delivered locally.

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Top Priorities for 2018/19

Listening to the views of local people; influencing service design and delivery and continuing to champion the voice of local people -

Top priorities include:

- **Mental Health services, access and experience for both adults and young people;**
- **Deaf Services - investigating the deaf patients experience accessing primary and secondary care;**
- **Homelessness - engaging with vulnerable groups at risk, identifying challenges, needs and support;**
- **Out of hours services - review of current services to include 111, extended hours and planned UTC.**

Recent Highlights 2018

Joint Working Board:

- HWCB & HWL collaborated on a joint consortium bid to tender for the provision of a local HW service in Luton, starting from 1st April 2018.
- Set up a Joint Working Board which feeds into the two individual Boards of each organisation.
- Role of JWG is to oversee and promote closer collaborative working across each organisation, with a particular focus on shared health and care services commissioned and delivered in Bedfordshire.

HWCB Awards:

- Central Beds Cheering Volunteering Award – HWCB Volunteer received 'Outstanding Contribution' Award in June 2018.
- HW Eng Network Awards 2018 – HWCB received 'Highly Commended' for 'Giving People the Advice and Information they need'.

Questions?

healthwatch
Central Bedfordshire

Central Bedfordshire Health and Wellbeing Board

31 October 2018

2019/20 BLMK Joint System Commissioning Intentions

Responsible Officer:	Alan Streets, Bedfordshire Clinical Commissioning Group Accountable Officer
Advising Officer:	Alan Streets, Bedfordshire Clinical Commissioning Group Accountable Officer

Public

Purpose of this report

1. To provide a final version of the 2019/20 Bedfordshire, Luton and Milton Keynes (BLMK) Joint System Commissioning Intentions
2. To summarise key intentions for improvement of the health and wellbeing of the local population

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. **Note the key priorities as set out in the report**
2. **Consider implications for the Health & Wellbeing Board Work Programme**

Issues

Purpose of the 2019/20 BLMK Joint System Commissioning Intentions

3. The Commissioning Intentions document builds on the Bedfordshire, Luton and Milton Keynes (BLMK) System Operating Plan 2018/19 and sets out initial plans for the commissioning of services in 2019/20.
4. It is the first time the CCGs have developed Joint System Commissioning Intentions and reflects the progress of the Integrated Care System (ICS).
5. It provides the context for constructive engagement with providers, partners and other stakeholders with a view to achieving the shared goal of improved patient outcomes and service improvement within the fixed resources available.

6. The intentions reflect the ambitions and vision set by the local system as we work in partnership to improve the health and wellbeing of our local population.

Summary of key intentions

7. The Commissioning Intentions have been developed into eight key priority areas with a description of some of the key intentions described in the following table. A full list of Commissioning Intentions can be found in the main document at Appendix A.

Priority Area	Summary of Intentions
Children, Young People and Maternity	▪ Integrate plans to deliver including preventative and early intervention provision ▪ Develop integrated services to deliver improved children and young people's mental health and emotional wellbeing, including an all age community eating disorder pathway, 24/7 crisis service and specialist perinatal mental health service ▪ Progress implementation of the Local Maternity System transformation plans, including improved safety, choice and personalized care plans, improve prevention and early help ▪ Improve the pathway for children and young people with complex and challenging behaviour by developing new models of care that strengthen early help and prevent escalation and crisis, multi- agency approach and specialist services at scale across BLMK
Primary Care	▪ Support the resilience of primary care workforce through new clinical roles and a recruitment and retention programme ▪ Implementation of Primary Care Home at scale across BLMK which improves networking and multi-disciplinary service provision ▪ Continue the integrated Health and Care Hub development such as the Biggleswade and Dunstable (outline Business Case) and further hub opportunities ▪ Prepare for delegated commissioning of Primary Care
Planned Care	▪ Improving integration of Long Term Condition Services across primary, community and secondary care ensuring patients have support to self-manage and rapid access to advice during exacerbation ▪ Continue to improve bowel, prostate and lung cancer pathways to improve Cancer diagnosis and outcomes and embed the Living with and Beyond Cancer Programme ▪ Provide common approaches to supporting people to recover from acute episodes of ill health, and those with

	specific requirements resulting from traumatic brain injury or stroke, allowing them to live independently for longer, stay well and where appropriate and safe to do so, recover closer to home ▪ Ensure patients are directed to the right place for their health needs by improving access to clinical advice, clinical triage and alternative models of care including use of technology
Urgent and Emergency Care	▪ Continue to review and develop the Urgent Treatment Centre throughout the duration of the pilot in order to inform the future commissioning arrangements ▪ Optimise the use of ambulatory emergency care pathways to reduce pressure on emergency admissions ▪ CCG's will increase direct bookings from 111 (and other providers) into services including general practice, walk in services etc ▪ Implement a BLMK System Resilience approach during the winter months, providing a robust and coherent approach to planning and managing System Resilience across the ICS
Out of Hospital Care	▪ Embed social prescribing community referral pathways and continue to with low acuity social prescribing for adults with non-clinical presentations ▪ BLMK will deliver the Personalisation Programme to ensure people have choice and control over decisions that affect their own health and wellbeing within a system that harnesses the expertise, capacity and potential of people, families and communities in delivering better outcomes and reducing health inequalities ▪ Continue, review and develop as necessary the Early Intervention Vehicles to a bespoke model to reflect the needs of the population in Central Bedfordshire and Bedford Borough ▪ Implement a Fracture Liaison service for patients in the south of Bedfordshire
Mental Health	▪ Deliver IAPT access target of 21% and an increase in trainee places to support additional capacity. Ensure emotional support is accessible for patients with long term conditions ▪ Deliver the Dementia Intensive Support Team to support the local population with a dementia diagnosis to remain at home or place of residence

	▪ Re-commission a residential care home for patients with mental health needs, in partnership both Local Authorities in Bedfordshire ▪ Develop a standardised approach for crisis care with opportunity local place flexibility including rapid response for patients in crisis including Liaison Psychiatry and Mental Health Street triage
Learning Disabilities	▪ To increase awareness and uptake of an annual physical heath check for individuals with Learning Disabilities in collaboration with Primary Care and community ▪ Development and implementation of a remodelled specialised learning disability provision for the local Bedfordshire population and specialist forensic solution for patients with a learning disability ▪ To implement a shared outcomes framework with service users and parents
Medicines Optimisation	▪ To embed the changes to prescribing outlined in NHS England consultations on Over the Counter / Self-care products ▪ Based on learning from Luton CCG - investigate the opportunity to reduce general practice workload through moving the on-going management of stoma patients to a Primary Care specialist stoma service ▪ To improve community pharmacists management of minor illness through an educational package which will deliver safer consulting skills and support the CCGs to promote self-care

Financial and Risk Implications

8. Proposed changes and developments will be subject to robust financial and management planning to ensure we are delivering value for money throughout our Commissioning plans.
9. Robust risk management will be critical throughout the development process. Strategies will be employed to ensure risks are acknowledged and mitigated.

Governance and Delivery Implications

10. There are no further governance implications as the document is final and was subject to agreement by the CCG and STP governance process.

Equalities Implications

11. As each intent evolves into a deliverable plan, the Equality Impact Assessment will be used as a key tool in assessing the impact to all individuals during design and planning.

Implications for Work Programme

12. Implications for the work programme to be considered by the Board

Conclusion and next Steps

13. In conclusion, the Commissioning Intentions act as the first stage of ambition towards improved health and wellbeing of our population. With a strong commitment to working together,

Appendices

Appendix A:

2019/20 BLMK Joint System Commissioning Intentions

Background Papers

Not applicable.

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Appendix A

Joint System Commissioning Intentions

2019/2020

Contents

1. Introduction and purpose

This document builds on the Bedfordshire, Luton and Milton Keynes (BLMK) System Operating Plan 2018/19 and sets out initial plans for the commissioning of services in 2019/20. It is the first time the CCGs have developed Joint System Commissioning Intentions and reflects the progress of the Integrated Care System (ICS). It provides the context for constructive engagement with providers, partners and other stakeholders with a view to achieving the shared goal of improved patient outcomes and service improvement within the fixed resources available. This document will also be informed by the new NHS 10 year plan due to be published in November 2018.

As the ICS continues to embed, the system is developing its approach to balance BLMK-wide ambition and direction while instilling a clear sense of place and ensuring that the differences at a local level are understood. As such, Transformation Boards have been established for each place, and they have developed Transformation Board place-based strategies. Increasingly the intentions will reflect these local strategies and be more co-produced in future to result in system intentions that articulate both system level and local change required to meet the specific needs of each place population. The closer alignment of CCG strategy and system-wide priorities will be strengthened through the appointment of a single Accountable Officer and Joint Executive Team (JET) which will be in place by the end of quarter three 2018/19.

2. Developing our plans

2.1 National and local strategy and links to the ICS

The System Commissioning Intentions 2019/20 have been developed in line with applicable strategies including:

- NHS Mandate
- Five Year Forward View
- BLMK Sustainability and Transformation Plan
- BLMK System Operating Plan 2018/19
- Transformation Board place-based strategies

The key difference with the design of the Joint System Commissioning Intentions for 2019/20 is that they have been developed as a system, as the ICS has a shared responsibility for delivering financial targets, performance targets and setting goals and aspirations for continuing to improve health outcomes. All of the partner organisations within the ICS have had the opportunity to review and add to the emerging intentions, and the ICS Chief Executives Forum has been consulted on specific elements as part of the development process.

Although not directly Commissioning Intentions, the ICS has an ambitious approach to system transformation which involves joint system wide planning for the longer-term, some of which will have short-term contractual implications. This approach will be driven into our 2019/20 Single System Operating Plan, implementing local priorities, and the national NHS planning guidance, as well as the related contractual negotiations.

In-line with the Sustainability and Transformation Plan submitted in October 2016, The BLMK ICS is focussed on cross-system planning; bringing providers together to better deliver outcomes for our populations. In 2018/19 we developed a Single System Operating Plan, and in 2019/20 we will further work across traditional divides to focus on a system plan that straddles the traditional purchaser-provider split. This means that we are here developing ‘system’ intentions, in a different

process, and this signals a different approach to implementing the planning guidance as it is published.

Across BLMK some Community Health contracts will need revisiting in 2019/20. The Commissioners will work with the BLMK ICS to explore new contractual options that have been developed within the New Models of Care Team. These will evolve out of the current consultation on the Integrated Care Partnership contract. These approaches will be actively considered in 2018/19. Our focus will be on collaboration rather than competition.

Within existing contractual relationships we are already seeking considerable innovation, and will look to extend the identification of cohorts of patients against which we can focus new approaches to risk mitigation between partners. This will expand on current work to place the financial risk with partners best equipped to mitigate it; this is often the Community Health Service provider. Moreover, this will have added patient value and improve the patient experience.

There is an intention in different areas of BLMK to move to much greater integration between Local Authorities and the NHS, and this unified planning will proceed in 2019/20. Critical within our approach will be the enabling place-based decisions to be made by commissioners and providers, allowing local decision-making, under the STP umbrella, but attuned to local context.

2.2 Design assumptions

In the absence of national planning guidance for 2019/20, we have made a number of design assumptions. They include:

- That we are planning for a one year contracting round
- That even if there are changes to the provider landscape, e.g. a merger of Bedford and Luton and Dunstable Hospitals, the contracts are likely to remain separate in 2019/20
- Whilst the commissioner landscape may change before April 2019, we will be expecting to contract at individual CCG level as we do now
- That we are likely to need to amend these intentions to reflect the national guidance once it is issued

These assumptions were checked with the ICS Chief Executives Forum and were supported.

2.3 Engagement with stakeholders

The initial development of these intentions started with a BLMK-wide commissioner workshop which involved commissioners from both CCGs and Local Authorities. Commissioners worked together in their specialist areas to reflect national and local strategy, and what we needed to do in 2019/20 to deliver the national, BLMK and place-based priorities. From the outputs, a draft document was developed that was then tested back with commissioners, as well as ICS programme leads, providers, patient representatives, and others.

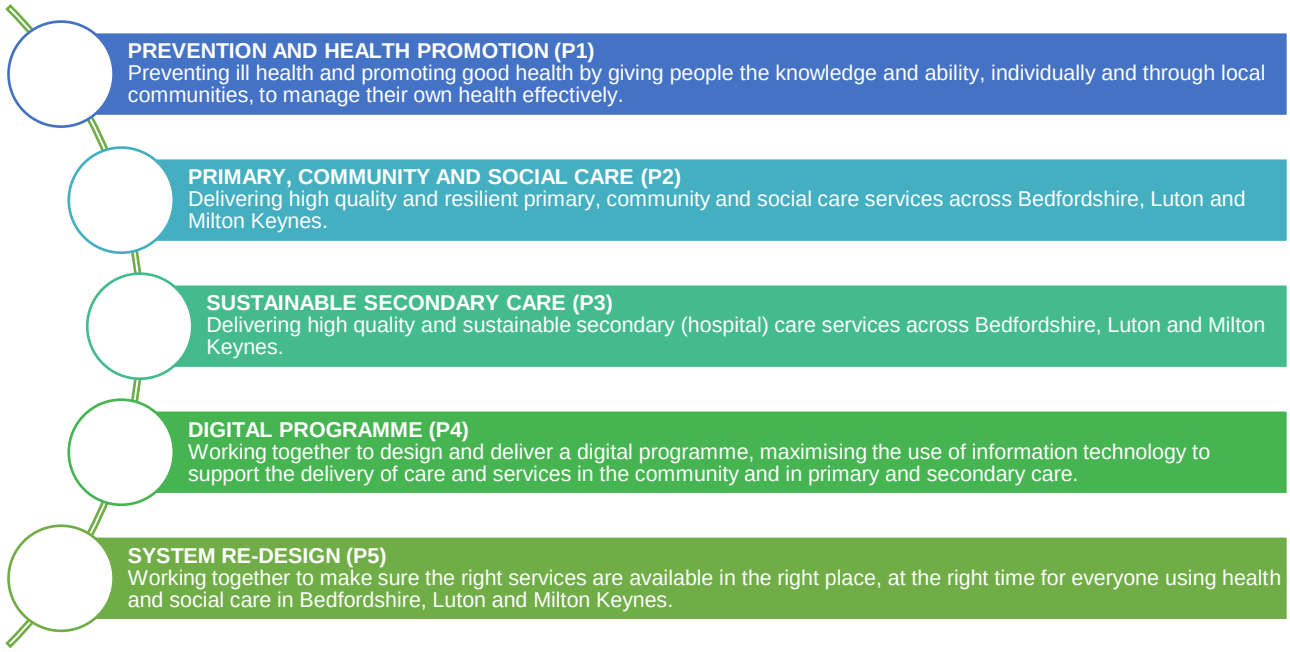
As these intentions are based on existing strategy, it was decided that rather than running a series of events specific to the Commissioning Intentions development process, we should instead take the draft document through existing local place-based forums to ensure that any place priorities were captured. This includes Health and Wellbeing Boards, Transformation Boards, Patient Reference Groups and others. A set of slides on the development process had been developed to ensure that each group received consistent key messages. Feedback gathered through this engagement has directly influenced the further development of the document.

2.4 Priority areas

The Commissioning Intentions have been developed for each of the following priority areas:

- Children, Young People and Maternity
- Primary Care
- Planned Care
- Urgent and Emergency Care
- Out of Hospital Care
- Mental Health
- Learning Disabilities
- Medicines Optimisation

They have been mapped, where appropriate, to the ICS priority workstreams which are:



3. The Joint System Commissioning Intentions

3.1 Children, Young People and Maternity

The Children, Young People and Maternity agenda is driven by the 18/19 Next Steps on the Five Year Forward View which includes specific deliverables for children and young people within the mental health; transforming care for people with learning disabilities and maternity sections. Additionally, there is a clear interface with the prevention and health promotion and urgent and emergency care priorities.

The Children and Families Act 2014 sets out a range of statutory responsibilities to improve outcomes for children with Special Educational Needs and Disabilities.
Children and Maternity commissioners from across BLMK have been meeting on a regular basis to establish a joint understanding of the challenges and opportunities. A BLMK 'Clinical Conversation' took place in January 2018 with stakeholders from across BLMK to further explore priorities and opportunities relating to the children and young people agenda.

The Local Maternity System (LMS) has been established across BLMK and the expectation is the updated plans to improve mental health and emotional wellbeing of children and young people will also be produced as a system at BLMK level.

In the last year, each place progressed implementation of CCG plans to improve children and young people's mental health and emotional wellbeing and commenced monitoring of the associated 'access target'. We have also established the LMS governance arrangements, identified baselines and set trajectories and plans for improvement. Work has been progressed to reduce attendances at emergency departments and zero length of stay hospital admissions. Arrangements have also been put in place for the local implementation of Special Educational Needs and Disability actions and the procurement of a BLMK (plus Northamptonshire) AQP framework for providers of care packages for children with continuing care needs.

The system will continue to work together to safeguard vulnerable children and young people. We will collectively work to improve identification and help for children affected by abuse and neglect, child sexual exploitation, female genital mutilation, domestic violence and those children who live in families affected by mental ill health, drugs and alcohol.

Close working with non-NHS commissioners of services for Children, Young People and Maternity will continue and evolve. This will include, but not be exclusive to Local Authorities, including commissioning of 0-19 universal services; NHSE England for public health interventions such as vaccinations and immunisations; and Specialised Commissioning for services, such as CAMHS Tier 4. We aim to have integrated 'system' commissioning intentions for future years, incorporating NHS England, Local Authorities along with the BLMK CCGs.

