This meeting may be filmed.*

Central Bedfordshire Health and Wellbeing Board

Agenda

Meeting Title:	Central Bedfordshire Health and Wellbeing Board
Date:	Wednesday, 23 January 2019
Time:	2.00 p.m.
Location:	Council Chamber, Priory House, Monks Walk, Shefford

1. **Apologies for Absence**

   Apologies for absence and notification of substitute members.

2. **Election of Vice-Chairman 2018-19**

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

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

4. **Minutes**

   To approve as a correct record the Minutes of the last meeting held on 31 October 2018 and note actions taken since that meeting.

5. **Members' Interests**

   To receive from Members any declarations of interest.

6. **Public Participation**

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

HEALTH AND WELLBEING STRATEGY

Item	Subject	Lead
7	**Health and Wellbeing Board Strategy delivery**	**MS**

To receive an outline of the proposed areas of focus for the delivery of the Joint Health and Wellbeing Strategy.

8	**Overview of actions proposed to reduce excess weight**	**IB**

To receive an outline of the actions and timelines for a 'whole systems approach' to tackling obesity in Central Bedfordshire, as part of the Joint Health and Wellbeing Strategy objective "Enabling people to optimise their own and their family's wellbeing".

OTHER BUSINESS

Item	Subject	Lead
9	**Integrated Care System update**	**RC**

To receive a progress update on the priorities of the Integrated Care System (ICS) in Bedfordshire, Luton and Milton Keynes (BLMK).

10	**Integrated Health and Care Hub Programme update**	**JO**

To receive a progress update on delivery of the Integrated Health and Care Hub Programme.

11	**Work Programme 2019/20**	**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
Mr D Carter	Chief Executive, Luton and Dunstable Hospital
Mr S Conroy	Chief Executive, Bedford Hospital Trust
Dr K Corlett	East London NHS Foundation Trust
Mrs P Davies	Joint Accountable Officer, Bedfordshire, Luton and Milton Keynes, Clinical Commissioning Group
Cllr S Dixon	Executive Member for Families, Education and Children and Lead Member for Children's Services, Central Bedfordshire Council
Mr M Coiffait	Director of Community Services, Central Bedfordshire Council
Dr N Evans	East London Foundation Trust
Mrs S Harrison	Director of Children's Services, Central Bedfordshire Council
Cllr C Hegley	Executive Member for Adults, Social Care and Housing Operations, Central Bedfordshire Council
Dr C Marshall	Deputy Clinical Chair, Bedfordshire Clinical Commissioning Group
Mrs H Moulder	NHS Bedfordshire Clinical Commissioning Group Clinical Chair
Mrs J Ogley	Director of Social Care, Health and Housing, Central Bedfordshire Council
Mrs M Scott	Director of Public Health, Central Bedfordshire Council
Cllr B Spurr	Chairman of the Health and Wellbeing Board and Executive Member for Health, Central Bedfordshire Council

please ask for	Sharon Griffin
direct line	0300 300 5066
date published	10 January 2019

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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, 31 October 2018

PRESENT

Cllr B J Spurr (Chairman)
Mr A Streets (Vice-Chairman)

Mrs D Blackmun	Chief Executive Officer, Healthwatch Central Bedfordshire
Mr R Carr	Chief Executive
S Dixon	Executive Member for Families, Education and Children and Lead Members for Children's Services
Mrs S Harrison	Director of Children's Services
Ms C Hegley	Executive Member for Adults, Social Care and Housing Operations (HRA)
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: Mrs E Barter
Mr D Carter
Mr M Coiffait

Members in Attendance: Cllr Mrs T Stock

Officers in Attendance:		
	Dr S. Chakrabarti	Clinical Lead, BCCG
	Mrs P Coker	Head of Service, Partnerships - Social Care, Health & Housing
	Ms C Frost-Bryant	Head of Strategic Growth
	Ms S Griffin	Committee Services Officer
	Mr T Keaveney	Assistant Director Housing Services
	Dr J McGowan	Public Health Registrar
	Mrs C Shohet	Assistant Director of Public Health
	Ms L Waller	Senior Public Health Officer for Excess Weight

HWB/18/12. **Chairman's Announcements and Communications**

The Chairman referred to the recent budget announcement by the Chancellor of the Exchequer. The full impact of the measures announced had yet to emerge.

The Chairman thanked schools for participating in the Schools Health Education Unit Survey.

The Chairman referred to the presentation slide shown at the start of the meeting which showed the story of a pregnant woman and her journey to stopping smoking.

HWB/18/13. **Minutes**

RESOLVED that the minutes of the meeting of the Central Bedfordshire Health and Wellbeing Board held on the 11 July 2018 be confirmed as a correct record and signed by the Chairman.

HWB/18/14. **Members' Interests**

None were declared.

HWB/18/15. **Public Participation**

No members of the public had registered to speak.