The following table details the areas of focus in 2019/20 for **Children, Young People and Maternity**, along with the associated timeframes for delivery:

Commissioning Intention	Description
Children and Young People's Mental Health	Integrate place-based plans to deliver a BLMK transformation plan to improve children and young people's mental health and emotional wellbeing including: • Strengthen preventative and early intervention provision • Develop an all age community eating disorder pathway • Develop 24/7 crisis service • Implement specialist perinatal mental health service • Ensure delivery of access and waiting times standards • New care models to reduce need for Tier 4 mental health inpatient beds
Local Maternity System Transformation	Progress implementation of the Local Maternity System transformation plans to: • Improve safety by reducing still births, brain injuries and maternal deaths • Improve choice and personalisation by implementing continuity of care, personalised care plans and more choice to enable women to give birth in midwifery-led settings • Strengthen prevention and early help • Enable delivery of the LMS priorities through strategic oversight, collaboration, co-production, workforce planning and digital opportunities

Paediatric emergency care	Reduce avoidable attendances at emergency departments and zero length of stay hospital admissions through: • Learning programmes for community and primary care • Rapid response nursing • Care co-ordination • Improving self-care • Ensuring a consistent approach to short stay tariff
Complex and challenging behaviour	Improve the pathway for children and young people with complex and challenging behaviour (including neurodevelopmental disorders, ASD, epilepsy, sexualised behaviour) including: • Identify new models of care that strengthen early help and prevent escalation and crisis • Develop pathways and interventions with local authorities for a multi-agency approach • Identify opportunities for delivering at scale for very specialist services
Transforming Care for People with Learning Disabilities and/or Autism	Establish a Children and Young Persons Transforming Care Operational Group to drive: • Consistent approach to care, education and treatment reviews and Local Area Emergency Protocol • Early identification of need and personalised support
SEND	Enhance joint commissioning 'at place' arrangements to support Special Educational Needs and Disabilities agenda, including: • Improve the experience of children and young people with special educational needs of health services • Increase access to personalised care • Improve access to therapies • Special schools development programme
Children's Continuing Care	Review new Any Qualified Provider Framework for Children eligible for Continuing Care and assess whether further procurement of providers required to meet demand.
Looked after children	Review quality and provision of health assessments for Looked After Children. Implement East of England protocol for reciprocal funding arrangements (Bedfordshire and Luton).
End of life care	Scope provision of end of life and palliative care provision across BLMK to ensure parity of access and consider if there are opportunities around economies of scale.
Place-specific intentions	Luton: - Development of a more integrated children's service across Luton in 2018/19 to be implemented in 2019/20 Bedfordshire: - Improve cost effectiveness and efficiency of Equipment services

3.2 Primary Care

A new model of Primary Care is required for the future with general practice needing to transform to ensure GP's and other staff have a manageable and appropriate workload, and teams are resilient to fluctuations in demand. The environment is now better than ever to enable change:

- The capacity, scale and resilience of the prevailing operational and business model in primary care across BLMK is acknowledged as unfit to respond effectively to future challenges
- Whilst there are examples of good Primary Care in BLMK, we know that there is considerable variation in access to care and in health outcomes
- The General Practice Forward View has highlighted to the local system that a significant change in the level of investment and support being offered for general practice is required
- Infrastructure plans need to be forward looking and demonstrate how the asset base will be developed to be a key enabler for service transformation
- There is considerable interest amongst local GP's (and other providers) to examine the benefits that may arise from introducing new models of care and realising the benefits of working at scale

The future vision for primary, community and social care across BLMK is predicated on strengthened Primary Care-led, integrated services. BLMK have adopted the Primary Care Home (PCH) approach to strengthening and redesigning Primary Care where staff come together as a complete care community to focus on local population needs and provide care closer to patients' homes. The model is underpinned by an enhanced General Practice offer, which is supported by a health and social care integrated multidisciplinary workforce wrapped around GP services, to offer coordinated, joined up, place-based care. This approach enables us to think differently about how teams of staff support general practice workload and consider what aspects of GP care could be delivered by a range of other staff groups.

GP practices across BLMK have been configured into 20 provider clusters / networks covering populations of up to 65,000 people, and this is the foundation for delivery of the BLMK PCH model. Each cluster / network has identified, or is in the process of identifying, a transformation project based on a segment of their population where it would be advantageous if practices and other providers are working more closely at scale to deliver care for their patients. This includes the cluster/network actively:

- Recruiting to new roles
- Sharing resource and infrastructure
- Adopting the locally commissioned Multidisciplinary Team approach
- Working to understand their population health needs and data

The GP Forward View and other transformation funds have been utilised to deliver a number of initiatives locally including:

- Practice staff training initiatives have been deployed so we have:
    - ✓ Signposting supporting patients to identify the right care at the right time
    - ✓ A significant number of practice staff trained across BLMK as Clinical Administrators to ensure optimum workflow to release GP time to care
    - ✓ An education programme designed to support our local practice managers, supported by an emerging BLMK Strategic Practice Managers Network
- Milton Keynes CCG is now a national early adopter providing Extended Access for its population with Luton and Bedfordshire CCGs preparing to go live with Extended Access in 2018/19
- A programme agreed, in line with the STP Strategic Estates Plan, with each Local Authority to develop community hub facilities with GP practices at the core based on, and to enable, the PCH model. The system is also working in partnership to secure new/improved premises for the delivery of care to address the needs associated with housing growth

- A number of workstreams are on-going across BLMK to develop SystmOne to enable a tactical shared care record. Plans are also in place to pilot online consultations and remote monitoring for patients with complex needs

Work is required across the BLMK STP to develop an environment across primary, community and social care that breaks down barriers between funding streams and services and encourages GPs and practice managers to make professional integration in the community a reality, including access to statutory Local Authority services and safeguarding referrals. The system is required to demonstrate the key characteristics of PCH, with general practice at the heart moving at pace and scale towards the levels of maturity that reflects our local ambition and NHS England aspirations for Primary Care within an Integrated Care System.

Our General Practice Workforce Plan and Development Programme covers a range of new roles and ways of working, recruitment and retention and education, training and development initiatives that address our workforce challenges. The ambition is to make BLMK a differentially attractive place to work. This approach enables us to think differently about how teams of staff support general practice workload and consider what aspects of GP care could be delivered by a range of other staff groups, offering an attractive career model and working environment for new clinicians and admin staff as well as incentives for existing clinicians to continue practising. The Primary Care Home initiative will continue to provide a test bed for new ways of working in General Practice that will be rolled out across BLMK to develop strengthened, enhanced GP services.

It is recognised within BLMK there is a wide variation in patient's perception of access to Primary Care. We will utilise commissioning opportunities to encourage shared workforce, infrastructure and a pooled responsibility to improve access to urgent and pre-bookable Primary Care services. One example is the requirement to roll out extended access from a number of Primary Care sites with services accessible for 100% of the BLMK population.

The following table details the areas of focus in 2019/20 for **Primary Care**, along with the associated timeframes for delivery:

Commissioning Intention	Description
General Practice Forward View	Continue implementation of the Forward View for General Practice including: - Online consultations - Workforce changes – clinical pharmacists, new clinical roles, training hubs and recruitment and retention schemes - High Impact actions to address workload issues - Ensuring the appropriate infrastructure is in place to deliver sustainable Primary Care including information sharing, GP IT framework, ETTF digital, ETTF estates and the HUB programme
New Models of Care	Continue to implement Primary Care Home at scale across BLMK, implementing networks / clusters and integration with community, local authority and out of hospital services through multidisciplinary team working. This includes the delivery of extended access, and brings in reinvestment plans for PMS.
Primary Care at scale	Investments in to Primary Care will be focussed on patient management that results in a reduction in urgent and emergency activity and admissions. This prevention approach will need a closer working relationship with Public Health and ensuring that the needs of the local population are understood. Underpinned by best practice and local models, we will undertake a review of minor surgery procedures, review the safe treatment scheme, and develop

	pathways that build on the opportunities of federations and clusters. Local Enhanced Services will be reviewed by each CCG.
New Exeter GP Payment	Consistent and managed transition to the new national GP payments system when it is implemented including implications for in and out of hours Primary Care.
Workforce development	Work to make BLMK an attractive place to work for Primary Care professionals, practice managers, and other non-clinical roles in Primary Care. This includes training and development schemes, training hub development and mentoring. We will establish a standard BLMK locum market rate.
Changing the 'opening hours'	We will continue to embed extended access to Primary Care, but we will also look at how we work differently to deliver out of hospital care through Primary Care in a different way, with more flexible working patterns and blended skill sets that are available at the times they are most needed by the population.
Place-specific intentions	Milton Keynes: - Procurement of Whitehouse APMS - Increase proportion of Urgent Treatment Centre/Out Of Hours capacity that can be directly booked - Integrate enhanced opening appointments into the GP Access Fund capacity Luton: - Hub programme - Redesign of Kingsway Health Centre Bedfordshire: - Premises programme – The programme aims to secure and improve both the premises and capacity in Primary Care - In conjunction with Central Bedfordshire continue the integrated Health and Care Hub development such as the Biggleswade and Dunstable (outline Business Case). Further, continue to work with CBC around further opportunities around Integrated Health and Care Hubs. - In conjunction with Bedford Borough progress with the recommendations of the Hub feasibility study - Review of all locally commissioned services and ascertain value for money - Determine and reinvest PMS released funds back into Primary Care - Prepare for delegated Primary Care commissioning

3.3 Planned Care

The NHS is under significant pressure with unprecedented levels of demand, approximately 1.5 million patients are referred for consultant-led treatment each month and referrals are rising annually by an average of 4% per year. Since 2005/6 total outpatient appointments have nearly doubled from 60.6m to 118.6m.

The BLMK system is committed to ensuring the best possible outcomes for our patients and ensuring the most efficient use of finite resources. Our planned (elective) care commissioning intentions aim to effectively manage demand across our system ensuring patients are referred into services, so they get the 'Right Care, in the Right Place, at the Right Time'. We will draw from a variety of sources to inform evidence-based pathway transformation. These sources include:

- Right Care
- High Impact Intervention guidance and specifications
- Specialty-based Transforming Elective Care Handbooks

- 100 Day Challenge Methodology
- Getting It Right First Time (GIRFT) Programme

The BLMK commissioning intentions for planned care align with the Five Year Forward View aspiration to reduce the avoidable demand for elective care and tackle unwarranted variation, as demonstrated by Right Care. We will do this by:

- The utilisation of clinical peer review in Primary Care, embedding shared decision making, and ensuring advice and guidance options are widely available for Primary Care
- Redesigning and creating efficient integrated pathways and service provision which meet patient's needs, make the most efficient use of resources and reduce duplication

During 2018/19, we have made significant progress as a system across a number of service areas, including:

- Community Musculoskeletal Service – Improved referral management and shared decision making for MSK related conditions through enhanced MSK triage services in the community including pathways for orthopaedic, rheumatologic and pain
- Procedures of Limited Clinical Effectiveness (POLCE) – Integrated BLMK POLCE development process with the Bedfordshire and Hertfordshire Priorities Forum allowing partial alignment of POLCE policies across the STP
- Advice and Guidance – Access to specialist advice for Primary Care leading to improved multi-professional working through electronic and telephone advice and guidance services.
- Integrated community models of care for patients who are frail, and those with long term conditions
- Transformation of diabetes across BLMK utilising the national Treatment and Care Programme funding - to improve access to structured education, improve achievement of the 3 NICE treatment targets for patients, develop multi-disciplinary foot care pathways, and ensure access to diabetes specialist nurses for patients who are admitted to hospital - leading to less complications and better longer-term outcomes for our population with diabetes
- Implemented the BLMK Cancer Transformation Programme to standardise the diagnosis and treatment options for key pathways (Prostate, Lung and Colorectal cancers). Developed new models of care to support people living with cancer. Prioritised areas of opportunity for Trusts working together on pathways

The following table details the areas of focus in 2019/20 for **Planned Care**, along with the associated timeframes for delivery:

Commissioning Intention	Description
Referral Management	Ensure patients are directed to the right place for their health needs, by adopting clinical peer review, advice and Guidance and national Consultant to Consultant referral of good practice.
Advice and Guidance	Adopting a common approach to consultant led advice and guidance - supporting Primary Care capacity and capability to manage care effectively and reduce unnecessary referrals.
Ophthalmology	Undertake demand and capacity reviews across cataract, glaucoma and macular degeneration pathways to support the development of sustainable services.
First contact practitioner (FCP)	Maximising the opportunities arising from the BLMK and national FCP pilots and improve Primary Care access to Physiotherapy for musculoskeletal care.

Transformation and clinical pathway development	Improve out of hospital care across a number of specialities, including Gastroenterology, Urology, ENT and Neurology. BLMK review of pain, Rheumatoid Arthritis and Osteoporosis pathways.
Integrated Long Term Conditions Services	Improving integration of Long Term Condition Services across primary, community and secondary care ensuring patients have support to self-manage and rapid access to advice during exacerbation. Explore service provision for patients with more than one co-morbidity. Develop a single Integrated Diabetes Service Specification for BLMK.
Rehabilitation	Provide common approaches to supporting people to recover from acute episodes of ill health, and those with specific requirements resulting from traumatic brain injury or stroke, allowing them to live independently for longer, stay well and where appropriate and safe to do so, recover closer to home.
Diagnostics	Reducing unnecessary diagnostic tests that may not contribute to patient care and/or improved outcomes. Continue to develop and Improve access to cancer diagnostics.
Cancer	Continue to improve bowel, prostate and lung cancer diagnostic pathways through the STP Cancer Transformation programme working towards improved diagnosis by day 28. Embed the Living with and Beyond Cancer programme, including developing risk stratified pathways. Review of radiotherapy provision. Review of Clinical Nurse Specialist workforce.
Alternative approaches	Use technology where appropriate and virtual/non-face to face appointments reducing the travel burden e.g. community Dermatology enabled by TeleDermatology. Maximise the use of GPwSI and community resource for outpatient delivery.
POLCE	Development of a single POLCE specification across BLMK taking full consideration of the recommendations from the national consultation which commenced in July 2018. In addition, standardising operational processes and maximising IT solutions to reduce the impact on patients and the administrative burden for clinicians.
ENT	Development of a community ENT service across Bedfordshire and Luton based on the current Milton Keynes service.
Place-specific intentions	Bedfordshire: - Development of community outpatient services for a range of specialties improving access to specialist consultations and diagnostics out of hospital. - Development of Stroke Rehabilitation Unit providing comprehensive rehabilitation out of hospital. Luton: - Development of services for patients with vague symptoms to address possible delays in cancer diagnosis. The model will be designed in 2019/20 with a plan to implement in 2020/21

3.4 Urgent and Emergency Care

Urgent and Emergency Care (UEC) continues to be a high priority nationally and locally. The focus remains on the four-hour ED standard and Delayed Transfers of Care, but there is also now an emphasis on length of stay, “stranded patients” and the broader Integrated Urgent Care agenda.

BLMK performs comparatively well against the four-hour target. In June 2018 BLMK was 6th out of the 42 ICS's with overall performance of 94.4% (as per NHSE monthly figures). Performance against Delayed Transfers of Care (DTOC) is positive for Bedfordshire and Luton although remains challenged in Milton Keynes. However, through focussed work this has been resolved with performance for June 18 for Milton Keynes Unitary Authority recorded locally as 3.1%, which is below trajectory and the national target.

Luton and Bedfordshire CCG's have already developed a close working relationship around UEC as evidenced by their joint procurement of 111/Out of Hours (Integrated Urgent Care) services in 2017. This close working is likely to develop as the secondary care providers integrate. MK has considerably different patient flows and providers, but there is a commitment across all 3 partners to work at scale whenever it is practical to do so. However, rather than an emphasis upon shared providers, BLMK plan to utilise all opportunities for partners/workstreams to function on a networked and virtually integrated level. This will commence with Directory of Services (DOS) management.

There are significant synergies between the UEC priority and the Mental Health priority, as many patients presenting with an urgent care need have multi-morbidities and mental health needs.

The following table details the areas of focus in 2019/20 for **Urgent and Emergency Care**, along with the associated timeframes for delivery:

Commissioning Intention	Description
Ambulatory Emergency Care Pathways	Optimise use of ambulatory emergency care pathways to reduce pressure on emergency admissions.
Aligned approach to payment for Ambulatory Care	Each of the local providers charges a different tariff for ambulatory care. The CCGs are committed to negotiating a standardised local tariff for this activity.
Integrated Urgent Care	a) Clinical Advisory Service The CCG's and providers of Clinical Advisory Services will identify potential for networked working and shared resource e.g. "does each CCG need to commission Mental Health input to the individual CAS's or can it be co-ordinated across the ICS?" b) NHS 111 Online The CCGs will work to align pathways and approach to NHS111 Online to ensure all BLMK Patients receive the same "offer". c) Directory of Services The CCGs will work to align the Directory of Services to assess opportunity for efficiencies of scale and to ensure the pathways are aligned where required. CCG's will also share learning and best practice around current DOS management and move to networked working.
Directly bookable Appointments	CCG's will increase direct bookings from 111 (and other providers) into services including general practice, walk in services etc. sharing learning and best practice from across BLMK
Reducing Length of Stay (LOS)	CCG's will work with partners to reduce "stranded patients" and reduce LOS in line with national guidance. Best practice and learning will be shared across BLMK.
Whole system risk share	Continue to work with partners to understand how risk and reward around shifts in emergency activity can be shared across Place.

Out of hospital/Case management	Implementation of case management/out of hospital services within the community with the intention of mitigating pressures on secondary urgent/emergency care and reducing ED attendances and emergency admissions.
Resilience / OPEL framework alignment	Employ a BLMK System Resilience Lead to give specific focus to System Resilience during the winter months, providing a robust and coherent approach to planning and managing System Resilience across the ICS standardizing process where appropriate whilst being sensitive to place-related nuance. Alignment of the OPEL framework and resilience process across the three CCGs including: - Agreed actions / steps at the point of surge (local and ICS) - Increased cross-system working The role will also take a coordinating lead in winter reporting to NHSE
System reviews	Develop an aligned approach to system reviews and focussed discharge events building on the successes of System Assessment Days and MADE events.
Place-specific intentions	Milton Keynes: - Undertake a consultation on "Urgent Same Day Care" provision across the health system - Increase proportion of Urgent Treatment Centre/Out Of Hours capacity that can be directly booked - Increase direct booking from 111 to other services - Increase access to clinical support and information for ambulance staff to reduce conveyance to ED e.g. enhanced GP triage, enabling access to care records and providing detail of alternatives to conveyance to ED Luton: - Review priority given to developing appropriate pathways for patients with mental health needs within urgent and emergency care settings where the primary reason for presentation is not mental health to support those with multi-morbidities and mental health issues Bedfordshire - Continue to review and develop the Urgent Treatment Centre throughout the duration of the pilot in order to inform the future commissioning arrangements. *Please also see Out of Hospital draft intentions which will work to mitigate reliance on acute emergency services including ED attendances and emergency admissions*

3.5 Out of Hospital Care

The Five Year Forward View set out an ambition for out of hospital care to integrate Health and Social Care to deliver better outcomes for patients and reducing net costs and to enable care closer to home bringing more appropriate care models into local community setting. Across BLMK we want people to have the knowledge and support to live healthy lives, to manage long-term conditions and to have access to community, primary and social care which is personalised and organised around the individual. We will aim to build on the BLMK Single System Operating Plan 2018/19 priorities for OOH Care which focus on a standardised approach at scale and pace delivery for:

- Self-care to reduce non-medical demand
- Residents with complex needs
- Effective care delivery for residents in crisis

Over the last 12 months, progress has been made across the BLMK footprint on the development and implementation of new models of out of hospital care. This includes:

- Proof of concept place-based system wide approach to care navigation/case management in Primary Care networks (MK)
- Commissioning community service outcomes based contracting model
- Delivery of STP wide Personalisation Programme
- Enhanced Step Up Care
- High Intensity Service User MDT intervention multi-agency case management for risk stratified patients with complex needs delivered at place
- Phase 1 place-based mobilisation of GP Advanced Care Planning for End of Life
- Effective Care delivery for residents in crisis including extending Complex Care Teams to weekends and Emergency Intervention Vehicles
- In reach community and social care support into emergency care to fast track patients into community settings
- Trusted assessor and red bag schemes embedded in acute settings
- Streamlining of pathways to support delayed transfers of care to obtain <3.5% reduction
- Complex Care
- BLMK system-wide implementation advanced care planning, medication optimisation and UTI hydration schemes localised for place-based delivery specifically for care homes as part of enhanced health in care homes programme
- Delivery of Enhanced Health in Care Homes Programme including digitalisation/telephony programme(s) to provide care home workers access to shared care records and specialist support
- Focus on delivery of end of life transformation programme
- Continuing Health Care
- CHC service configuration including fast tracking of pre-assessments to community referrals, reduction in 'hotel rates' and night visits

Out of Hospital care across BLMK should have a 'single offer' with standardisation of scope, terms and delivery. This may include the relationships with broader community organisations such as community pharmacies and third sector providers. This would support place-based contracting and remove disparity across BLMK geographical boundaries.

The following table details the areas of focus in 2019/20 for **Out of Hospital Care**, along with the associated timeframes for delivery:

Commissioning Intention	Description
Out of Hospital Core Values	BLMK will aim to work to define shared core values and principles across the footprint. There will be some areas where standardisation of scope, terms and delivery are useful. For example, system wide offer for phlebotomy access and provision to help address current variation across geographical boundaries.
Social Prescribing	We will embed social prescribing community referral pathways and continue to with low acuity social prescribing for adults with non-clinical presentations.
Personalised Agenda	BLMK will deliver the Personalisation programme to ensure people have choice and control over decisions that affect their own health and wellbeing within a system that harnesses the expertise, capacity and potential of people, families and communities in delivering better outcomes and reducing health inequalities.
Transitions of Care	We will reduce length of stay and patient/client de-compensation by focusing on 'stranded patient flows' in acute settings.

Intermediate Care	We will deliver a system wide approach to community provision for step up/step down intermediate care.
Community Beds	We will optimise utilisation of community beds by developing a whole system wide approach to streamline patient flows.
Complex Care	We will continue to refine the model for Primary Care multi-disciplinary support to avoid unplanned admissions (focussing in some areas on care homes and increasing community Geriatrician support).
Continuing Health Care	We will continue with development of a single CHC function with appropriate integration with local authorities focusing on embedding NHS Personal Health Budgets and Local Authority Personal Budgets.
Shared Care Records	We will continue to make progress on the digitalisation programme to support 'shared care' access and documentation for all care/link workers.
Care Navigation/Case Management	We will rollout place based care navigation/case management across Primary Care networks as part of our work on complex care focusing on frequent attenders/users of health and social care services e.g., improvements to frail/elderly pathways to reduce avoidable admissions.
High Intensity Users	We will continue to focus on high intensity users' schemes to optimise admission avoidance pathways.
Personalised Care	We will continue to: • Expand coverage of Personal Health Budgets • Focus on personalised care and support planning • Increase social prescribing • Focus on self-care and peer support
Place-specific intentions	Luton: - We will improve referral and access routes to community beds to support discharge from HASU Milton Keynes: - We will develop the first stage for place-based end of life 24/7 coordination of care provision in collaboration with partners across health, social and third sector Bedfordshire: - Develop Joint Health and Social Care plans across Bedfordshire in line with the planned demographic and housing growth over the next 3-7 years - Continue, review and develop as necessary the Early Intervention Vehicles to a bespoke model to reflect the needs of the population in Central Bedfordshire and Bedford Borough - Implement the Community Health Service Transformation plan - Implement a Fracture Liaison service for patients in the south of Bedfordshire - Utilising the EOL audit at BHT, develop a community based service to support EOL at home and/or place of residence (choice) - Re-design the Tissue Viability Service to improve outcomes across Bedfordshire

3.6 Mental Health

The Five Year Forward View for Mental Health has set ambitious but achievable expectations for all areas of England across all ages. During 2017/18 BLMK has developed an ambitious STP mental health plan and established a mental health workstream, which includes senior representatives from

each of the key commissioning and provider partners, the East of England Clinical Network, and the national NHSE Five Year Forward View Mental Health Team. A central focus of the mental health workstream is driving rapid and tangible progress in improving mental health outcomes for the citizens of BLMK, in particular in implementing Five Year Forward View (FYFV) for Mental Health and GP Five Year Forward View.

Significant progress is expected towards achieving the FYFV for Mental Health targets. Highlights include:

- A successful bid for Wave 2 funding from NHS England for perinatal mental health services across BLMK, including developing a specialist service across Luton and Bedfordshire
- A successful bid for funding from NHS England for Individual Placement and Support (IPS; an employment support model), with a service across Luton and Bedfordshire in the first phase, with Milton Keynes developing at a later phase
- Submitted workforce returns to NHS England nationally and regionally
- An ICS mental health investment plan is being developed, identifying costs of full FYFV delivery through to 2021 and including investment requirement, return on investment through integrated care, and innovation
- Developing a consensus model for mental health in Primary Care Home, including range of preventative and treatment modalities for people with common mental health problems, serious mental illness and dementia. In 2018/19, the mental health workstream is working with the Kings Fund to develop a model for mental health in Primary Care Home. This is a major strand of work timetabled for 2018/19, which will be supported by the BLMK Mental Health Programme Manager
- Review of urgent care/crisis care pathways for people with mental health problems, developing case for change
- All areas are achieving the target that 53% of patients requiring early intervention for psychosis receive NICE concordant care within two weeks.
- Across BLMK there is a very low level of inappropriate adult acute out of area placements; BLMK has one of the lowest levels in England
- All areas are working to achieve the dementia diagnosis rate of two thirds (66.7%) of prevalence and improve post diagnostic care, consistently.
- BLMK is developing a multi-agency suicide prevention plans, working towards a national 10% reduction in suicide rate by 2020/21
- All areas of BLMK working towards 21% IAPT access target & achieve the 50% recovery target
- A BLMK action plan is being developed to deliver physical health checks to 60% of patients with serious mental illness (SMI) on the SMI register

The following table details the areas of focus in 2019/20 for **Mental Health**, along with the associated timeframes for delivery:

Commissioning Intention	Description
Mental Health closer to home	Transformation of services towards alignment with the Primary Care Home model, community services and local authority services. Increase the proportion of patients seen in a non-acute setting.
IAPT	IAPT access target of 21%, and an increase in trainee places to support additional capacity. Ensure emotional support is accessible for patients with long term conditions.
Serious Mental Illness	Physical health checks for people with SMI, working towards the 60% of people on the SMI register.

Perinatal Mental Health	Perinatal mental health services achieving access targets across BLMK, and ensuring sustainability of the new service in Luton and Bedfordshire.
Early Intervention in psychosis	All areas to achieve the target that 60% of patients requiring early intervention for psychosis receive NICE concordant care within two weeks.
Urgent Care	Embedding new urgent care/crisis pathways and ensuring sustainability of model(s).
Individual Placement & Support	Ensure that the IPS services are achieving targets and are sustainable.
Workforce	Workforce plans to align with mental health investment standard expectations.
Crisis care	Develop a standardised approach for crisis care with opportunity local place flexibility including rapid response for patients in crisis including Liaison Psychiatry and Mental Health Street triage
Complex mental health placements	Develop options for BLMK-wide service transformation including the development of a local inpatient unit to reduce out of area patients, and keep patients closer to their communities.
Place-specific intentions	Bedfordshire: - Dementia Intensive Support Team- to support the local population with a dementia diagnosis to remain at home or place of residence through the development of the Dementia Intensive Support team - Re-commission a residential care home for patients with mental health needs, in partnership both Local Authorities in Bedfordshire Milton Keynes: - MK CCG intends to decommission Cherrywood in its current model and work with CNWL on a new specification for a service for people with complex needs, with the aim of reducing out of area placements. We will evaluate a range of options, including managed access in-patient units as well as high level supported housing.

3.7 Learning Disabilities

Transforming Care Partnership

The Transforming Care Partnership (TCP) comprises three clinical commissioning groups (CCGs), four local authorities (LAs) and crosses two specialised commissioning (SC) hubs.

The partners are: Luton CCG (lead for the TCP), Milton Keynes CCG, Bedfordshire CCG, Luton Borough Council, Milton Keynes Council, Bedford Borough Council, Central Bedfordshire Council, NHS England Midlands and East (East of England) SC hub, and NHS England Midlands and East (East Midlands) SC hub.

All of the CCGs, LAs and SC are represented on the TCP partnership board, which is chaired by the Senior Responsible Officer (SRO) who is the Director of Quality and Clinical Governance for Luton CCG.

These organisations all contributed to the development of the local plan which was formally agreed at board level through the partnership's agreed governance structure. The plan sets out key priorities that will increase community capacity and resilience that will ensure local community provision can meet the needs of those individuals being discharged from hospital and to also prevent people being admitted into specialist learning disability inpatient provision.

The aim of the TCP

The Transforming Care programme aims to improve the lives of children, young people and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition.

The programme has three key aims:

- To improve quality of care for people with a learning disability and/or autism
- To improve quality of life for people with a learning disability and/or autism
- To enhance community capacity, thereby reducing inappropriate hospital admissions and length of stay

The following table details the areas of focus in 2019/20 for **Learning Disabilities**, along with the associated timeframes for delivery:

Commissioning Intention	Description
Transforming Care Programme (TCP)	Continue to work in close partnership with key stakeholders across the Transforming Care Programme (TCP) BLMK footprint to deliver change and reduce inpatient admissions by providing the least restrictive community provision for individuals presenting with high levels of complexity and need
Physical health checks	To increase the number of people identified as having a Learning Disability on GP registers to ensure reasonable adjustments are considered when offering an annual health check.
Physical health checks	To increase awareness and uptake of an annual physical heath check for individuals with Learning Disabilities in collaboration with Primary Care and community.
Children and Young People	Review the workings and funding framework and terms of reference for individual packages of education, health and social care. Establish a dynamic risk register and early intervention processes and communicate this to wider partners. To develop a shared outcomes framework with service users and parents.

Place-specific intentions	Bedfordshire:
	- Specialist Learning Disability Remodelling - The development and implementation of a remodelled specialised learning disability provision for the local Bedfordshire population
	- Learning Disability Forensic Provision - The development of a specialist forensic solution for patient with a learning disability
	- Children and Young People:
	  - Review the workings and funding framework and terms of reference for individual packages of education, health and social care
	  - Implement a dynamic risk register and early intervention processes and communicate this to wider partners
	  - To implement a shared outcomes framework with service users and parents

3.8 Medicines Optimisation

Medicines are the most common therapeutic intervention in the NHS. Used correctly they can make a major impact on years of life e.g. cancer treatments, the ability to sustain a normal life e.g. biologics in inflammatory conditions, where there has been a radical change to the short, medium

and long-term health outcomes to patients with rheumatoid arthritis where previously patients frequently would suffer with irreversible multiple and severe joint damage and organ function deterioration. However, when medicines are used incorrectly they can cause significant harm to patients that may result in an emergency hospital admission.

Spend on medicines in Primary Care has remained static over the last few years and is generally around 12% of the CCG budget. Spend in secondary care drugs has risen steeply over the past decade and recent yearly increases have averaged around 12%.

Medicines are an important consideration in all the ICS priority workstreams and are a component in all the commissioning intentions' eight priority areas. The Medicines Optimisation commissioning intentions are those that are being driven by the Medicines Optimisation teams linking in with colleagues in commissioning, in provider organisations and to the wider community.

The following table details the areas of focus in 2019/20 for **Medicines Optimisation**, along with the associated timeframes for delivery:

Commissioning Intention	Description
Self-care and Items less suitable for prescribing in Primary Care	To embed the changes to prescribing outlined in NHS England consultations on Over the Counter / Self-care products and Items less suitable for prescribing in Primary Care and any subsequent areas consulted on by NHS England and NHS Clinical Commissioners.
Biosimilar medicines	To build on the current experience of introducing biosimilar medicines to ensure that all future biosimilar medicines are introduced in such a way as to maximise the savings opportunity for the NHS.
Stoma	To investigate the opportunity to reduce general practice workload through moving the on-going management of stoma patients to a Primary Care specialist stoma service. LCCG is currently piloting with a view to up scaling across the STP.
Continence	To investigate the opportunity to reduce general practice workload and improve cost-efficiency of continence supplies through formulary management, and preferred providers.
Self-Care	To improve community pharmacists management of minor illness through an educational package which will deliver safer consulting skills and support the CCGs to promote self-care.
Place-specific intentions	Luton: - Woundcare – To reduce general practice workload through redesigning the supply of wound dressings. - Paediatric Dietetics – Redesign the service for the on-going management of children with a dietetic need to a Primary Care specialised dietetic service - Specialist Medicines Optimisation Pharmacists – The Medicines Optimisation team provide a general package of medicines optimisation support to practices. However, there is an increasing need seen locally to support general practice in the management of patients with more complex health. This need is no more apparent than in the cohort of children on complex medicines who commonly attend multiple health providers and present with congenital anomalies. Luton's children population could be seen to be at higher risk of morbidity as they have higher than average exposure to some of the

	wider determinants of child morbidity such as poverty, poor housing and consanguinity. Milton Keynes: - Undertake a publicity campaign aimed at decreasing medicines waste and supporting patients to re-order their repeat prescriptions in a timely and efficient way.

4. Our plans to engage with the patients and the public

Involving local patients, members of the public, carers and patient representative groups, as well as providers is important to the CCGs so that we can be assured of commissioning the best possible services that meet the needs of local patients and that represent the best possible value for money. Therefore, we will need to formally consult with interested parties and the public, where our plans involve a significant service change.

Many of the proposals for change set out in this paper have been co-produced with partners in the local area, including the local authority and providers. By publishing our intentions formally, we are able to discuss our plans further with them, and confirm alignment. Over time we expect this to be more and more a feature of the way in which we commission services, as part of an integrated care system.

Most of our commissioning intentions will not require formal consultation. Instead they are about pathway changes designed to improve services often through better integration and co-ordination of care between providers. Some of our intentions may be about changing the provider of services through a procurement process, with the service delivered remaining broadly similar. In these circumstances, engaging with users of the services is really important, so we can build their views into the service commissioned.

4.1 Engagement in design

We will ensure that engagement takes place with a variety of existing groups and networks to make sure the changes we make work well. These groups include but are not limited to Health Overview and Scrutiny Committees, Health & Wellbeing Boards, Partners in the Integrated Care System, Healthwatch, Patient Participation Groups and relevant third sector partners.

Engagement describes the continuing and on-going process of developing relationships and partnerships. We undertake engagement so that the voice of local people and partners is heard and that our plans are shared at the earliest possible stages. Examples of this type of engagement would include the work we do with our patient participation groups and when we ask patients and the public to comment on or get involved in various pieces of work. It also describes activity that happens early on in an involvement process, including holding extensive discussions with a wide range of people to develop a robust case for change.

4.2 Formal and informal consultation

Formal consultation is the statutory requirement for NHS bodies, like the CCGs, to consult with health overview and scrutiny committees (OSCs), patients, the public and stakeholders when we are considering a proposal for a substantial development of the health service, or for a substantial variation in the provision of a service.

We will undertake a formal consultation if a change is 'significant'. This is determined where the proposal or plan is likely to have a substantial impact on one or more of the following:

- Access (an example would be a reduction or increase in service due to a change of location or opening times)
- Wider community (for example economic impact, transport, regeneration)
- Patients or users (either current or future)
- Service delivery (including methods of delivery or relocation of services)

The outcome of a formal consultation must be reported to the CCG's Board, together with the feedback received, and it must show how this has been considered in any recommendations and decision making.

5. Contracting Intentions

The National Operating Framework (and any other appropriate national mandatory guidance) will be implemented when issued by NHS England in autumn 2018. The Operating Plan underpinned by the national financial allocations will provide a clear framework for the negotiation of all provider contracts.

All providers are required to transact their information flows in compliance with Information Governance regulations as set out by the Information Commissioner's Office.