HWB/18/16. **Joint Health and Wellbeing Strategy 2018-2023**

The Board considered Central Bedfordshire's proposed Health and Wellbeing Strategy for 2018-2023. The Strategy proposed a focus on three issues;

- Driving change to improve mental health and wellbeing for people of all ages
- Enabling people to optimise their own and their family's health and wellbeing
- Ensuring that growth delivers improvements in health and wellbeing for current and future residents

The Strategy included measures which could help the Board monitor progress. The next stage of the work was to develop delivery plans which would be presented to a future meeting.

The Chairman thanked the officers for their work to produce the Strategy.

RESOLVED

that the Joint Health and Wellbeing Strategy 2018-2023 be approved.

HWB/18/17. **Improving outcomes for patients with Diabetes**

The Board received presentations on improving outcomes for patients with diabetes and reducing excess weight.

Reducing Excess Weight

1. Levels of excess weight in Central Bedfordshire were similar to the England average at 64% of the adult population and slightly worse than its statistical neighbours. The statistics for Children and Young People in Central Bedfordshire were lower than the national average and similar to

the regional average (1:5 children aged 4-5 years and 1:3 children aged 10-11 years).

2. Trends were fairly stable with a decrease being shown for reception children, and recently published data showing improvement in Year 6.

3. There was the opportunity to strengthen prevention work taking place both in early years and later on in life.

4. Thought needed to be given to system-wide interventions, the nature of interventions being proposed, the anticipated level of impact and what was achievable.

Improving outcomes for patients with Diabetes

5. The number of patients developing diabetes continued to rise with an increase of a further 9.2% forecast by 2035.

6. The data for Central Bedfordshire showed some progress, but more was required. The local dashboard was starting to show small changes but it was early days. The annual data for 2017-18 was due to be published and could be presented at a future meeting of the Health and Wellbeing Board with a Central Bedfordshire focus.

7. Approaches which included engagement with patents and residents and more integrated and personalised care were to be promoted.

8. Research and data showed individuals who were overweight were more likely to develop diabetes. Social circumstances, environment and lifestyles were also contributing factors. Work needed to take place on prevention and putting the right support in place to enable healthy choices to be made.

NOTED

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

RESOLVED

that the scope for broader, system-based approaches to tackle Excess Weight and improve outcomes for patients with Diabetes, be brought to a future meeting of the Health and Wellbeing Board.

HWB/18/18. **Director of Public Health Report 2018: Homelessness and Health**

The Board received an update on the Director of Public Health's Report for 2018: Homelessness and Health.

1. The focus of the report was on improving the health of the people in Central Bedfordshire, and in particular, the key public health challenge of homelessness.

2. A particular issue for Central Bedfordshire was the increase in the demand for temporary accommodation.

3. Research showed that living in temporary accommodation had an impact on the health and life expectancy of individuals. The last estimate of the average life expectancy of homelessness in 2012 was 47 years for men and 43 years for women. There were also barriers to accessing services whilst living in temporary accommodation.

4. Rough sleepers represented the 'tip of the iceberg' of the homelessness and were the most visible group affected. There was a much larger group of vulnerable people which included those living in temporary accommodation, the 'hidden homeless' (including those known as 'sofa surfers') and people without access to safe and secure housing.

5. There had been considerable work in Central Bedfordshire to reduce homelessness and rough sleeping over the last few years, which included additional transitional accommodation.

RESOLVED

that the recommendations set out in the full report be endorsed, which in summary were to:

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

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

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

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

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

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

HWB/18/19. **Healthwatch Annual Report 2017/18**

The Board considered Healthwatch Central Bedfordshire's 2017/18 annual report which set out the functions, structure, activities, highlights for the period of June 2017 to May 2018 and the top priorities for 2018/19.

1. A key function of Healthwatch was its role as an independent consumer champion created to gather and represent the view of the public.

2. Surveys, questionnaires and reports were published on Healthwatch Central Bedfordshire's website and shared with providers.

3. The Festival for Older People took place in October 2018. The event gave older people the opportunity to gather advice and guidance about social care, health and housing services available to support them in the local area.

4. A dedicated officer had been recruited for Young Healthwatch. The role of the officer would include gathering evidence for the design of services for children and young people, visiting schools to obtain increased feedback from young people and recruiting more young people to start working on projects.

5. East London Foundation Trust (ELFT) currently did not have a Patient and Participation Liaison officer in Central Bedfordshire. Regular meetings took place with Healthwatch which included the provision of feedback on how to improve the quality of the service.

6. The possibility of carrying out Enter and View visits at Luton and Dunstable Hospital as part of a joint programme in partnership with Luton Healthwatch was being discussed.

NOTED

the Healthwatch Annual Report 2017/18.

HWB/18/20. **2019/20 BLMK Joint System Commissioning Intentions**

The Board considered the final version of the 2019/20 Bedfordshire, Luton and Milton Keynes, (BLMK) Joint Commissioning Intentions.

Points and comments included:

- This was the first time the CCGs had developed Joint System Commissioning Intentions. The Intentions reflected the progress of the Integrated Care System (ICS).

- Engagement had taken place with providers, partners and other stakeholders to ensure that the Joint Commissioning Intentions reflected the wider Health and Wellbeing Strategy rather than just the Commissioning Strategy.