The providers will have met the compliance standards set out in 2017/19 including but not limited to:

- Compliance with ISN 0149 where completion of NHS Numbers is a mandatory requirement
- Use of e-referral as the only referral method in line with the published guidance
- Sharing aggregate data to provide population health analytics across the STP
- Continued and on-going compliance with the reporting requirements of Strategic Data Collection Service (SDCS) (formerly UNIFY 2), SSNAP, Open Exeter, SUS, and any other national or locally mandated datasets
- Submission of any patient confidential data to the DSCRO (Data Service for Commissioners Regional Offices) timetable
- Where statutory reporting is required to SDCS, eReferral service, Omnibus, Open Exeter and other statutory reporting, the provider should ensure that they are and continue to be N3 compliant

We will continue to use existing and new benchmarking information to compare provider and CCG peers to highlight difference in services and performance. Working across BLMK commissioners will develop approaches taking best practice for commissioning services through evolutionary and or transformational change in the:

- Delivery of the service
- Recording and coding of the service
- Payment for the service, and
- Understand variance

The contracting process will bring together the separate strands of commissioning through:

- Service specifications
- Quality requirements (national and local)
- Activity plans and activity planning assumptions

- Information requirements (national and local)
- Overall financial envelope

The proposed approach for the development of initial activity plans will be to use:

1. The latest available Freeze finance & activity reports as the starting point for contract baselines with adjustments for the following:

    a. Historical growth trends
    b. Seasonality
    c. Predicted waiting list position/RTT position
    d. Unresolved contract challenges
    e. Any known or proposed service changes
    f. Changes to national payment mechanisms, currencies and tariff
    g. QIPP, efficiency exceptional
    h. Inflation and deflation requirements
    i. Policy changes that impact activity levels
    j. Demographic and non-demographic growth
    k. CQUIN incentive payment mechanism changes
    l. Emergency Threshold and Emergency Readmissions requirements
    m. Other locally identified contractual items

Any adjustment to the initial baseline activity and finance plans when adjusted if required, will identify the refreshed changes 'below the line' so as to promote transparency and openness in discussion between individual providers and the BLMK commissioners

The coming together of the three CCGs in the BLMK area will require changes to be made across a broad spectrum and this will affect the approach the commissioners will need to take in relation to the contracting round. The key impacts for the contracts with providers of NHS funded care will include, but not limited to the following:

- The contracts that are due to expire on 31 March 2019 will be re-negotiated for a minimum 12 month period. Contracts without competition will require the necessary waiver in line with the local financial rules policies/SFI/STO.
- Multi-year contracts that do not expire on 31 March 2019 will be varied using the national variation process set out in the NHS Standard Contract.
- Development and refinement of an advanced information strategy to overcome the inherited systems that are driving differences between provider and commissioner data sets with the aim to get common, consistent and accurate activity reporting within and across the three CCGs. This could be driven from within the DQIP or SDIP processes set out in the Contract.
- Local pricing across the three CCGs will be reviewed with the aim to move along a progressive plan to a common pricing structure to ensure all commissioners pay the same price for the same commissioned service from the same hospital. This process is likely to be phased depending upon the scale of change and the impact and measurement of the risk of unintended consequences for both provider and commissioners.

- Where 'block' payments are made the CCGs will work with the providers to understand the suitability of this payment type for services. A programme of work has been identified with provider for implementation from the new contract year.
- We will continue to apply nationally mandated deflators/inflators to non PbR prices in line with the National Tariff Payment System (NTPS). Any other changes to Non PbR prices will need to be negotiated and explicitly agreed with both parties.
- Performance standards, methods of measurement, thresholds and financial consequences will be reviewed across all contracts for consistency. Whilst this review is undertaken all historic financial consequences will be retained until completion and agreement of review. Specific and proportionate financial consequences will be attached where applicable.
- Planned programmes of work relating to aspects of the contract and current methods of funding e.g. block arrangements will be reviewed against an agreed programme which will be set out in specific SDIPs. The outcome of any review will require the necessary variation to be agreed if the existing contract is to be changed.

Commissioning Intention	Description	Timeframe for delivery
LDH Specific Intentions		
Critical Care Pricing	The CCG would like to agree with the Trust specific prices for Critical Care by organs supported in line with National Guidance	March 2019
Counting and coding of Multiple Diagnostics	On 29th September 2017 formal notice was given of a change to the counting and coding of activity for patients with a multiple diagnosi9tc imaging procedure on the same day within the same modality. The notice specified this should be grouped under a single HRG to reflect the number of body parts scanned rather than multiple single body part HRGs. This change reflects the National Guidance NTPS Annex D, paragraph 30.	March 2019
Block Items	All block items with the contract require a full MDS to be submitted on a monthly basis, any block items charged for without a full MDS will not be paid for.	March 2019
Best Practice Tariff	All Best Practice Tariffs charged within the SLAM should be flagged to allow for identification and validation. Providers are also required to submit evidence of compliance of BPT criteria, where this information is not provider commissioners will not fund the additional top up tariff.	March 2019
Emergency Readmissions	Emergency readmissions from both the same provider and other providers should be flagged in the SLAM.	March 2019
Maternity Dataset	It is essential that providers continue to supply a fully populated local submission for the emergency pathway. In the absence of a National system for Maternity activity and related financial reconciliation for this activity Maternity challenges will be run using Freeze data instead of the normal flex submissions.	March 2019
Diagnostic Imaging	Diagnostic Imaging (DI) is not being correctly encoded with the outpatient commissioning dataset. It is not sufficient for providers to send separate local submission for this unbundled activity element, as it does not provide all the information which is required for validation of the data. Therefore, providers will be required to fully encode this data within	March 2019

	national SUS data in line with national guidance, commissioners will only pay for DI activity which is recorded correctly in SUS.	
Unbundled Activity	Commissioners will require a separate data flow submitted as part of SLAM backing data to validate unbundled activity. This should additionally be submitted via SUS according to the rules for identification of such activity as outlined in national SUS submission guidance. Providers will be required to fully encode this data within national SUS data in line with national guidance, Therefore, Commissioners will only pay for unbundled activity which is recorded correctly in SUS.	March 2019
Outpatient Clinics	The provider is required to submit a list of outpatient clinics at the start of the year.	March 2019
Admission Method	To ensure data can be validated and analysed accurately the provider must ensure the correct admission method for spells is recorded in the data.	March 2019
Start and conclusion times in SLAM	To ensure data can be validated and analysed accurately the provider must ensure the start and conclusion times for A&E attendances are recorded accurately in SLAM.	March 2019
Maternity Dashboard	The provider is required to submit the Maternity Dashboard by the 15th working day of each month.	March 2019
A&E and Admission figure	There is a requirement for the provider to submit daily A&E and admissions figures to the CCG.	March 2019

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CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of Meeting 31 October 2018

Update on the Bedfordshire Luton and Milton Keynes Sustainability and Transformation Partnership (STP) and Integrated Care System.

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Public

Purpose of this report.

1. To provide an update on the progress of the Sustainability and Transformation Partnership (STP) across Bedfordshire, Luton and Milton Keynes (BLMK).

2. To receive Central Bedfordshire's Place Based Plan in response to BLMK's Single Operating Plan.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. Note the progress on the five key priorities of BLMK Integrated Care System (ICS).

2. Receive the Place Based Plan for Central Bedfordshire and note the priorities which underpin it.

Background	
	Bedfordshire, Luton and Milton Keynes Integrated Care System
1.	Bedfordshire, Luton and Milton Keynes STP, is one of the first wave of Integrated Care Systems in the Country. The 15 STP partners continue to work closely to design a more integrated system. Access to transformational funding has helped to enable delivery of change and to secure improved outcomes for local people, at a faster pace.

2.	BLMK Integrated Care System published a Single System Operating Plan for 2018/19 based on each 'Place' producing a place-based delivery plan. The BLMK Single System Operating plan for 2018/19 describes how health and care partners will build on achievements during 2017/18 and sets out what the focus will be for the coming year. http://blmkstp.co.uk/wp-content/uploads/2018/05/BLMK-ICS-Single-Operating-Plan-Narrative-FINAL-compressed.pdf
3.	The Single System Operating plan for 2018/19 retains focus on the five priority areas: • Priority 1 Prevention • Priority 2 Primary, Community and Social Care • Priority 3 Sustainable Secondary Care • Priority 4 Digital Programme • Priority 5 Systems Integration.
4.	A Central Bedfordshire Place Based Implementation Plan has been produced and further details are set out below.
	Central Bedfordshire Place Based Plan – Appendix One
5.	The place-based plan for Central Bedfordshire captures how the BLMK Single System Operating Plan (SSOP) will be implemented locally. It makes key assumptions on income, expenditure, activity and workforce alignment between commissioners and providers. It outlines the Central Bedfordshire system priorities and approach to transformation.
6.	Progress against Central Bedfordshire Place Based Plan, which was developed in conjunction with health and care partners will be monitored by the Transformation Board on behalf of the Health and Wellbeing Board.
	Progress in Key Priority Areas of the STP
7.	**Priority 1 Prevention** • **Social Prescribing** Social Prescribing has become increasingly commonplace across England and is one of the ten 'High Impact Actions' in the NHS England's GP Forward View to release capacity in primary care. It is estimated that around 20% of patients consult their health care professional for what is primarily a social problem and a large proportion of health outcomes, estimated at 70%, are the result of social and economic determinants of health including employment, financial security, housing, diet and exercise, familial and social networks. A social prescribing model which builds on the Village Care Scheme and supported by Community Wellbeing Champions has now been developed for Central Bedfordshire. Four locality Community Wellbeing Champions (CWC) have now been recruited to deliver the scheme which will initially

	be rolled out in a few selected GP surgeries in each of the four locality areas. The Community Wellbeing Champions have established links with a range of voluntary organisations and will be an integral part of GP practices and multidisciplinary teams in each locality. The CWCs will provide a step-by-step action plan to help people requiring a non-medical intervention connect with relevant existing services and activities in their local community. The opportunities provided by social prescribing may include: arts, creativity, physical activity, gardening, learning new skills, volunteering, befriending, community activity and social groups, as well as accessing specialist services for housing, benefits, finance, debt, and employment support and advice. The impact of social prescribing and outcomes delivered will be monitored over the next few months. There is at present no additional funding expected from the ICS. Funding for the scheme in 2018/19 has been identified from Public Health reserves as part of the Better Care Fund Plan. Options for future funding beyond 2019 will be pursued. • **Detection of abnormal heart rhythm and high blood pressure in community pharmacies** Seven community pharmacies have been funded to screen residents for hypertension and atrial fibrillation (AF) in 3 Central Bedfordshire Wards where there are higher levels of deprivation and cardiovascular disease. The pilot which ran from mid-April to June finished with lower than expected activity numbers. Participating community pharmacies have been followed up for evaluation and reflection, and they shared their resident's experiences. Following this insight phase 2 is now being considered and programme evaluation of the effectiveness of the scheme will follow once 6 months of activity data has been collected. • **Clinical Conversation – Making Time for Prevention** The July event was very well attended by clinical and non-clinical colleagues. The key note speaker Dr William Bird MBE delivered a thought-provoking presentation 'Prevention is the new treatment' – and explored factors of people, place and purpose leading to chronic stress which results in poor health behaviours and adverse health outcomes. Work is ongoing within this workstream to explore how to build on the momentum of this event to achieve a social movement for health. • **Influenza** The BLMK Seasonal Flu media and communication plan, including extensive outreach, is now operational and on track. This year the

	adjuvanted trivalent form of the flu vaccine has been licenced for those aged 65 and over (previous years has been quadrivalent) which has caused some confusion across the System. Therefore, System promotion of the uptake of the flu vaccine, including workforces, is crucial. NHS England has provided additional funding to support the delivery of flu immunisation for social care workers that offer direct patient/client care. Health and social care staff, employed by a registered residential care/nursing home, registered domiciliary care provider or a voluntary managed hospice provider who are directly involved in the care of vulnerable patients/clients who are at increased risk from exposure to influenza are eligible for the vaccine.
8.	**Priority 2 Primary, Community and Social Care** **Primary Care** The five clusters continue to develop. West Mid Beds has been one of the first clusters locally, working with the National Association of Primary Care, to extract and segment their cluster population and the learning from this is being shared with other clusters. The ICS, using National Association of Primary Care (NAPC) and CCG primary care leads, has assessed each cluster against a maturity matrix that has 4 steps – Foundation, Step 1, Step 2 and Step 3 each of which has a set of criteria demonstrating maturity against the model. As at August 18 all of the CBC clusters are at Foundation level (as are most of BLMK clusters), An ambition has been set for all the clusters to be operating as a minimum at Step 1 by spring 2019. This will require a step change in development with health and social care partners working together to support cluster development as well as aligning those other local and ICS wide projects and programmes that will enable the progress e.g. digitisation, GP Forward View, organisation development and leadership. The plans to do this are being completed. **Mental Health** A successful workshop focused on Mental Health in Primary Care was held in August. Mental health is now being aligned with the Primary Care Home programme and is increasingly a common population segment that the GP clusters and partner organisations are seeking to prioritise. The focus on delivering enhanced core 24/7 mental health support for patients with physical health needs being managed within hospital settings is continuing. Work is ongoing to develop a Mental Health Investment Plan, a national requirement, which will set out the plans and resources required to deliver mental health transformation.

	Workforce A recent focus has been on implementation of a scheme to retain GPs and the development of leadership and Organisation Development programmes. In addition, BLMK was successful in gaining 8 places on a high-profile national programme for Leading Transformation in Primary Care. Successful candidates include two of the Central Bedfordshire Cluster chairs. NHSE have funded an ICS Primary Care Workforce Development resource which will help to join up the various workforce plans across the system, including Mental Health. An evaluation of a pilot in Ivel Valley that looked at future workforce modelling at cluster/locality level, is due to be published in October.
9.	**High Intensity Users** Central Bedfordshire's approach to managing High Intensity Users (HIUs) has now been agreed. The approach is centred on primary care and multidisciplinary teams. The following actions will be taken over the next three months • Locality Boards will continue to oversee this work stream and discuss and monitor management of HIUs. • Embed the proactive care and management of appropriate HIUs as part of the Multidisciplinary Team (MDT) clusters. • Investment in a Health and Wellbeing mentoring resource, which will be aligned to the Community Wellbeing Champions (Social Prescribing) to offer one to one support, where appropriate, • Establish a framework for key worker support to HIUs to provide personalised support, where appropriate • Ensure all HIUs for the six months to 30th June 2018 have been reviewed by 1 November 2018 and referred, where appropriate, to the cluster MDT for a care plan to be developed or reviewed if already in place. For those who are not appropriate for MDT assurance that they have been referred to other services or managed appropriately by the practice. • Continue to develop a comprehensive directory of services to inform and support signposting, building on the Place-Based Team Resource Directory and the Active Signposting Directory of Services.
10.	**Priority 3 Sustainable Secondary Care** Bedford Hospital and Luton & Dunstable Hospital Merger – The Care Quality Commission have been observing the Boards of the two Trusts. Capital investment to support the merger was the key priority of the STP Capital Estates Strategy, decisions on which by NHS England are awaited.

11.	**Priority 4 Digitisation** **BLMK Digital Strategy and Target Architecture** has been produced and is one of ICS's investment priorities. The strategy which supports the delivery of wider priorities will be presented as a separate item on the HWB Board's agenda. **Progress to date** **Information Sharing Phase 1 Programme** **Information Sharing Agreements:** the vast majority of sharing agreements have been returned and GP systems have largely been configured to allow for safe and effective sharing between a wide number of services. This will support multidisciplinary working within localities. IT solutions which will enable GPs to work more collaboratively, including offering extended opening hours during evenings and weekends are being rolled out. **End of Life Beacon project at Luton and Dunstable Hospital Trust:** the team have a SystmOne unit ready to use (expected to go live in next couple of weeks), it will enable them to access the same record and care plan as GPs, community services and Hospices to enable more seamless care for some of our most vulnerable patients. Over the next few months, the Therapy teams at Bedford Hospital and the Luton and Dunstable Hospital will have access to SystmOne modules which would enable them to see and write into patient records to facilitate more integrated working. Central Bedfordshire multidisciplinary teams have expressed a wish to design a template which will be on SystmOne which will support an integrated case management and proactive care approach. Online consultations pilot within six GP surgeries in Central Bedfordshire is due to commence. **Care Homes Digitisation Programme** The programme of work to provide Care Homes with digital capability and to ensure compliance with Information Governance standards is continuing. This is an important part of supporting care homes in managing complex care of residents within the Home as well enabling access to shared care information. 15 Care Homes in Central Bedfordshire have completed the training and support to complete the new governance toolkit has commenced.

	Update on remote monitoring Eight Care Homes in Central Bedfordshire are participating in a remote monitoring pilot, using a product called Whzan, it enables staff in care homes to take clinical readings and establish a baseline for their residents. The equipment can alert staff to a change in a resident's condition, so the resident can be monitored more frequently and conversations with doctors can include detailed data e.g. temperature, blood pressure. The pilot will last until 31st May 2019, with an interim report due at the end of February 2019. **Social Care data and cyber security discovery programme** The LGA, Care Provider Alliance and Department of Health and Social Care are working with the Institute of Public Care (IPC) to improve the understanding of data and cyber security risks across adult social care providers and offer support required to help those risks to be managed. The one year discovery programme which is funded through the National Cyber Security Strategy, is working with 25 randomly selected Central Bedfordshire Care Providers who will receive on-site practical support from IPC relating to their data and cyber security arrangements. The findings of the on-site work will inform a set of recommendations to support the adult social care provider sector in this area moving forward.
12.	**Priority 5 System Re-engineering** The purpose of this workstream is to deliver an Integrated Care System in BLMK. Peter Howitt has been appointed as the **Director of System Re-design**, on an 18-month secondment from the Department of Health and Social Care, where he was Deputy Director for Commissioning, Integration and Transformation. The **Chief Information Officer** has been appointed. Mark Thomas will be joining BLMK as Chief Information Officer (CIO) from 1 October. Mark has significant experience in driving digital transformation in the NHS and was instrumental in bringing the systems together around the Great North Care Record and large-scale reconfiguration to support the delivery of the Cramlington Emergency hospital in Northumberland. **Strengthening CCG Leadership** Following the agreement to establish a joint Executive Team across the three BLMK CCGs, An Accountable Officer, Patricia Davies and a Chief Finance Officer, Chris Ford have been recruited and will start work on 1 November 2018. The plan at present is to recruit three further Chief Operating Officers who will be aligned to the CCGs.

	Work on scoping out possibilities for cross-CCG governance arrangements is ongoing. **Commissioning Intentions** A BLMK CCG work to develop single set of Commissioning Intentions for 2019/2020 has been completed (Appendix 2)
13.	The latest monthly brief (September) from BLMK STP can be accessed here: http://blmkstp.co.uk/wp-content/uploads/2018/09/September-18-Bi-Monthly-Brief-BLMK-STP.pdf
	Next Steps
14.	Work will continue to progress the priority areas of the ICS to benefit the population of Central Bedfordshire.
15.	The key priorities for delivery in the Central Bedfordshire 'Place' based implementation plan will be progressed through the Transformation Board.
16.	Bedfordshire CCG and Central Bedfordshire Council leads will work on establishing a strategic framework to support Central Bedfordshire as a 'Place' within the context of the ICS and the emerging CCG Leadership approach.
17.	The Transformation Board will continue to monitor progress on the key projects for the BCF and ICS as well as ensuring that a single delivery framework for the key Integration and transformation strategies aligned to the Single System Operating Plan is in place.
Implications for Work Programme	
18.	Further update reports on the STP priorities, emerging Integrated Care System and an Implementation Plan for the Single System Operating Plan narrative will be presented to the Health and Wellbeing Board at future meetings.