- The BLMK Joint System Commissioning Intentions would contribute to and feed into the Integrated Care System (ICS).

- Following consultation and engagement work in August 2018, the 2019/20 BLMK Joint System Commissioning Intentions document was published on the 30 September 2018.

NOTED

1. **the priorities as set out in the report.**

HWB/18/21. **Update on the Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Partnership (STP) and Integrated Care System**

The Board received an update on the progress of the Sustainability and Transformations Partnership (STP) across Bedfordshire, Luton and Milton Keynes (BLMK) and Central Bedfordshire's Place Based Plan in response to BLMK's Single Operating Plan. A presentation was given outlining the BLMK Interoperability Architecture Programme.

- Engagement had taken place with organisations and staff to identify the benefits of a joined up digital system. Sharing data and the quality of health was key to the digitisation programme.

- BLMK had been allocated £6.6m to progress the digital architecture. The programme had been approved regionally. National sign off was awaited before market testing could take place.

- The aim of the programme was to achieve joined up working and to enable improved access to patient records and move to population analytics which could inform preventative interventions.

NOTED

1. **the progress on the five key priorities of the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System.**

2. **the Place Based Plan for Central Bedfordshire and the priorities which underpin the Plan.**

3. **the presentation on the BLMK Interoperability Architecture Programme.**

HWB/18/22. **Central Bedfordshire's Integration and Better Care Fund**

The Board considered a report that provided an update on the progress of the Integration and Transformation projects incorporating the Better Care Fund Plan and improving outcomes for frail older people.

- Central Bedfordshire's Integration and Better Care Fund Plan was progressing and was delivering the national conditions and targets.

- Next steps included the progression of the schemes included in the Better Care Fund Plan in line with the national conditions and in conjunction with the priorities of the Integrated Care System.

NOTED

the progress on delivering the Integration and Better Care Fund Plan and the performance against the national conditions and metrics.

HWB/18/23. **Integrated Health and Care Hub Development**

The Board received a presentation on the Integrated Health and Care Hubs Programme in Central Bedfordshire.

- The hubs would enable greater focus on prevention and early intervention but would also have sufficient capacity to deliver regular services closer to where people lived.

- The two forms of business cases were being developed in tandem. The first business case was for Central Bedfordshire Council to justify capital investment and demonstrate a reasonable return; the second was to assess the revenue implications and the affordability of rent reimbursement for the NHS.

- The outline timescales were discussed and the Board looked forward to delivery of the first hubs in late 2021.

NOTED

1. **the system-wide ambition for locality based integrated health and care hubs as the focal point for provision of out of hospital services.**

2. **the progress on the programme underpinning delivery of the Hubs.**

3. **the alignment of the Hub programme with the Primary Care Home programme and the wider Integrated Care System ambition for out of hospital services.**

4. **the wider implications of the significant growth in housing in Central Bedfordshire and the constraints of the current primary and community care estate.**

HWB/18/24. **Work Programme 2018/2019**

RESOLVED

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

- Excess Weight Overview - 23 January 2019
- Digital Strategy and Target Architecture - 10 April 2019
- Improving outcomes for people with Diabetes - 10 April 2019

- Central Bedfordshire Place Based Plan - 10 April 2019

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

(Note: The meeting commenced at 2.00 p.m. and concluded at 5.15 p.m..)

Chairman …….

Dated ……..

Central Bedfordshire Health and Wellbeing Board

23 January 2019

Delivery of the Joint Health and Wellbeing Board

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

Advising Officer: Celia Shohet, Assistant Director of Public Health
Celia.Shohet@centralbedfordshire.gov.uk

Public

Purpose of this report

To outline the proposed areas of focus and approach for the delivery of the Joint Health and Wellbeing Strategy.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. **Consider initial areas of focus for delivery of the strategy, the proposed mapping work in mental health and scoping for building resilient communities.**

2. **Consider the proposal to test some approaches in one or more areas initially before wider roll-out**

Issues

1. The Joint Health and Wellbeing Strategy (JHWS) identified system-wide actions to deliver the three key ambitions of Driving change to improve mental health and wellbeing; Enabling people to optimise their own and their family's health and wellbeing; Ensuring that growth delivers improvements in health and wellbeing for current and future residents.
2. The strategy is appropriately ambitious and long term, the next stage is to determine the initial areas of focus for the Board. These will not necessarily be the 'quick wins' but where the Board initiates and drives new action, unlikely to be initiated and co-ordinated elsewhere. There will be some programmes of work underway which are on track and do not require additional HWB support, simply encouraging or watching.

3. The principle of co-constructed solutions with services users and residents is one that the Board endorses and will be applied where possible in the delivery of the strategy

Options for consideration

4. Appendix A shows mind maps for each of the three key ambitions, main work programmes with some areas identified for consideration as initial areas of focus. The areas of focus have been proposed because they require the system wide working and evidence suggests that they will impact positively on the outcomes required. The Board is asked to consider these proposed areas and suggest additions or changes where appropriate

5. Actions to drive change to improve mental health and wellbeing are being taken across the system but the extent to which this aligns with the strategy or meets the needs of residents of Central Bedfordshire is not completely clear. It is therefore proposed that, as part of a Needs Assessment, an initial piece of work will be to understand the current work underway and identify gaps. The areas of focus and governance required will be informed by this.

6. There is a clear strand of work which crosses each of the key ambitions, the need to build resilient communities and develop community cohesion. Initial discussions, and learning from previous local work and best practice, indicates that it would be helpful to undertake some detailed work to understand what is required to deliver this outcome. It would be helpful to build a picture with residents of local assets, needs, managed expectations and motivations. This work would need to be scoped and prepared in the spring to be delivered in summer 2019. It would be scoped with a wide range of partners including the community and voluntary sector, residents, town councils, front-line workers and other statutory agencies. Whilst additional capacity will be required to do this work, it will be co-constructed and delivered with local people.

7. The recent analysis of population changes and outcomes in Houghton Regis (presented later in the meeting) illustrates that outcomes vary within Central Bedfordshire and inequalities exist. The Fair Society: Healthy Lives report (Sir Michael Marmot 2010) outlined the concept of proportionate universalism – that to reduce inequalities in health, actions must be universal but with a scale and intensity that it proportionate to the level of disadvantage. Therefore, to test or pilot some of the actions required to deliver the JHWS, the Board may want to consider starting and evaluating approaches first in areas of greatest need (geographically or with vulnerable groups) within Central Bedfordshire.

Legal Implications

8. Under section 116A of the Local Government and Public Involvement in Health Act 2007 (as amended) the Council and CCGs have a statutory duty to produce a Joint Health and Wellbeing Strategy to meet the needs identified in the joint strategic needs assessment. This report outlines the proposed areas of focus, governance and approach for the delivery of the Strategy.

Financial and Risk Implications

9. The Strategy will need to be delivered primarily within existing resources of all partner organisations, but opportunities to obtain national or regional funding to support the aims of the strategy may be sought.

Governance and Delivery Implications

10. The governance arrangements for delivery of the strategy vary by priority area and will be agreed once detailed delivery plans have been developed.

11. The impact of the delivery of the strategy will be further developed but Appendix B shows the initial suggestions

12. Delivery of the strategy will require programme and project management as well as commissioning additional capacity / interventions e.g. building community capacity

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. As well as considering inequalities on a geographical area, the strategy will ensure that it considers the needs of groups who can experience worse physical and mental health outcomes than the rest of the population, particularly homeless people, transgender people, Gypsies, Roma and Travelers, refugees and asylum seekers and people with learning disabilities.

Implications for Work Programme

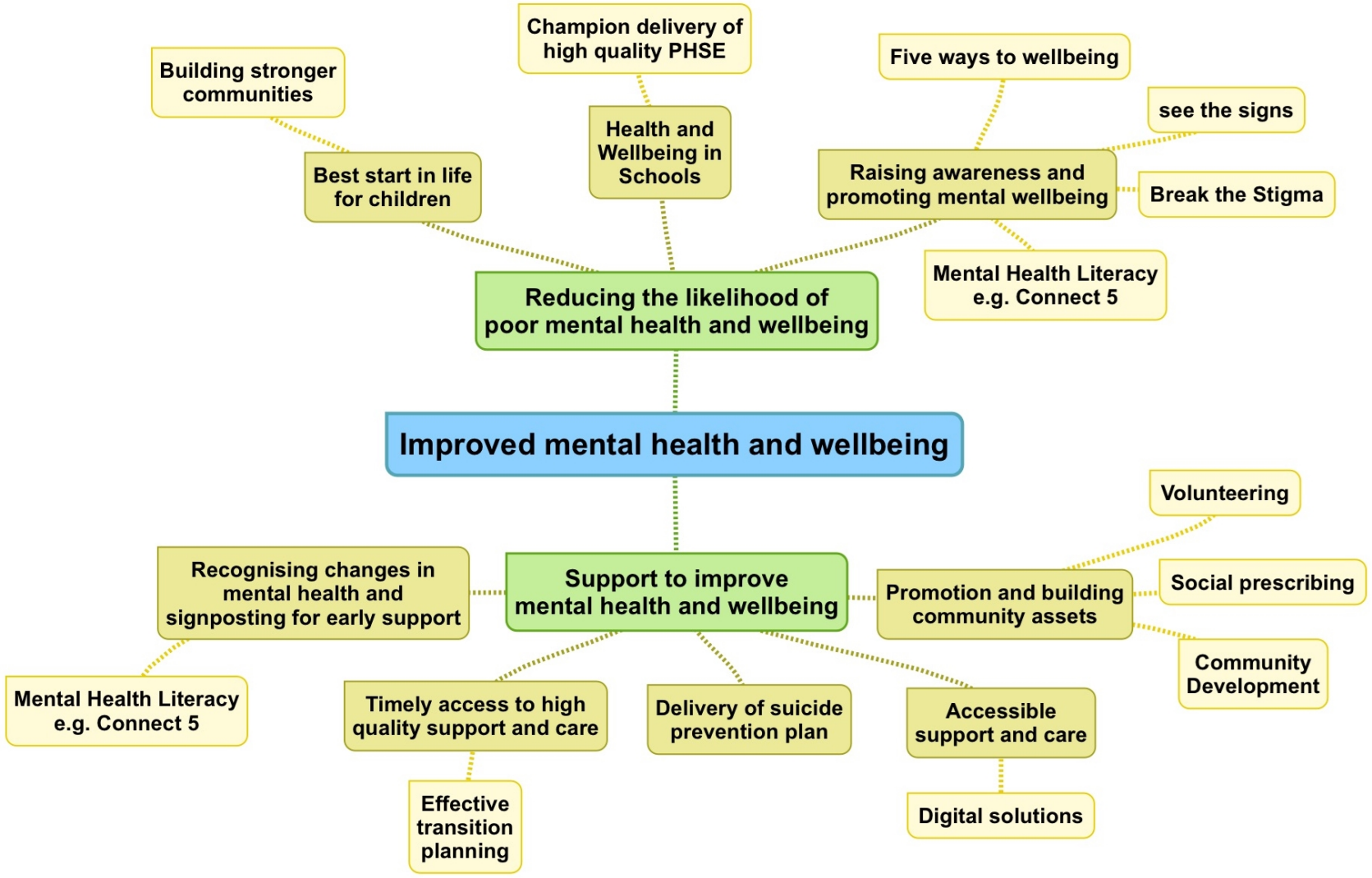
15. The work programme will be developed to ensure that progress to deliver the JHWS is effectively monitored.