Reasons for the Action Proposed	
19.	Health and Wellbeing Boards have a key role in shaping the future of health and social care in their areas and need to ensure that they have meaningful input to the STPs. The emerging vision and priorities of the STP are consistent with the priorities of Joint Health and Wellbeing Strategy for Central Bedfordshire for improving health, wellbeing and reducing health inequalities.
20.	Health and care systems have been asked to come together to create their own ambitious local blueprint for implementing the Five Year Forward View, covering

	Oct 2016 to March 2021. NHS England will assess each STP. Plans of the highest standard will gain access to transformation funding from April 2017.
21.	NHS England planning guidance 'Refreshing NHS Plans' 2018/19 makes clear that STPs are expected to take an increasingly prominent role in planning and managing system-wide efforts to improve services.
22.	The STP has implications for Central Bedfordshire's vision for integration and Out of Hospital services.
23.	The proposed leadership structure for BLMK CCGs has important implications for the Central Bedfordshire vision for securing integrated outcomes across health and social care.

Issues	
Governance & Delivery	
24.	The BLMK STP programme has been overseen and driven by an STP Steering Group. This includes 15 key STP partners, all of whom act as equal partners in the STP programme. Representation on the STP Steering Group is at the CEOs and/or Director level. The Chief Executive of Central Bedfordshire Council is lead officer for the Bedfordshire, Luton and Milton Keynes Integrated Care System. The overarching design principle used to formulate the STP work programme has been that, as far as practical, the STP working groups draw on resources provided and/or insourced from STP partners. This helps to ensure that: • Ownership is achieved • Barriers in accessing data, intelligence, people and advice are reduced • Local expertise is harnessed • Third party costs are minimised
25.	A Central Bedfordshire Transformation Board has been established. The Board is a sub-group of the Health and Wellbeing Board and oversees the delivery of transformation projects and the BCF Plan on behalf of the HWB.
Financial	
26.	One of the triple aims of the STPs is to secure financial balance across the local health system and improve the efficiency of NHS services. However, the financial position of Bedfordshire Clinical Commissioning Group remains of concern in the wider ACS position.
27.	As an ACS in 2018/19 the system will need to be managed with a single system based budget, balancing pressures between partners.
28.	In 2017/18 the continued rapid growth in emergency admissions, and A&E attendances, compared to last year, reflects sub-optimal experience for our residents and is creating financial pressure within the system.

Public Sector Equality Duty (PSED)	
29.	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.
30.	Are there any risks issues relating Public Sector Equality Duty Yes/**No**
31.	If yes – outline the risks and how these would be mitigated

Source Documents	**Location (including url where possible)**
BLMK Single System Operating Plan	**http://blmkstp.co.uk/wp-content/uploads/2018/05/BLMK-ICS-Single-Operating-Plan-Narrative-FINAL-compressed.pdf**

Appendices

Appendix 1 - Central Bedfordshire Place Based Plan 2018/2019

Appendix 1

Central Bedfordshire
Better care locally

Central Bedfordshire Place Based Plan 2018/2019

Central Bedfordshire

NHS

Version Control			
Publication Date	July 2018		
Description	This document has been produced following the development of the Single Operating Plan (SOP) for BLMK in April 2018. The place based plan for Central Bedfordshire captures how the SOP will be implemented and outlines key assumptions on income, expenditure, activity and workforce align between commissioners and providers. It outlines the Central Bedfordshire system priorities and approach to transformation.		
Distribution Summary	Draft v1	24th May	CS, PC & MP– initial outline & content
	Draft V3	25 June	PC contributions
	Draft V4	26 June	CS, MP, (JO in PC's absence) contributions
	Draft V5	12 July	PC edits with EG comments
	Draft V5pc	18 July	PC Edits , CS
	Draft V5pc	20 July	PC; Rachel Porter, Nikki Barnes, Mike Thompson,
	Draft V5pc	20 July	Deliverables MP contribution
	Draft V5pc	23 July	Richard Fradgley contribution

1. Introduction

Welcome to the first Central Bedfordshire 'Place' based Implementation Plan. This Implementation Plan provides a 'Place' specific response to the Sustainability and Transformation Partnership's (STP) Single System Operating Plan (SSOP) which describe the transformation ambitions for the Bedfordshire, Luton & Milton Keynes (BLMK) Integrated Care System (ICS).

This Place Based Plan outlines how in Central Bedfordshire we will:

- deliver the national priorities and ambitions set out in our SSOP;
- continue to focus on improving the health and wellbeing of our population ;
- improve quality of care;
- improve efficiency and productivity.

Our Place based plan recognises the need for pace and scale in delivering transformation and builds on the work that is already ongoing. **This plan provides a summary of the implementation of the STP Single Operating Plan in Central Bedfordshire** to drive better care delivery, improve health outcomes and reduce inequalities for our local population, whilst at the same time making significant progress in ensuring a sustainable financial position going forward.

Although this is not a new strategy, it is a plan of the Health and Wellbeing Board and describes how STP priorities are delivered in Central Bedfordshire. It sets out what we will do, by when, by whom and with what impact.

2. Context & Purpose

In 2018/19 NHS England expects that STPs will take an increasingly prominent role in planning and managing system wide efforts to improve services and to ensure our residents -

- Experience **seamless access** to a timely, coordinated offer of health and care support
- Can access a wide range of support to **prevent ill-health** with increasing emphasis on early interventions through the support of voluntary, community and long term condition groups
- Are supported to **remain independent** through integrated GP and multi-disciplinary teams delivering the care within their own home, wherever possible
- Have access to a wider range of health and care **services in the community** that will help to avoid unnecessary hospital admission and, following any necessary admission, will enable discharge to home care as soon as it is safe to do so;
- Have access to **mental health services that are integrated with physical health and social care services**, through acute, primary, community and specialist teams and aligned to Integrated Health and Care Hubs.
- Have access to **integrated rehabilitation and reablement** services that will avoid or minimise the need to enter into residential or nursing home care;
- Experience **reduced variations** in care with improved outcomes;
- Have **support for carers** that is timely and person centred with an integrated response underpinned with joint planning and assessment, as appropriate;
- Experience services that are **person-centred,** highly responsive and flexible, designed to deliver the outcomes important to the individual; and
- Benefit from stream-lined and integrated working with **joint information systems**.

These ambitions are consistent with Central Bedfordshire's vision for better integrated care delivery, improved health outcomes and reduced inequalities for our local population.

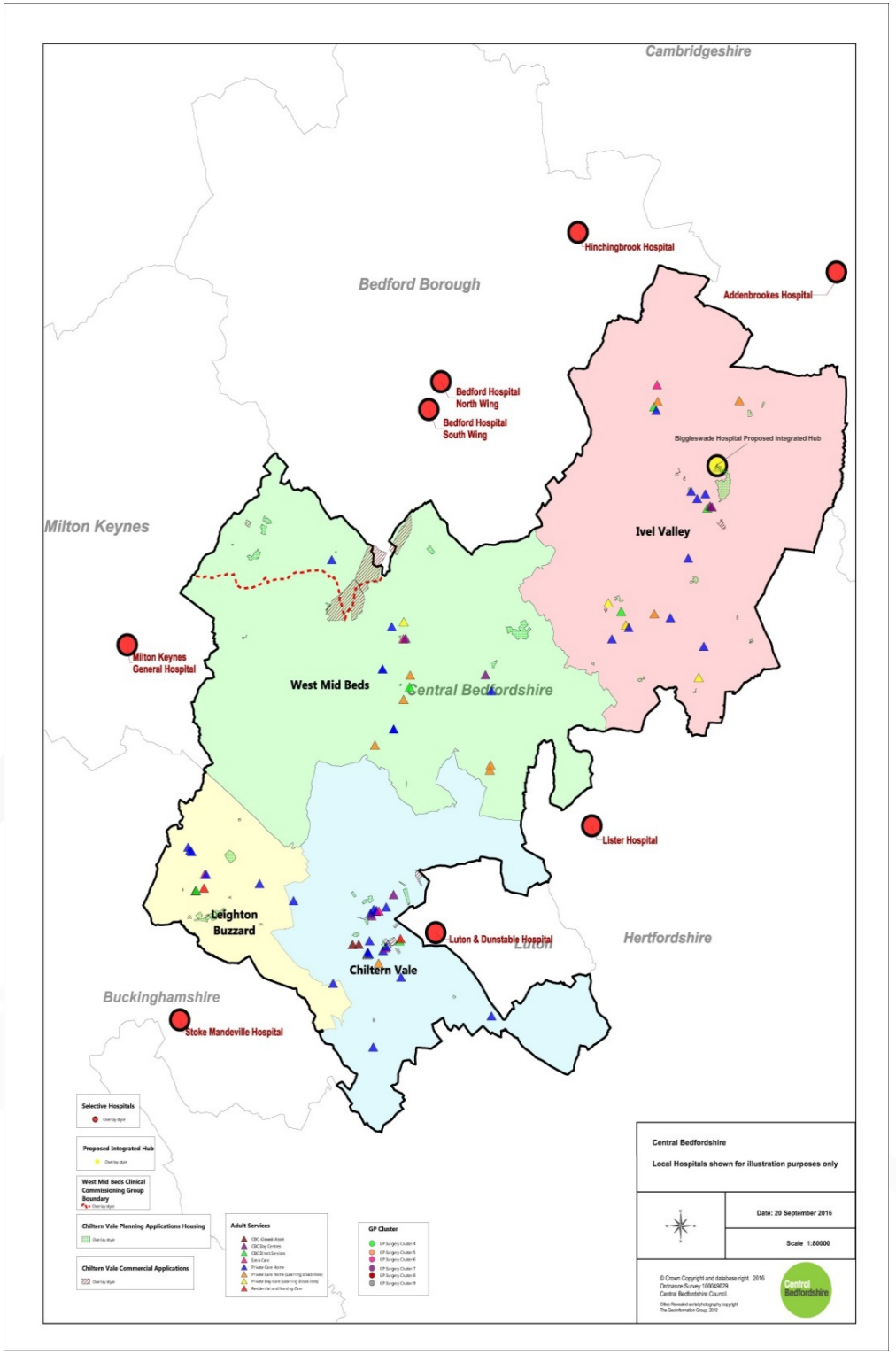
Central Bedfordshire is considered to be a highly desirable place to live and work. It is a area of significant growth with the current population estimated to be over 270,000 rising to 330,000 by 2031. This increase is driven in part by demographic change and also by considerable planned housing expansion. The population composition is also expected to change further in view of new housing developments bringing in younger families and children.

We have an increasing and ageing population. The number of people aged 85 and over is projected to double by 2035 and there will be a higher than average growth in number of adults aged 65 and over and the number of children and young people aged 0-14 years old.

Central Bedfordshire is predominantly rural and considered to be the most rural, least deprived and least diverse of the four areas in the STP footprint. There are however pockets of deprivation and around 30% of residents use other acute hospitals outside the STP footprint.

The largest towns in the area are Leighton Buzzard (41,000), Dunstable (38,200), Biggleswade (18,800) and Houghton Regis (18,500) (Source: ONS, 2015 mid year estimates).

There are also significant differences in demography and deprivation within Central Bedfordshire, with important variations in health and wellbeing outcomes and gaps in quality of care.



Central Bedfordshire Health and Wellbeing

Life expectancy and health inequalities

- Life expectancy across Central Bedfordshire has been risen over the past 10 years by 3.6 years for men and 2.1 years for women, although is now plateauing.
- Male life expectancy at birth is now 81.5 years and for females 84.0 years. However healthy life expectancy is much lower, at 67.5 years for men and 64.4 years for women, with **men spending an average of 14 years in poor health and women almost 20 years** – this is the period when health and care requirements are likely to be greatest.
- There are significant gradients of life expectancy within each local authority area. For men the life expectancy gap between the least and most deprived areas is 6.4 years and for women it is 5.4 years

Wider determinants of health

- Wider determinants of health including social, economic and environmental factors contribute to an estimated 50% of health outcomes.
- Central Bedfordshire is ranked 88/151 Authorities for GCSE achievement, with disadvantaged pupils underperforming by 1.5 grades relative to other pupils in every subject they take at GCSE
- Although 71% of children achieve a good level of development by the end of their reception year, this is significantly below statistical neighbours
- Less than half of adult social care users in CB report that they have as much social contact as they would like.

Health behaviour and risk factors

- 20% of children aged 5 to 6 are overweight or obese, rising to 30% by age 10 to 11.
- In line with the national trend, hospital admissions for self-harm are rising
- Four unhealthy behaviours are responsible for the majority of preventable ill health and mortality: smoking, poor diet, lack of physical activity and excessive alcohol consumption.
- Compared to statistical neighbours, death rates under 75 are worse than average for cancer (particularly breast cancer) heart disease and stroke, lung disease (predominantly chronic obstructive pulmonary disease) and liver disease.
- Alcohol related admissions continue to rise.
- 64% of adults in Central Bedfordshire who are overweight or obese

What does our System Look Like Now

The focus on population based integrated health and care systems aims to overcome the substantial organisational, professional and regulatory boundaries within the health and care sector to ensure that people receive the most cost-effective care when and where they need it. Key issues for us are as follows:

- Central Bedfordshire is not coterminous with an acute hospital and our residents use up to seven hospitals in surrounding areas, four of which are outside the STP footprint
- We have an ageing population and increasing demand and expectation for health and social care
- Insufficient and fragmented capacity within the community to respond appropriately to local needs
- Data sharing and timely access to information for health and care service delivery across a wide range of provider organisations and different systems remains a challenge
- The adult social care market is under pressure, fragmented and complex. Sustainability, particularly in the Home Care market remains a concern
- Both the local authority and Bedfordshire Clinical Commissioning Group have important financial challenges. The council has to make significant efficiency savings and has sought to protect the Adult Social Care market. Bedfordshire CCG is in financial recovery with important challenges ahead. As part of an integrated care service we see important opportunities to help address some of these challenges
- Central Bedfordshire is an area of projected housing growth, some of the towns will double in size. This will have significant impact on the shape of the population and the supporting health and care infrastructure
- Current primary care estates are not fit for future needs and new ways of working

Our Local Vision

Our local vision is for the people of Central Bedfordshire to have access to good quality, safe, local health and social care across its towns and rural areas.

This will be centred on the integration of health and social care through a whole system and seamless approach to improving physical and mental health, so that people can experience care 'better care, locally without organisational boundaries'. Integrated Health and Care Hubs will act as focal points for joining up health and social care and provide facilitate the Primary Care Home model and the ambitions of the GP Five Year Forward View.

We want care to be coordinated around an individual's needs with prevention and support for maintaining and maximising independence at its core and underpinned by the following principles:

- Care coordinated around the individual
- Decisions made with, and as close to, the individual as possible
- Care should be provided in the most appropriate setting; and
- Funding flowing to where it is needed.

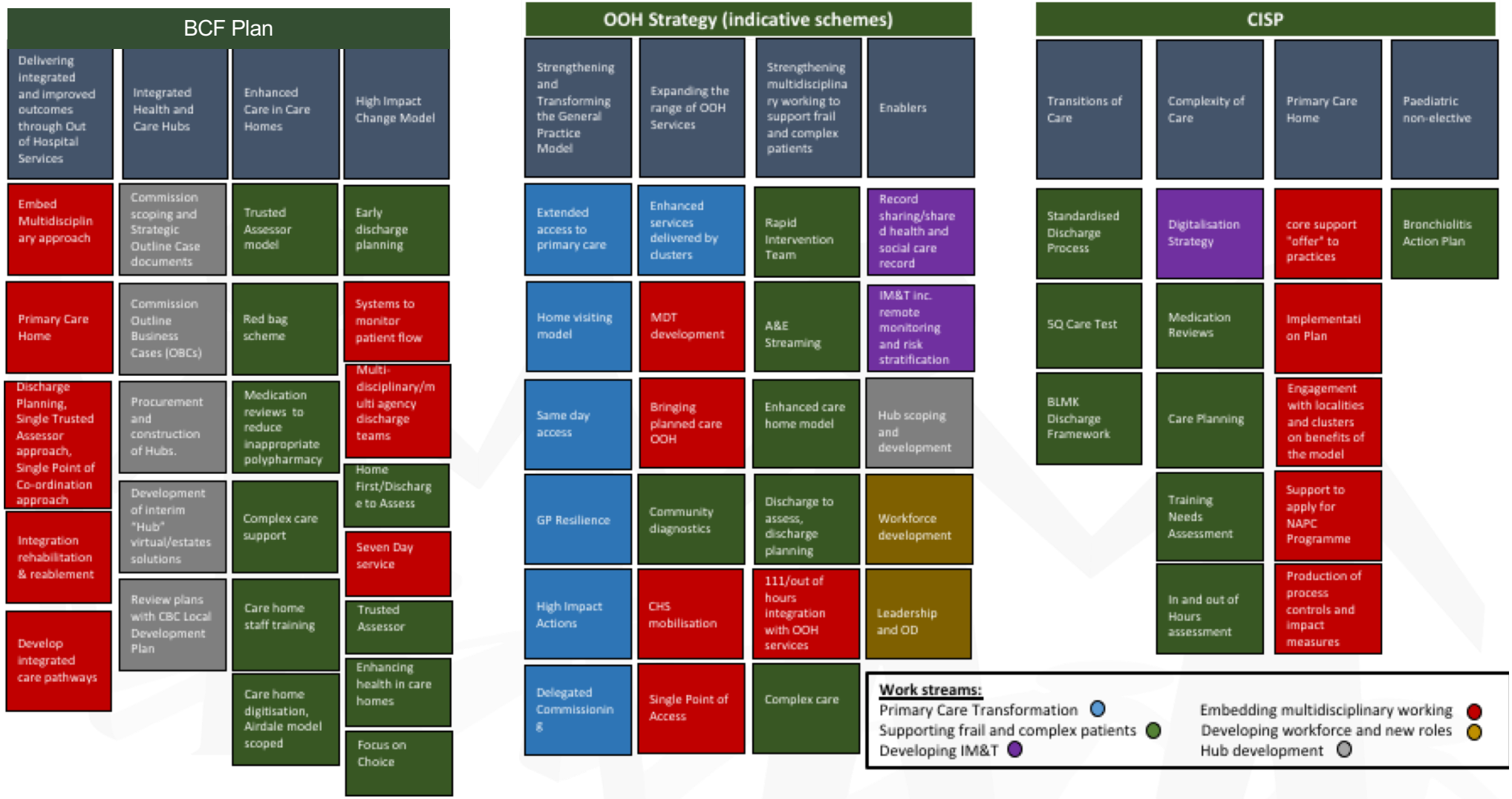
This will ensure our populations are provided with the opportunities to realise their full potential and have the support they require to lead healthy and independent lives; that they receive timely access to high quality services such as health and care when they need it.

Our Place based focus

In order to secure the key priorities for 2018/19, and ensuring we address the current and challenges facing our health and care system, we will focus on:

- **Streamlining our Health & Social Care system** to reduce fragmentation and variations to access and quality of care
- Developing five **Integrated Health and Care Hubs** which enable the primary care home model and access to a wider range of out of hospital services
- **Prevention and early intervention** and empowering children, their families and adults to develop well, remain independent and self care
- Delivering better care locally by ensuring a **person centred approach** across organisational boundaries through multidisciplinary working
- Delivering **integrated solutions** which extend beyond health, social care and housing, that takes account of the wider determinants of health in partnership with community and voluntary sector organisations
- Meeting the **challenges of an ageing population** with increasing level of disability and frailty. This includes depression, social isolation, dementia, bereavement, and long term conditions
- **Reducing reliance on institutional forms of care** and pressure on hospitals such as reducing non-elective admissions and ensuring admission avoidance plans are in place where necessary
- **Shaping the care market** with partners to design and create diversity in the care market through new and innovative care models, particularly for the rural communities. As well as mitigating key areas of risk in care market, this includes capacity and workforce challenges.
- Establishing **integrated joint commissioning** approaches to ensure cohesion in contractual and management arrangements as well as maximising our resources.
- Planning for **significant housing delivery** across Central Bedfordshire which will increase the population, twofold in some cases ensuring that primary and social care estate and infrastructure needs are addressed.

Central Bedfordshire Place Based Transformation Programme



What do we want the future to look like?

We want to shift the balance of care for Central Bedfordshire residents so that they only need to go into hospital when they require highly specialist acute care. That the services people experience are person-centred, highly responsive, flexible, reduces variations and designed to deliver the outcomes important them. Through the strong partnership between the council, health providers and the wider voluntary and community sector, our residents, will receive health and care services in integrated health and care hubs in their communities, where they:

- Experience timely and seamless coordinated offer of health and care support with an increased emphasis on early interventions through the support of voluntary, community and long term condition groups
- Are supported to self-care, with appropriate technology as well as access to a wide range of support to prevent ill-health.
- Will be supported to remain independent through integrated GP and multi-disciplinary teams delivering the care within their own home wherever possible
- Have access to a wider range of health and care services in the community that will help to avoid unnecessary hospital admission and, following any necessary admission, will enable discharge to home care as soon as it is safe to do so;
- Access to mental health services that are integrated with physical health and social care services, through acute, primary, community and specialist teams in local communities.
- Receive integrated rehabilitation and reablement services that avoids or minimises the need to go into residential or nursing home care;
- Benefit from stream-lined and integrated working with joint information systems to facilitate joint care planning and assessments.

What will be different?

Improved

- Resident patient and carer experience of our services
- Outcomes for our people, focusing in 18/19 on high priority areas of variation to national outcomes, Cancer, Mental Health, Respiratory, Cardio Vascular Disease (Including Diabetes)
- Focus on early intervention, prevention and promotion of independence
- Self management and prevention of health and social care service need
- Access to primary care services
- Staff satisfaction, retention of workforce.
- Service collaboration, resilience and service sustainability with capacity and capability to provide high quality services for our growing and increasing complex and rising comorbidities of our residents
- Robust Care Market and a multidisciplinary workforce

Reduced

- Ambulance conveyancing where historic crisis support has necessitated this
- High end service utilisation by mental health needs
- Demand on urgent services and acute inpatient services
- Non-medical demand on Primary Care
- Non-medical use of acute provider beds resulting from delayed transfers of care to appropriate alternative environments

Changes

Create financial sustainability of our system, creating circa an additional £15 – 30m savings through collaboration and partnership resolving complex service issues at the point where our organisational boundaries have historically inhibited shared innovation.

Priority 1 – Prevention

CB's approach (what)
To reduce the likelihood of developing preventable long term conditions we will:

- Support schools to deliver high quality personal, health and social education (PHSE);
- Ensure that residents have access to the information and advice they need to optimise their own health and wellbeing e.g. easily available trusted sources of advice and information;
- Develop a detailed understanding of what would help local residents to adopt healthier lifestyles, including the impact of growth;

To ensure that those with long term conditions or with poor health have appropriate support we need to:

- Encourage front-line staff to take a more pro-active preventative approach, prompt decisions, deliver brief interventions and signpost people to sources of additional support and advice;
- Provide lifestyle services for those people who require additional support, particularly in the more vulnerable groups;
- Deliver social prescribing and self management initiatives to support and enable people to take control of their health and wellbeing
- Increase uptake of seasonal flu vaccination;

Lead: CBC Public Health

High level actions (how and when)

- Reducing non-medical demand on Primary Care – through implementation of Social Prescribing, social support, health coaching and navigation.
- Deployment of social prescribing using Health and Wellbeing Champions aligned to Primary Care and Village Care/Good Neighbour Schemes.
- Support residents to optimise their own health & wellbeing including effective use of information & guidance and digitised solutions.
- Interventions and brief advice for smokers and harmful drinkers through community services provider and primary care commencing in April 2018
- Flu campaign and priorities to be agreed and delivered in Q2 2018 with the ambition that seasonal flu vaccination will be delivered before end Q3
- Participation in BLMK wide cardiovascular prevention communities of practice, including working with private business to secure greater awareness of early identification of cardiovascular disease
- Commission customer insight for delivery in Q3 2018

Additional resources requirement
CB share of £65k across BLMK (remainder of 17/18 allocation) to continue the pilot of the detection of atrial fibrillation and hypertension
CB share of £496k across BLMK (remainder of 17/18 allocation) to deliver full roll-out of social prescribing

Impact
Improved population level outcome measures for smoking prevalence, excess weight, physical activity and alcohol related admissions. Residents and pupil surveys will show improved measures of health and wellbeing. Main outcomes of social prescribing are improvements in individual wellbeing and reduced primary and / or social care use.
Longer term outcome is increasing Healthy Life Expectancy.

Priority 2 – Delivering high quality and resilient primary, community and social care services

CB's approach (what)

1. Implementation of the **Primary Care Home model** is a key priority for the STP. The approach is to support and accelerate the development of primary care networks / primary care home for our local communities with a focus on population health management. Six clusters of GP Practices are signed up to NAPC Programme to support delivery of primary Care Home model and the Clusters are required to demonstrate Level 2 of NHS E ICS Primary Care maturity matrix by end of 18/19.

2. Five **Integrated Health and Care Hubs** as focal points for Primary Care Home model for delivery of primary care led, integrated multidisciplinary out of hospital teams and services.

3. Complex **Proactive Care**: Residents with complex needs and those at high risk of deterioration are identified and supported within a multidisciplinary framework. Ambition is to proactively support complex care patients; prevent rising health care risks, improve primary care access for patients, and reduce inappropriate preventable crisis demand on the acute sector.

4. Delivering **enhanced health in care homes** and implementation of a frailty index to improve outcomes for frail older people and better complex care management in the community.

5. **Transitions of care** – (See Collaborative Investment Savings Plan) At "Home First" and "Discharge 2 Assess" focused on reducing DTOCs and Length of stay alongside improving access to urgent care and primary care services to avoid unnecessary A&E and inpatient admissions.

6. **Children and Young people** – 2018/19 initiatives to focus on reducing NEL activity and providing care closer to home and transformation of CAMHS

7. Delivering in line with the Five Year Forward View to secure rapid and tangible progress in improving mental health outcomes. **Parity of esteem for Mental Health** With a focus on implementing early intervention programmes to prevent development of mental health problems and improved support at times of crisis.

8. Condition Specific Focus on: **Diabetes** - improve health outcomes and reduce unplanned episodes of care and **Respiratory Conditions**

Lead and partners(who). GP Clusters; ELFT /CBC , BCCG and Community and Voluntary sector

Priority 2 – cntd

High level actions (how and when)

Primary Care Home

- GP Clusters collaborate to make best use of shared assets and workforce; uniformly deliver care through integrated teams to high risk groups; make use of data to understand their populations, identifying variation in resource use and outcomes, and guiding clinical decision making.
- Clusters have developed transformation project and development plan to work collaboratively to deliver services out of hospital and extended access to primary care. (by Oct 18)
- PMS scheme for 18/19 to support cluster practices to work together with other health and social care teams to expand the multidisciplinary working approach currently in place across all Central Bedfordshire localities
- Continued delivery of GPFV commitments and alignment of projects and activities with primary care home model.
- Target use of additional NHSE primary care resource to align with local investment opportunities, STP, Locality and overarching programme.
- Development of Business Cases for Integrated Health and Care Hubs. OBC/FBC for Dunstable and Biggleswade Hubs.

Complex Proactive Care

- Community provider incentive scheme to develop names cohort of patients within agreed criteria to be proactively managed by community provider supported by GPs, social care, and voluntary sector.
- Multi-disciplinary approaches are being implemented as set out in the BCF. High level actions are as described in the Integration and Better Care Fund Plan (BCF).
- Implementation of CHS transformation and agreed outcomes
- Ensuring appropriate access to urgent and emergency treatment centres for the whole of the population
- Ensuring that people with mental health problems (including dementia), drug and alcohol problems and learning disability are explicitly included in the developing model for complex care
- Key outcome areas include Discharge to Assess; End of Life and ACP for dementia patients
- Delivery of Enhanced Health in Care Homes and High Impact Change Model (see BCF Plan)

Transitions

- Reviewing points of access, clear discharge to assess model
- Implementation of telemonitoring support to Care Homes (Airedale).
- Development of integrated complex discharge teams for Central Bedfordshire residents providing system-wide response to reducing DTOC
- Development of Single Point of Access / Assessment solutions and ensure continuity of services

Children

- Roll out of additional 6 high volume pathways across primary care; Formalisation of urgent A&G; Front door triage; Community Nursing for children with acute short term illness.
- Implementation of Local Transformation Plan including further development of Specialist Eating disorders community service (across STP); 7 day crisis service; Early intervention and schools support; Roll out of CYP IAPT; Development of seamless pathways for inpatient admission with specialist commissioning

Priority 2 – cntd

High level actions (how and when)

- Improved service provision and management of bronchitis pathway
- Saturation monitors to be distributed during May / June 2018.
- CAKES training for assessing children with acute short term illness and train the trainer sessions to be provided Practice Nurses.
- Joint initiative with NSHI delivering paediatric asthma management guidelines targeting high referring GP practices rolling into Yr2 delivery.

Mental Health

- Delivering Five Year Forward View for Mental Health priorities, including:
- Achieving 67% of people with dementia having a diagnosis
- Meeting the national access requirements for CAMHS, IAPT, developing the mental health offer to schools and Early Intervention Services
- Improving the physical health checks for people with serious mental illness (physical health checks)
- Working with the STP to develop a multi-year mental health investment plan
- Continue to develop dementia services with support to care homes
- Work with ELFT to embed mental health in multidisciplinary working across clusters.
- Housing Officers support to mental health patients
- Scope the potential for achieving economies of scale and improving specialist mental health pathways through provision across the STP footprint

Diabetes

- Two-year NHS Diabetes Prevention Programme providing education and support for people at risk of diabetes to help prevent or delay onset
- Patient participation in care planning as part of annual review including jointly agreed care plan
- Improved access to services including health and well-being services and structured education, provided by Integrated Diabetes Service
- Early identification of foot problems and referral to specialist MDFT services, Investment within the Integrated Community Diabetes Service to support patients who are struggling to optimise control of their diabetes and tailored support to practices where indicated by current outcomes and performance

Respiratory conditions

Children:

- Ensuring all Practices have access to paediatric oxygen saturation monitor with the necessary equipment and training
- Mobilisation of the local bronchiolitis management pathway
- Provision of Paediatric Community Nursing support, in line with what is already available in Luton and MK

Adults:

- Structured preventative care in primary care to
- Proactive recall of patients at risk of COPD for spirometry
- Enhance delivery of community based services.
- Providing access to timely treatment and support significantly impact on patients quality of life, psychological issues associated with chronic conditions and co-morbidities such as obesity, social isolation and mortality, which create pressures on other areas of the system

Priority 2 – cntd

Additional resources requirement

- Capital Funding applied for development of Integrated Health and Care Hubs in localities to provide a range of primary care and out of hospital services – closer to home.
- CB share of NAPC development programme (circa £90k)
- CB share of £1.4m business case for STP transformation funds
- Funding required for 2019/20 to develop Outline Business Cases for Hubs in Leighton Buzzard, West Mid Bedfordshire and Houghton Regis. – may be able to use ETTF funding from NHS England.
- Investment to support additional workforce to strengthen multidisciplinary place based teams in localities
- An ICS mental health investment plan identifying costs of full FYFV delivery through to 2021 and including investment requirement, return on investment through integrated care, & innovation is being developed
- Awaiting outcome of bid submitted as part of national Wave 2 perinatal process to secure NICE guidance compliant perinatal mental service across ICS.
- An STP wide workforce plan is being developed

Impact

- 100% coverage of self-identified primary care networks, mitigating primary care workforce recruitment and retention issues
- Access to care from fully integrated teams in primary care home model
- Improved and extended access to integrated services in the community including delivery of primary care at scale
- Reduced A&E attendances and hospital outpatient appointments
- Avoid unplanned hospital admissions across all ages
- Reduce length of stay in hospital
- People are supported to better understand their condition and improve self-management
- People with long term conditions, including dementia have person-centred care plans in place
- Improved outcomes for adults and children with mental health issues.
- Complex care support to Care homes residents and equitable access to health and care services
- Increased access to mental health support for children and young people,
- improved access to psychological therapies for people with common mental health problems
- Increased the number of people being diagnosed with dementia and receiving post diagnostic care
- Improved physical health care for people with severe mental illness (SMI)
- Increased access to perinatal mental health support.
- To reduce hospital admissions for people with diabetes, reduced length of stay and reduction in foot amputations

Priority 3 – Sustainable Secondary Care

CB's approach (what)

1. Support the delivery of high quality and sustainable secondary (hospital) care services, across the BLMK footprint in conjunction with other STPs which reflects the wider use of hospitals outside of BLMK. Working with Acute hospitals to support delivery of out of hospital services in Integrated Health and Care Hubs.
2. The merger of the Luton and Dunstable and Bedford Hospitals, working together as a bigger, stronger organisation, means the two hospitals will be able to expand the range of services and support delivery of out of hospital services to meet the extra demands of an ageing and growing population. A key focus for Central Bedfordshire residents in in managing frailty (complex care) to deliver streamlined integrated care.
3. A focus on shifting the balance of care to the community will help towards secondary care resilience and sustainability.

Lead and partners(who) Acute Trusts; ICS PMO

High level actions (how and when)

Cancer

BCCG is lead CCG for Cancer across the STP and as such will continue to work with the Cancer Alliance to develop the EoE Cancer ambitions across the STP In 18/19 the CCG will focus on performance, improving 1 year survival, implementing national best practice pathways for Breast, Lung, Colorectal and Urology services and developing a strategy for Cancer as a long term condition. The STP Cancer Delivery Plan and NHSE Cancer Transformation Funding will support delivery against the plans, which cover Early Diagnosis and Living with and Beyond Cancer

Maternity

Delivery of Local Maternity Services Plan. In line with 'Better Births' the LMS is the basis on which future BLMK maternity services will be taken forward as shown in detail on slide 31. In summary priorities include *Improve the safety of maternity services; Create a joined-up approach to workforce planning; Develop and implement standardised pathways; Improve choice and personalisation of maternity services.* Place based workstreams are focussed on effective service user co-production and the establishment of independent, formal, multidisciplinary "Maternity Voice Partnerships" to influence and share decision making. Service quality in order to show that by 2020/21 BLMK maternity services have made significant progress towards the "halve it" ambition to reduce still births and neonatal deaths, maternal death and brain injuries during birth by 50% by 2030. A newly developed Maternity dashboard to monitor progress against Better Births Standards has been added to BHT contract this year .

Alignment of Local Maternity Services in Integrated Health and Care Hubs.