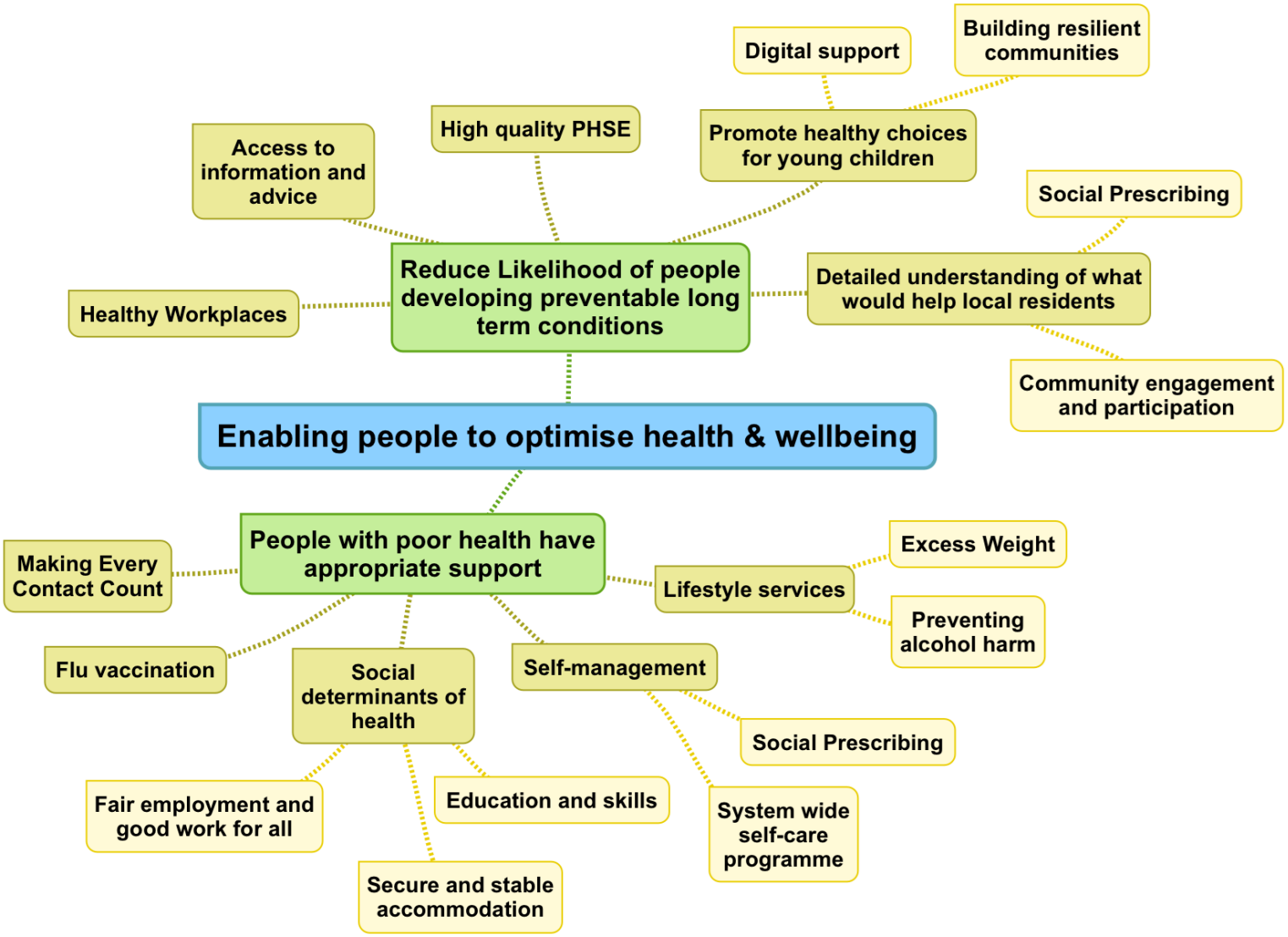
Conclusion and next Steps

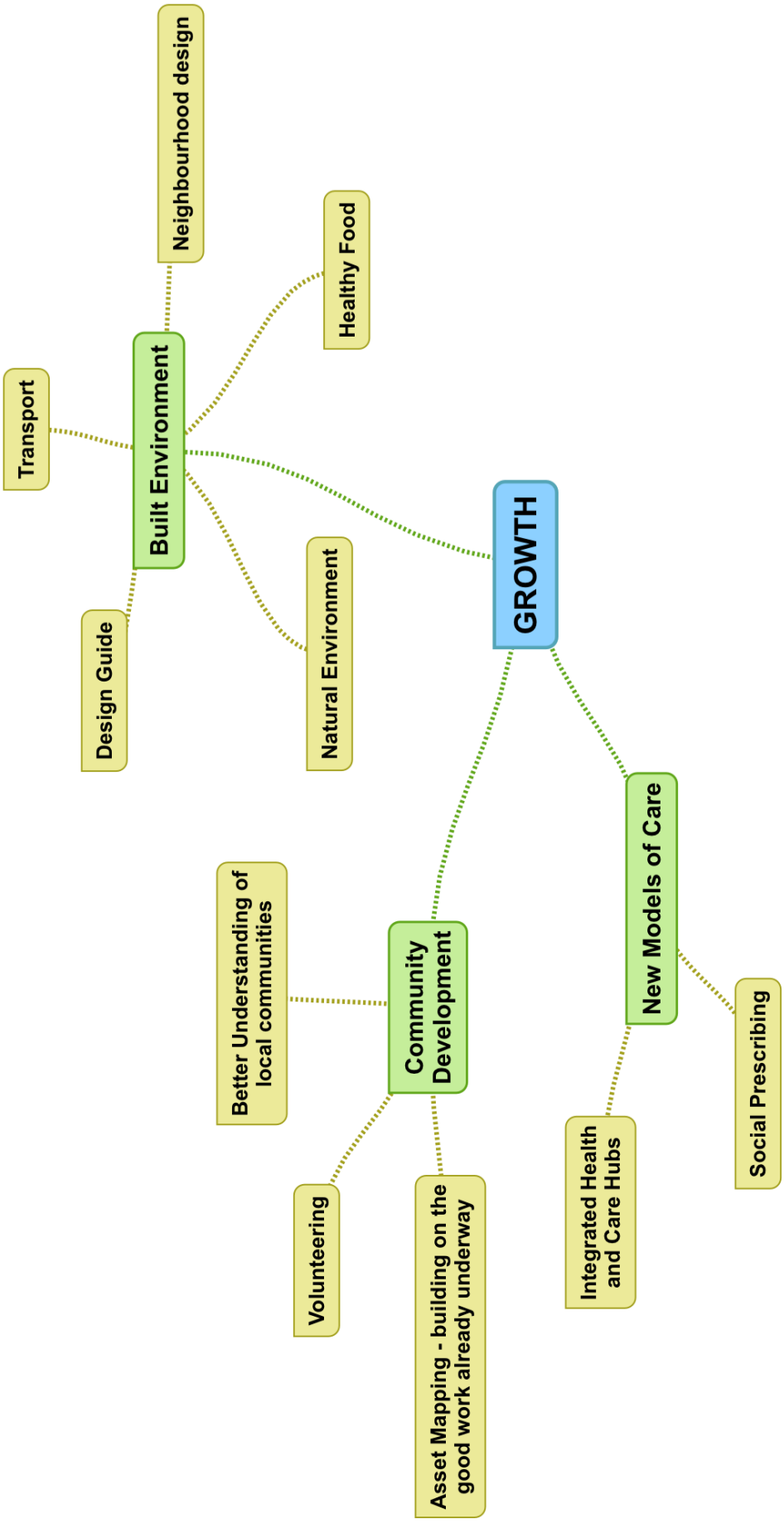
16. The JHWS provides the Board with a strategic framework to deliver improvements in health and wellbeing across Central Bedfordshire and importantly to reduce health inequalities. Identifying initial areas of focus will allow the Board to initiate and drive new action, unlikely to be initiated and co-ordinated elsewhere.

17. The Board is asked to consider the areas of focus and the proposal to test some approaches in a few communities first before wider roll-out.
18. Next steps include understanding the current work and gaps to improve mental health and wellbeing as part of the Needs Assessment, to scope the work to build resilient communities and to identify communities or groups where approaches can be piloted.