Additional resources requirement - TBA

Impact

Through the integration of clinical services and teams, it is anticipated the merged Trust will deliver high standards of inpatient care that is safe, timely, effective, efficient and patient focused, and can be used to drive a system-wide approach to the delivery of streamlined integrated care

System Enablers – Priorities 4 and 5

Priority 4 – Digitisation

CB's approach (what)
Place based implementation in conjunction with Digital Transformation workstreams. Key delivery focus are as follows:

- **Implementation of Shared health and Care Records:**
- Data sharing agreements and IG agreements between Practices and with STP Providers supporting development of shared care records across clusters and Place.
- **Rollout of SystmOne** to ELFT PC link workers, Clinical System Reviews and template alignment for multidisciplinary teams and primary care
- Care Homes undertaking IG toolkit readiness and **assessment to expand on the LGA funded pilot**.
- **Delivery of Bronze and silver levels for digitisation in Care Homes**
- Social care workforce primed for agile working.
- Remote monitoring in Care Homes Tele-health Phase 1
- **Central Bedfordshire commissioning case management system (SWIFT replacement)**
- Whole population health analytics – for risk stratification

Priority 5 – System Redesign

CB's approach (what)
During 2018/19, continue the work to design the place based framework for Central Bedfordshire and support key transitional steps to progress the journey towards an ICS including:

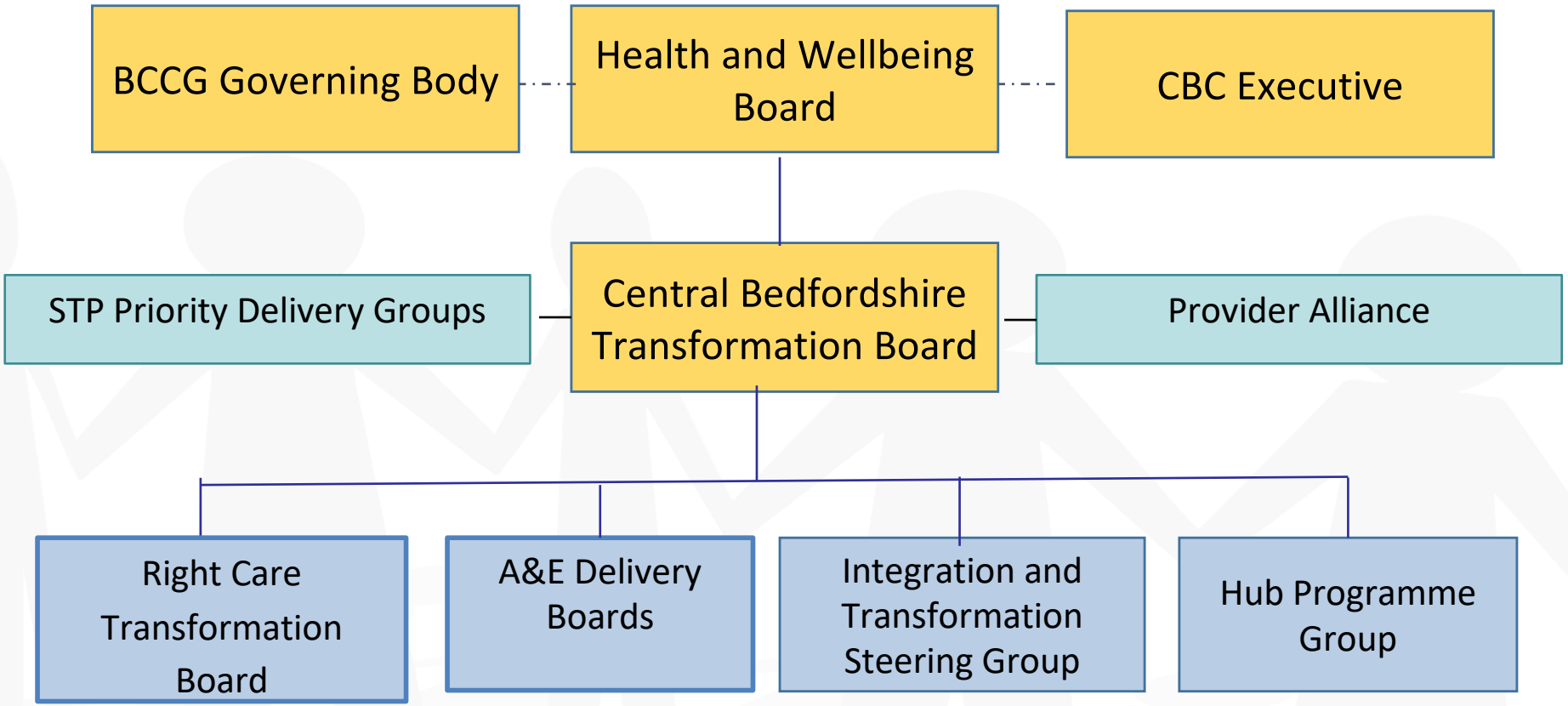
- The implementation of new CCG Leadership arrangements that support greater integration of **commissioning at scale and at place**
- Building the ICS infrastructure
- **Refreshing the partnership governance** for Central Bedfordshire Health and Wellbeing and Transformation Boards for a whole systems approach
- **Consolidating the established Provider alliance** partnerships and networks to progress greater integration between health and social care.
- Establishing an **understanding the collective resource for Central Bedfordshire** as part of the maturing collective financial management arrangements across BLMK, including managing and delivering the BLMK system control totals
- Implementing whole population health management capability as a key enabler to the ICS becoming operational

Lead and partners(who) Programme Boards and ICS PMO

Additional resources requirement

- Understanding of Place based resource
- Transformation fund
- Capacity to support 'Place' based delivery

Central Bedfordshire's Governance



Key Deliverables and Milestones

	Milestones	2018/19			
Prevention		Qtr1	Qtr2	Qtr3	Qtr4
	Deployment of social prescribing				
	Implementation of health coaching and navigation				
	Flu campaign and vaccination				
	Effective use of information & guidance and digitised solutions.				
	Develop customer insight into health, well-being and growth				
Primary, Community, Social Care and Mental Health					
	Level 2 of ICS Primary Care maturity matrix				
	Integrated teams operating in each network (cluster) with practice participation and proactively managing patients				
	Information Sharing Agreements for practices, clusters and health and social care partners in place				
	Clusters working collaboratively to deliver services out of hospital and extended access to primary care.				
	Engagement by all clusters with NAPC support programme				
	Implementation of extended access requirements (GPFV)				
	Development of Business Cases for Integrated Health and Care Hubs.				
	OBC/FBC for Dunstable and Biggleswade Hubs				
	Complex Proactive Care: High Intensity User programme delivery – implementation of service model to deliver care to agreed cohort				
	Implementation of Discharge to assess model at Luton & Dunstable and Bedford Hospitals				
	Identification of patient cohort and design of model to support proactive care to high risk patients				
	Children and Young people – 2018/19 initiatives to focus on reducing NEL activity and providing care closer to home and transformation of CAMHS				
	Implementation of telemonitoring support to care homes (Airedale model)				
	Redesign children's community services				
	Embed programme of dementia services support to care homes				
	Improved and seamless specialist mental health pathways				

Key Deliverables and Milestones

	Milestones	2018/19			
Primary, Community, Social Care and Mental Health					
	Diabetes				
	Increase provision of DESMOND courses 20-30 per year				
	Implement training for community staff to improve knowledge, skills and confidence in delivering care to patients with diabetes				
	Medicines Optimisation Team to monitor appropriate use of medication				
	Respiratory conditions				
	Ensuring all Practices have access to paediatric oxygen saturation monitor with the necessary equipment and training				
	Comprehensive review of Respiratory pathways in line with NHS right care – COPD, Asthma, Pneum/Flu				
	Bronchiolitis pathway developed/agreed and circulated across system including GPs				
	Cancer				
	Agree pathways and process for Collaborative Commissioning (NHSE and CCG)				
	Urology unit offering daily one stop shop model at BHT and L&D				
	Further improve results of National Cancer Patient Experience Survey				
	Improve 1-year survival rates				
	Improve lung cancer screening uptake				
	Digitisation				
	Technology: SMS messaging in practices rolled out across STP; Development and procurements for online consultations; Telehealth monitoring pilots begin in Care Homes.				
	All Care Homes to achieve Bronze level in digitisation				
	Central Bedfordshire commissioning case management system (SWIFT replacement)				
	System Redesign				
	Continue the work to design the place-based framework for Central Bedfordshire				
	Consolidating the Provider alliances/partnerships and networks to progress greater integration between health and social care.				
	Establish understanding of the collective resource for Central Bedfordshire as part of the maturing collective financial management arrangements across BLMK				

	Central Bedfordshire Place Based Progress Dashboard						
	Measure	**Frequency of reporting**	**YTD Target (2017/18)**	**CBC progress as at end of Q3 (17/18)**	**CBC Overall Progress to end of financial year (2017/18)**	**RAG**	**Comments**
Paediatric Non-Elective Activity	ED attendances, 0 - 4 for respiratory conditions	Monthly	No Target	246	567		The increase in figures from November 2017 is due to East & North Herts including the diagnosis code in their A&E data. This had previously not been coded. There has also been an increase at the Luton & Dunstable Hospital from December 2017 for attendances for respiratory conditions however the overall number of attendances has not increased. This could be due to improved diagnosis coding. April 2018 has seen a decrease in the number of A&E attendances for respiratory conditions. 64 of the 67 attendances were for non-asthma respiratory conditions and the majority of attendances
	NE admissions, 0 - 4 for respiratory conditions	Monthly	No Target	850	1,150		The increase in admissions in November and December 2017 are at Bedford Hospital for acute bronchiolitis and acute lower respiratory tract infections, Luton & Dunstable for acute bronchiolitis, upper respiratory tract infections and acute lower respiratory tract infections and Milton Keynes for viral infections, acute bronchiolitis and acute lower respiratory tract infections. April 2018 has seen a decrease in admissions with acute tonsilitis and acute upper respiratory infections being the main conditions for admission. The start if 2018/19 has seen a reduction on the previous two years; and is a greater reduction than previously observed.
Transitions of Care	A&E Attendance	Monthly	No Target	50,391	66,941		2017/18 saw a similar trend to 2016/17 with an increase in attendances of 1859 overall. 2017/18 followed a similar trend to 2016/17; however final outturn was higher in 2017/18 at 64,082, compared to 66,941. the start of 2018/19 has seen a reduction from the end of the previous year. this again follows the trend of earlier years. April and May are both higher than earlier observations.
	Non-elective admissions	Monthly	28,100	22,132	29,814		2017/18 saw an increase of 1,647 Non-Elective admissions compared to 2016/17. 2017/18 saw an increase in non-elective admissions on previous years, finishing the year nearly 2,000 more than 2016/17. 2017/18 also saw a somewhat insteady trend through the year with a sharp increase in the earlier months. Initial comparison of April and May with previous years identifies a similar trend to that seen in 2016/17 with a slight increase between the two months.
	30 day non-elective re-admissions	Monthly	No Target	3,052	4,056		2017/18 saw an increase of 134 30 day re-admissions compared to 2016/17. Overall, 2017/18 saw a slightly higher number of 30 day non-elective re-admissions but the increase has not been as great as previous years and is more in line with 2016/17.
	Delayed Transfers of Care	Monthly	5,737	4,958	5,058		2017/18 saw an increase of 1019 delayed days due to delayed transfers of care compared to 2016/17. Desite this increase on the number of delayed days, 2017/18 observed a downward trend when compared to 2016/17. April 2018 outturn is 443, much lower than the same period last year.
Care Homes	Care Home Call Outs	Monthly	No Target	1,340	1,876		Ambulance call outs to CBC care homes in 17/18 were on average lower than 16/17 however showed a slightly increasing trend with March 2018 been higher than the previous year. April and May 2018 show an increase on the previous year.
	Care Home Conveyances	Monthly	No Target	1,012	1,412		Conveyances from care homes show an upward trend for the second half of 17/18. There is variation month on month, overall there is a slight increase in 17/18 compared with 16/17. There were 123 conveyances from care homes in May 2018, an increase on the previous 2 years. Small increase identified between 2016/17 and 2017/18/; with April and May 2018/19 displaying a higher number of conveyances than previous years. .
	Admissions to Hospital from Care Home	Monthly	No Target	793	1,074		There is a slight upward trajectory in care home admissions in 17/18 with a slight increase on total numbers for 17/18, 1074, compared with 1049 in 16/17. There is variation month on month comparing the last 2 years, with no consistent pattern of higher or lower. May 2018 shows a decrease on 2018 with 79 admissions (first cut data). The complex care team have been supporting Ivel Valley locality with a week day service since October 2017, a paramedic service supporting care homes has been in place for west mid beds also since October 2017, an additional paramedic will begin in August 2018, doubling the capacity of the service. 2017/18 saw a slight increase on the previous year with a slight upward trend. Initial observations from April and May 2018/19 appears to be in line with 2016/17.

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BLMK P4
Digital Strategy & Target Architecture, OBC Update & Next Steps

Summary and recap

- Digital is one of BLMKs investment priorities
  - The strategy for BLMK will be transformational with opportunities to re-engineer the way we work
    - supports delivering primary care based Multi Disciplinary Teams
    - supports integration of primary, community social care
    - enables self-care and goal setting for individuals to support prevention

- Highest priority is linking existing systems to provide integrated health care
- The proposed technical solution is to buy a system architecture to ensure real time interoperability between systems to enable a shared care record

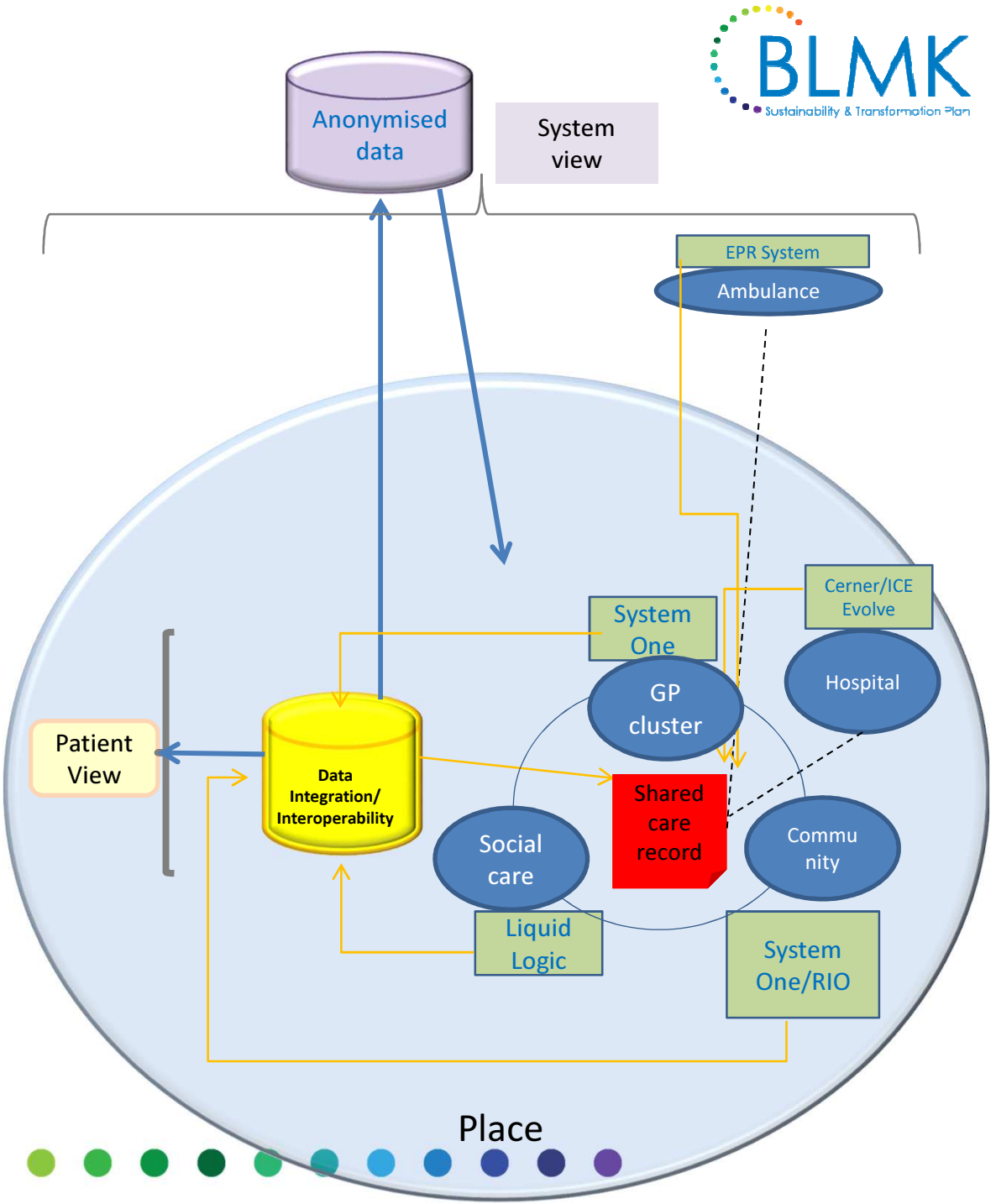
A flexible, scalable and affordable solution
delivering real benefits to residents and organisations

Types of data:

Assessors & Provider
- Individual care record
- Shared Care record
- Referrals/results
- Prescriptions

Patient
- Own data
- Goal setting

System view
- Planning data for use at system level and/or for re-identification at place /cluster.



Health System Led Investment

Six national priorities for system digitisation

- [x] Deploying EPR solutions at scale across systems
- [Y] Extending system capacity management
- [x] Improving system-wide staff rostering
- [Y] Extending real-time coded data collection in community and mental health settings
- [Y] Improving ambulance and first responder access to clinical information and support
- [Y] Sharing health and social care information to support health and care professionals working in people's homes

CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of Meeting 31 October 2018

Update on the Central Bedfordshire's Integration and Better Care Fund Plan.

Responsible Officer: Julie Ogley, Director of Social Care, Health and Housing
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Advising Officer: Patricia Coker, Head of Service
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Public

Purpose of this report

1. To update the Board on the Integration and Transformation projects incorporating the Better Care Fund Plan and progress on improving outcomes for frail older people.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. Note the progress on delivering the Integration and Better Care Fund Plan

2. Note the performance against the national conditions and metrics.

Background

2. Central Bedfordshire's Integration and Better Care Fund Plan is now in its second year and progress is continuing on delivering the national conditions and targets.

3. There is a close strategic fit between the aims of the Integration and Better Care Fund Plan (IBCF), and the Integrated Care System which are both centred on shifting the balance of care to focus on out of hospital services, promoting independence and wellbeing and reducing reliance on acute statutory services and on residential and nursing homes.

4. The key schemes of the Better Care Fund Plan and national conditions align closely with the Integrated Care System's priorities.

Integration and Better Care Fund Plan

5. Central Bedfordshire's Integration and Better Care Fund Plan is now in its second year and progress is continuing on delivering the national conditions and targets.

6. As part of the monitoring process, we hosted a successful 'local learning visit' for the NHS England team in August. Health and Social Care colleagues gave an overview of the joint working initiatives across health, social care and housing.

7. The visiting team received presentations showcasing several examples of good practice in housing and health and how the Improved Better Care Fund and other council funding is supporting the delivery of proactive and preventative services to vulnerable people.

8. The presentations also highlighted the complexity of the local health and care system as well as the challenges of facilitating transfers of care across a wide footprint but with emphasis on securing the best possible outcomes for service users.

9. The visiting team received a tour of Priory View and met with some of the residents who described their experience of living in Priory View.