Appendix A – Delivery Mind Maps




Digital support
Building resilient communities
High quality PHSE
Access to information and advice
Promote healthy choices for young children
Social Prescribing
Reduce Likelihood of people developing preventable long term conditions
Healthy Workplaces
Detailed understanding of what would help local residents
Community engagement and participation
Enabling people to optimise health & wellbeing
People with poor health have appropriate support
Making Every Contact Count
Excess Weight
Lifestyle services
Preventing alcohol harm
Flu vaccination
Social determinants of health
Self-management
Social Prescribing
Fair employment and good work for all
Education and skills
System wide self-care programme
Secure and stable accommodation


GROWTH
Built Environment
Neighbourhood design
Healthy Food
Transport
Design Guide
Natural Environment
Community Development
Better Understanding of local communities
Volunteering
Asset Mapping - building on the good work already underway
New Models of Care
Integrated Health and Care Hubs
Social Prescribing

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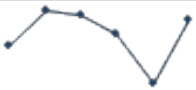
Appendix B: Initial suggested metrics to assess impact of the JHWS

Mental Health Outcomes					
KPI Description	Rank (among similar LA)	CBC Baseline	Best 5 %	Trend	Latest Data
Admissions for self-harm	8th/16	435.6	147		2016/17
Suicide rate (persons)	3rd/16	5.6			2014/16
Depression: QOF incidence (18+) - new diagnosis	3rd/16	1.2			2016/17
Access to IAPT (NHS Bedfordshire)	6th/11	16.9	24.3		2018 (March)
IAPT reliable improvement (NHS Bedfordshire)	10th/11	67.8	78.5		2017/18 Q4
Gap in the employment rate between those in contact with secondary mental health services and the overall employment rate	14th/16	74.7	58.7		2016/17
Carer with as much social contact as they would like	5th/16	41.6	46		2016/17
Percentage using adults social care services with as much social contact as they would like	12th/16	43.6	52		2016/17
% reporting depression or anxiety	5th/16	11.2	10.3		2016/17
Happiness (16+)		7.5			2012-2015
Life satisfaction (16+)		7.7			2012-2015
Worthwhile (16+)		7.8			2012- 2015
Life satisfaction inequality					
Anxiety		2.9			
Waiting times for services					
Experiences and outcomes for young people transitioning from children's to adults' services					

Self Care Outcomes

KPI Description	Rank (among similar LA)	CBC Baseline	Best 5 %	Trend	Latest Data
Healthy Life Expectancy (Male)	2nd/16	67.5	68		2014-16
Healthy Life Expectancy (Female)	13th/16	64.4	69.7		2014-16
Hospital admissions for alcohol-related conditions	5th/16	1073			2014/15
Smoking attributable admissions in 35+	10th/16	1419.0	1187		2016/17
Percentage diagnosed with dementia	13th/16	58.3			2018
Estimated diagnosis rate for people with diabetes aged 17 and over	13th/16	76.8			2017
Children with excess weight in Year R	4th/16	20.4	18.1		2016/17
Children with excess weight in Year 6	9th/16	30.1	27.4		2016/17
Smoking status at time of delivery	6th/16	8.8	3.5		2016/17
Immunisations: Flu vaccination <65 risk groups	10th/16	73.7	76.8		2017/18
Smoking prevalence in adults	13th/16	15.8	10.6		2017
Adults overweight or obese	14th/16	64.2	50		2016/17
Adults physically inactive	6th/16	18.0	16.6		2016/17
Admissions for ambulatory care sensitive conditions?					
Hits on websites					
Care processes completed					

Growth Outcomes					
KPI Description	Rank (among similar LA)	CBC Baseline	Best 5 %	Trend	Latest Data
Total voter turnout	5th/16	77.9	81.1		2016
Statutory homelessness	12th/16	1.5	0.5		2015/16
Using natural environment for health and exercise 16+	3rd/16	21.2	24.9		2015/16
Educational attainment	12th/16	58	69		2015/16
Access to woodland	11th/16	10.4	43		2015
Referrals to social prescribing?					
Community cohesion					
Opportunity to volunteer					
Housing in poor condition					
Evidence from survey of new developments?					

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Central Bedfordshire Health and Wellbeing Board

23 January 2019

Overview of actions proposed to reduce excess weight

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

Advising Officer: Ian Brown
Ian.brown@bedford.gov.uk

Public

Purpose of this report

This report outlines the actions and timelines for a 'whole systems approach' to tackling obesity in Central Bedfordshire, as part of the Joint Health and Wellbeing Strategy objective "Enabling people to optimise their own and their family's wellbeing".

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1 Recognise the importance of tackling obesity in Central Bedfordshire for all partner organisations.

2 Endorse the proposed universal 'whole systems approach', incorporating focused efforts on a geographical area of higher need.