Q1 Return

10. Quarter One summary on performance is attached as appendix one.

11. For 2018/19 the NHS and MHCLG submissions have been aligned into a single joint return. The return for Q1 was submitted on 20th July 2018.

12. The combined return reported on progress against plans and highlighted system challenges. Extracts from the submission providing performance against the national metrics, progress against the High Impact Change Model and summary of the successes and challenges throughout the first quarter are set out in Appendices 2A, B, C.

13. Progress against the Integration and Better Care Fund Plan including the Improved Better Care Fund was highlighted in the Q1 return and include the following updates.

Social Prescribing (aligns with STP Priority 1 – Prevention)

14. A social prescribing team comprising a coordinator and four locality-based Community Wellbeing Champions (CWCs) is now in place. Prior to taking referrals, the CWCs are 'asset mapping' in their localities, building up a

picture of the services and support available at a local level. These will be converted into a searchable database at a later date.

15. The **Multidisciplinary Approach**, which is aligned to the primary care clusters, is progressing, with Practice Managers now participating in the operational team meetings. All clusters of general practices are participating in Cluster MDT meetings. Mental Health social workers are now included within the primary care development framework. The work to co-locate the teams is ongoing as is the development of a Case Management function for the Multidisciplinary working on SystmOne.

16. The **integrated hospital discharge** service is working across all the hospitals used by Central Bedfordshire residents to track and enable transfers of care. A tracker has been developed and is being used to inform multidisciplinary teams to enable proactive care management

17. Key initiatives within the **Enhanced Health in Care Homes** are ongoing. These include:

- **Multidisciplinary support to Care Homes:** A MDT approach to Ferndale Care Home with Flitwick GP Surgery and Nursing from ELFT. The initial test period will be between October and December. The multidisciplinary approach involves providing training to Care home staff, proactive support to avoid unnecessary GP involvement and improving wellbeing.

- **Trusted Assessor Scheme:** The Trusted Assessor is in post and is reporting 100% of assessments being completed within 24 hours of notification.

- Use of **Red Bags** continues with positive feedback from Care Providers, Hospitals and Emergency Services Staff.

- **Training and Development: Leadership Skills – Supporting Care Home Managers** To meet the management and leadership challenges currently faced by the Adult Social Care Sector, Central Bedfordshire Council has committed to support the sector by funding leadership skills for new and aspiring managers. The Lead to Succeed Programme, developed by Skills for Care, is designed for aspiring managers, such as senior care workers and team leaders, who want to progress into a management position.

18. The first programme ran in two cohorts with representation from 30 care homes across Central Bedfordshire. The evaluation of the first programme is currently under way however, initial anecdotal feedback has been extremely positive.

Next Steps

19. Work will continue to progress the schemes of the Better Care Fund Plan in line with the national conditions and in conjunction with priorities of the Integrated Care System.

Implications for Work Programme

20. There is a requirement for the Health and Wellbeing Board to have oversight of the Integration and Better Care Fund Plan. Updates on progress and emerging national guidance will be reported to future meetings of the Health and Wellbeing Board.

Reasons for the Action Proposed

21. 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.

22. 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.

Issues

Governance & Delivery

23. 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.

24. The Health and Wellbeing Board has a statutory responsibility for integration of health and social care and overall governance for the Integration and Better Care Fund Plan. The Health and Wellbeing Board will be supported by a Transformation Board comprising Chief Officers and Directors of the CCG, Central Bedfordshire Council and other Health and Care Service partners.

Financial

25. The required level of funding for the Integration and Better Care Fund increased in 2017/18 and for 2018/19 and includes the Improved Better Care Fund allocations.

26. The Central Bedfordshire Better Care Fund creates a pooled fund of £22.896m in 2017/18 and £24.312m in 2018/19 to support the delivery of integrated care. This is made up of a contribution of £5.536m and £6.511m from Central Bedfordshire Council; £15.549m and £15.844m from

Bedfordshire Clinical Commissioning Group as well as the Improved Better Care fund of £1.810m and £1.956m respectively, over the two years of the Plan.

27. The financial management, performance management and governance arrangements for the pooled fund are also specified in the S75 agreement.

Public Sector Equality Duty (PSED)

28. 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.

29. Are there any risks issues relating Public Sector Equality Duty Yes/**No**

30. If yes – outline the risks and how these would be mitigated

Source Documents

31. Better Care Fund Plan 2017/19

https://centralbeds.moderngov.co.uk/documents/s75265/8.%20Appendix%201%20Central%20Bedfordshire%20Integration%20and%20BCF%20Narrative%20Plan%202017-19.pdf

32. **Appendices**

Appendix 1. Central Bedfordshire Q1 Summary of Metrics Performance
Appendix 2A Central Bedfordshire Q1 Submission: National Metrics
Appendix 2B Central Bedfordshire Q1 Submission: Progress against HICM
Appendix 2C Central Bedfordshire Q1 Submission: Summary of the successes and challenges

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Appendix 1 - Central Bedfordshire Q1 summary of Metrics Performance

	Reporting Frequency	Most Current	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
Total non-elective General & Acute admissions per 100,000 population (all ages) - Quarterly NHS Derived	Quarterly	Q1 18/19	2652	2516.1	2699.6	2691.9	2677.241
	Performance		✗	✓	✗	✗	✗
	Target		2516.84	2518.98	2428.35	2490.72	2491.00
Rate of permanent admissions to care homes per 100,000 population aged 65+ (cumulative)	Quarterly	Q1 18/19	122.6	116.57	90.44	56.27	134.97
	Performance		✓	✓	✓	✓	✗
	Target		126.1	126.1	126.1	126.1	126.65
Proportion of 65+ still at home 91 days after discharge from hospital (Combined)	Quarterly	Q1 18/19	94.4%	97.4%	96.8%	97.6%	96.9%
	Performance		✓	✓	✓	✓	✓
	Target		90.0%	90.0%	90.0%	90.0%	90.3%
Total Delayed Transfers of Care (Aged 18+)	Quarterly	Q1 18/19		1779	1584	1036	1342
	Performance			✗	✗	✓	✓
	Target			1430	1347.2	1346.5	1389
Delayed Transfers of Care (Aged 18+) Attributed to NHS	Quarterly	Q1 18/19		1474	1272	922	1200
	Performance			✗	✗	✓	✗
	Target			1243.9	1135.2	1105.2	1163.7
Delayed Transfers of Care (Aged 18+) Attributed to Social Care	Quarterly	Q1 18/19		211	218	55	105
	Performance			✗	✗	✓	✓
	Target			144.1	165.6	181	170.6
Delayed Transfers of Care (Aged 18+) Attributed to both NHS and Social Care	Quarterly	Q1 18/19		94	94	59	37
	Performance			✗	✗	✓	✓
	Target			42	46.4	60.4	54.9

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Appendix 2A - Central Bedfordshire Q1 submission: National Metrics

Better Care Fund Template Q1 2018/19

Metrics

Selected Health and Wellbeing Board: Central Bedfordshire

Challenges Please describe any challenges faced in meeting the planned target
Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics
Support Needs Please highlight any support that may facilitate or ease the achievements of metric plans

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	Not on track to meet target	Reducing non-elective admissions remains a challenge and the health and care system are working to reduce demand in key areas such as older people and 0-4s.	Bedfordshire CCG is collaborating with neighbouring CCGs with a mutual 111 provider to implement the 111 online service. Herts Urgent Care (111 Provider) has put in place a revised clinical model which was approved and supported financially by BCCG. Extended GP access covering 100% of BCCG population is underway. Early Intervention Vehicle pilot with EEAST and the Council to provider paramedic and OT support to attend to residents in need of no-emergency support was successful. The work of the Enhanced Health in Care Homes workstream and complex care support for frail elderly people is aimed at reducing non-elective admissions from care homes. Proactive support to Care Homes was implemented in Ivel Valley and a frail elderly nurse practitioner is working across West Mid Beds to support people at home and in Care Homes. A number of preventative interventions are also being implemented. This includes baseline remote monitoring.	None
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	The challenge is availabilty of the right type of accommodation to meet the needs of an ageing population whilst maintaining focus on enabling people to remain independent for as long as possible. There are also important challenges of capacity in the home care market.	Additional investment in workforce supporting new framework for domiciliary care and incentive payments to hold packages when people are admitted to hospital. Implementing community catalyst to provide additional capacity in care market, particularly for rural areas.	None

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Data not available to assess progress	Due to reporting timescales, we are unable to report on Q1 outturn, as there is a timelag in securing the data.	Q4 outturn activity improved upon Q3. Q4 reported 97.6% of customers were still at home 91 days after discharge. The Rehabilitation and Reablement services are now working as an integrated	None
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	On track to meet target	Coordinating discharges across 7 hospitals remains challenging, however work is ongoing to liaise with partners in acute trusts to monitor patient flow.	Although full data for Q1 is not available, DToC for Central Bedfordshire has demonstrated a slight increase month on month from February 2018, but a review of April and May 2018 against performance in the same period last year indicates a decrease in the total delayed days per 100,000 population. Initiatives implemented to reduce delays include: A DToC tracker which provides oversight and opportunity for timely response to notification of discharge. Trusted Assessors in place , with 100% of assessments being completed within 24 hours, and safe and timely discharges being supported. The Red Bag scheme is in place and early feedback is largely positive.	None

Better Care Fund Template Q1 2018/19

4. High Impact Change Model

Selected Health and Wellbeing Board: Central Bedfordshire

Challenges Please describe the key challenges faced by your system in the implementation of this change
Milestones met during the quarter / Observed Impact Please describe the milestones met in the implementation of the change or describe any observed impact of the implemented change
Support Needs Please indicate any support that may better facilitate or accelerate the implementation of this change

		Maturity Assessment					Narrative			
		Q4 17/18	Q1 18/19 (Current)	Q2 18/19 (Planned)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	Early discharge planning	Established	Established	Mature	Mature	Mature		Coordinating early discharge planning across 7 hospitals used by residents of Central Bedfordshire, and recognising that there are different processes in place across the different acute trusts.	A Data Intelligence Officer is in post to manage and maintain a flexible and resilient approach to surge and escalation.	None
Chg 2	Systems to monitor patient flow	Established	Established	Mature	Mature	Mature		The current OPAL patient flow covers a proportion of Central Bedfordshire residents (those who attend Luton & Dunstable and Bedford Hospitals). Links are being developed to monitor patient flows to remaining hospitals.	A tracker has been developed to support the working of the Hospital Discharge Service. The functionality provides an early warning system for delayed/stranded patients alongside the ability to monitor patients from a place based approach. Further developments are being made to enable sharing of the trackers with primary care for the purpose of reducing non elective admissions alongside wider NHS system partners to enable a real time approach to the sharing of data regarding customers and the status within the assessment/discharge process.	None
Chg 3	Multi-disciplinary/multi-agency discharge teams	Established	Mature	Mature	Mature	Mature	Multidisciplinary approaches now in place across all clusters in Central Bedfordshire. Cluster MDT meetings now taking place. An MDT case management system for SystmOne is being developed.	Information sharing and shared case management systems across health and social care remains a challenge.	The Hospital Discharge Service works closely with acute and non acute multi disciplinary teams to support discharge planning across multiple sites. It is anticipated that Integrated Discharge Co-ordinator posts will join the service in Q2/3.	None
Chg 4	Home first/discharge to assess	Plans in place	Plans in place	Plans in place	Plans in place	Plans in place		There are some difficulties integrating access. Workforce capacity within current providers is limited, and decisions regarding ongoing care being made in acute settings. Further work is ongoing.	A home first/discharge to assess model is currently being worked up that will be complemented by the recruitment of discharge coordinator posts. The model will focus on discharging people through Intermediate Care in its initial stage.	None
Chg 5	Seven-day service	Established	Established	Established	Established	Established		Full range of support services is not always available 24/7. There is some difficulty extending a seven day service across the private community	An established and integrated hospital discharge service has provided a seven day approach for two years, and operates over multiple acute trusts.	None

Chg 6	**Trusted assessors**	Established	Established	Mature	Mature	Mature		Expanding the role to other acute hospitals used by Central Bedfordshire residents. Implementing this provision as a seven day service.	Trusted Assessor role implemented and hosted by the Hospital Discharge Service. There is a Trusted Assessor based at the Luton & Dunstable and Bedfordshire Hospitals; supporting both new care admissions and transfer arrangements of residents who are returning from both the Emergency Department and hospital wards to their usual place of care home residence. The Trusted Assessor joins the Service's daily briefing and supports the previously mentioned board round process for wards/departments with higher concentration of care home admissions. 100% of assessments have been completed within 24 hours).	None
Chg 7	**Focus on choice**	Established	Mature	Mature	Mature	Mature	Hospital Discharge Service works alongside and supports a range of acute trust choice policies. Developments are at planning stage to expand and enhance the support networks for those who fund care privately and choose not to engage with the local authority.	Patient choice for self-funders. Fragile market.	Work of the Community Catalyst continues to aid the development of a diverse care market and to build capacity especially in rural areas. Culture change workshops are taking place throughout July to focus development within the Ivel Valley locality. The Hospital Discharge service supports a range of acute trust policies associated to person choice. A partnership approach has been adopted with acute trust discharge teams supporting individuals to make appropriate and timely choices regarding their ongoing care arrangements.	None
Chg 8	**Enhancing health in care homes**	Established	Established	Established	Mature	Mature		The is a risk that number of initiatives care homes are being asked to support will overwhelm them. There is engagement and enthusiasm to support delivery, but there is some anxiety in the capacity to adopt the change. There is a rate of workforce turnover which could potentially delay development. Providing equitable access to enhanced care home support services across Central Bedfordshire.	Digitisation programme ongoing with Care Homes provide access to SystmOne and shared records. The Trusted Assessor is in place and engages with Care Homes. The Red Bag scheme has been implemented and there is good engagement with providers. Partnership work with Beds Care Group continues to progress and implement initiatives. Training support is being provided to enable complex care support within care home settings	None

Hospital Transfer Protocol (or the Red Bag scheme)										
		Q4 17/18	**Q1 18/19 (Current)**	**Q2 18/19 (Planned)**	**Q3 18/19 (Planned)**	**Q4 18/19 (Planned)**	**If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care**	**Challenges**	**Achievements / Impact**	**Support needs**
UEC	**Red Bag scheme**	Plans in place	Established	Established	Mature	Mature		Some care homes have indicated that completing the paperwork can take time, however this would be alleviated when electronic systems are in place.	The scheme has been implemented and there is good engagement with Care Providers. Early feedback indicates that the care homes are finding them useful and work is in progress with Beds Care Group to finalise data collection of quantative and qualitative data to measure impact.	None

Better Care Fund Template Q1 2018/19

5. Narrative

Selected Health and Wellbeing Board: Central Bedfordshire

Remaining Characters:	17,974

Progress against local plan for integration of health and social care

Work continues in the key delivery areas of the Integration and Better Care Fund Plan.

Social Prescribing is being implemented across Central Bedfordshire and is aligning Community Wellbeing Champions with Primary Care clusters, multidisciplinary teams and will build on the voluntary and community sector, such as Central Bedfordshire's Village Care and Good Neighbour Schemes. A referral template for social prescribing will be made available via SystmOne.

Multidisciplinary Approach is progressing well. An integrated hospital discharge service is in place working alongside an integrated triage team of OTs and reablement teams with staff from community health services and social care. This has enabled an alignment of teams to deliver integrated responses whilst retaining organisational identities. All clusters of general practices in Central Bedfordshire are participating in the Cluster MDT

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Remaining Characters:	19,288

Integration success story highlight over the past quarter

The joint appointment of an Associate Director for Community Health Services and Social Care is continuing with the new Community Health Provider (ELFT). This post is engendering development of further integration initiatives. An Integrated Triage Team has been established and now provides a single point of access for both ELFT Rehabilitation and the Council's Reablement service. An integrated discharge team with a single management lead across community health services and social care has been established.
Housing services are working closely with health. Some of this work has come to the attention of NHS England BCF/Integration national team who will be visiting Central Bedfordshire in August.

Please tell us about an integration success story observed over the past quarter highlighting the nature of the service or scheme and the related impact.

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CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of Meeting 31 October 2018

WORK PROGRAMME 2018/19

Responsible Officer: Richard Carr, Chief Executive
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 2018/19.

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 2018/19.

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.

Issue for Decision	Description	Indicative Meeting Date	Lead Director and contact officer(s)
School Health Education Unit Survey	Update on the actions being considered to address the results from the survey	23 January 2019	Muriel Scott, Director of Public Health Sue Harrison Director of Children's Services Contact Officer:Sarah James, Prinicipal Public Health Officer
Local Transformation Plan refresh	To receive an update on the Local Transformation Plan	23 January 2019	Alan Streets, BCCG Contact Officer: Karlene Allen
HW strategy delivery	To receive an outline of the delivery plans for the Joint Health and Wellbeing Strategy	23 January 2019	Muriel Scott, Director of Public Health, CBC Contact Officer: Celia Shohet, AD Public Health, CBC
Presentation on the population changes in Houghton Regis'	To receive a presentation on the population changes in Houghton Regis.	23 January 2019	Sue Harrison, Director of Children's Services Celia Shohet, AD Public Health, CBC
Safeguarding Annual Report	To receive the Safeguarding Annual Report	10 April 2019	Alan Caton, Independent Chair of the LSCB. Contact Officer: Phillipa Scott, Strategic Safeguarding Partnership Manager
To be Timetabled			
Children and Young People's Plan	To receive a report regarding the delivery of the plan for 2017-19		Sue Harrison, Director of Children's Services, CBC Contact Officer: Amanda Coleman, Partnerships and Performance Officer
Primary Care Service Development	To provide a progress update on Primary Care Service Development.		Accountable Officer, BCCG Contact Officer:
		Standing agenda items	
Sustainability and Transformation Plan	To receive an update on the Sustainability and Transformation Plan and the Central Bedfordshire Place Based Plan		Richard Carr, Chief Executive, CBC Contact Officer: Patricia Coker, Head of Partnership and Performance, CBC
Integrated Health and Care Hub Development	To receive an update on the Hub Programme work plan.		Julie Ogley, Director of Social Care, Health and Housing, CBC Contact Officer: Patricia Coker, Head of Partnership and Performance, CBC