Issues

The importance of tackling obesity

1. Obesity is one of the most serious public health challenges of the 21st century. It is having an impact on people's lives now, across the generations, in terms of quality of life, the risk of developing chronic diseases such as type 2 diabetes and its association with common mental health disorders.
2. Without action, the health of individuals will continue to suffer, health inequalities associated with obesity will persist and the economic and social costs will continue to increase.

3. Obesity is a complex problem with a large number of different but often interlinked causes, including personal, familial, societal and environmental factors. No single measure in isolation is likely to be effective in tackling obesity.
4. A system that supports people to maintain a healthy weight can improve workforce health, reduce sickness absence and contribute to a stronger local economy. It also serves to reduce social care costs[1].

The local picture for obesity

5. Despite emerging national policies and local action, 1 in 5 Reception age children are overweight or obese and this rises to nearly 1 in 3 by the time they leave primary school.
6. In Central Bedfordshire in 2017/18 19.3% of 4-5 year olds (663 children) were found to be overweight or obese. This is lower than the national average and is similar to the average of local authorities with a similar level of deprivation (i.e. the least deprived 10% of local authorities in England). The proportion of 4-5 year olds in Central Bedfordshire who are overweight or obese has remained stable since the records were first collected in 2006/07.
7. The proportion of 10-11 year olds who were found to be overweight or obese was 29.5% (874 children). This is lower than the national average and similar to local authorities with a similar level of deprivation. This proportion has also remained relatively stable since 2006/07.
8. Levels of obesity are disproportionally higher in more deprived socio-demographic groups and in some ethnic minority groups. Nationally, there is an almost linear relationship between excess weight prevalence in children and adults and the Index of Multiple Deprivation score for the area where they live. In Central Bedfordshire, for 4-5 year olds there is a 16.8% difference between the ward with the highest obesity rate (Tithe Farm) and the ward with the lowest (Shefford). For 10-11 year olds there is a 18.4% difference between the highest (Parkside) and the lowest (Ampthill).
9. For adults, the data is self-reported and should be interpreted cautiously, but in 2016/17 64% of adults in Central Bedfordshire were estimated to be overweight or obese; which was similar to the England average but higher than local authorities with a similar level of deprivation.

Building on foundations

10. Central Bedfordshire has had an Excess Weight Strategy in place since 2016 with four key aims:
    - Creating healthy environments which actively promote and encourage a healthy weight.

[1] Economic costs of obesity and the case for government intervention, Department of Health, 2007.

- Giving all children and families the best start in life and supporting them in achieving a healthy weight and lifestyle.
- Empowering adults and older people to achieve and maintain a healthy weight.
- Enabling practitioners working in Central Bedfordshire to have a meaningful discussion about weight in a confident and effective manner.

11. As part of this strategy, there are interventions and pathways in place to promote a healthy weight and manage excess weight. These include:
    - Weight management services for children, young people and their families, as well as an adult service.
    - Active lifestyle service for those with certain health conditions.
    - Active travel schemes such as Bikeability in schools and health walks.
    - A 'Healthier Options Award' for local food businesses that meet certain criteria.
    - 'Raising the Issue of Weight' training for health professionals.

Why do we need to approach obesity differently?

12. There is already a lot of local activity and commitment from partners, and while we can evidence the positive impact of some of the local interventions on individuals and families, it has not yet been possible to achieve population-level change, and inequalities persist.
13. Whilst weight management services are an effective, evidence-based intervention for individuals and families, and an important component of a wider strategy to prevent obesity, they will never have sufficient scale to deliver population-level impact.
14. 'Upstream' interventions that address the physical and social conditions in which we live, learn and work have greater potential to deliver population-level change.

Taking a 'whole systems approach' to tackling obesity

15. With the support of leaders and commitment of local partners we are reviewing the local excess weight strategy, identifying further opportunities to influence health behaviours, for example through further collaboration with planning and environmental health services and by improving the local maternal obesity pathway. This work will be framed as a 'whole systems approach' (WSA) using a nationally tested model.
16. A WSA seeks to address many of the influencing factors on obesity and requires coordinated action from multiple sectors including health, social care, planning, housing, transport and business to bring about a population-level change. This approach will require careful monitoring for impact and unintended consequences.

PHE whole systems toolkit

17. The Public Health England Whole Systems Approach to Obesity (WSO) toolkit aims to help local authorities and their partners deliver coordinated actions, involving stakeholders across the whole local system.
18. A key objective of the approach is to identify synergies and win-wins for local partners and co-benefits for communities and residents. For example, limiting the number of unhealthy food outlets in a local area could result in less littering and a more diverse high street, in addition to meeting the core objective of delivering a healthier local food environment.
19. At the same time, by working collaboratively to develop a range of actions across sectors, negative unintended consequences of individual actions are more likely to be anticipated and avoided. For example, if increasing activity levels in adults and children leads to increased use of leisure centres, the outcome could be undermined if parallel action is not taken to encourage healthier catering and vending within these facilities.

What the approach will look like

20. Public Health England have developed a route map to support local implementation of the whole systems approach (**Figure 1**). This will be used as a template but will be adapted to meet the needs of Central Bedfordshire, particularly in the latter phases.

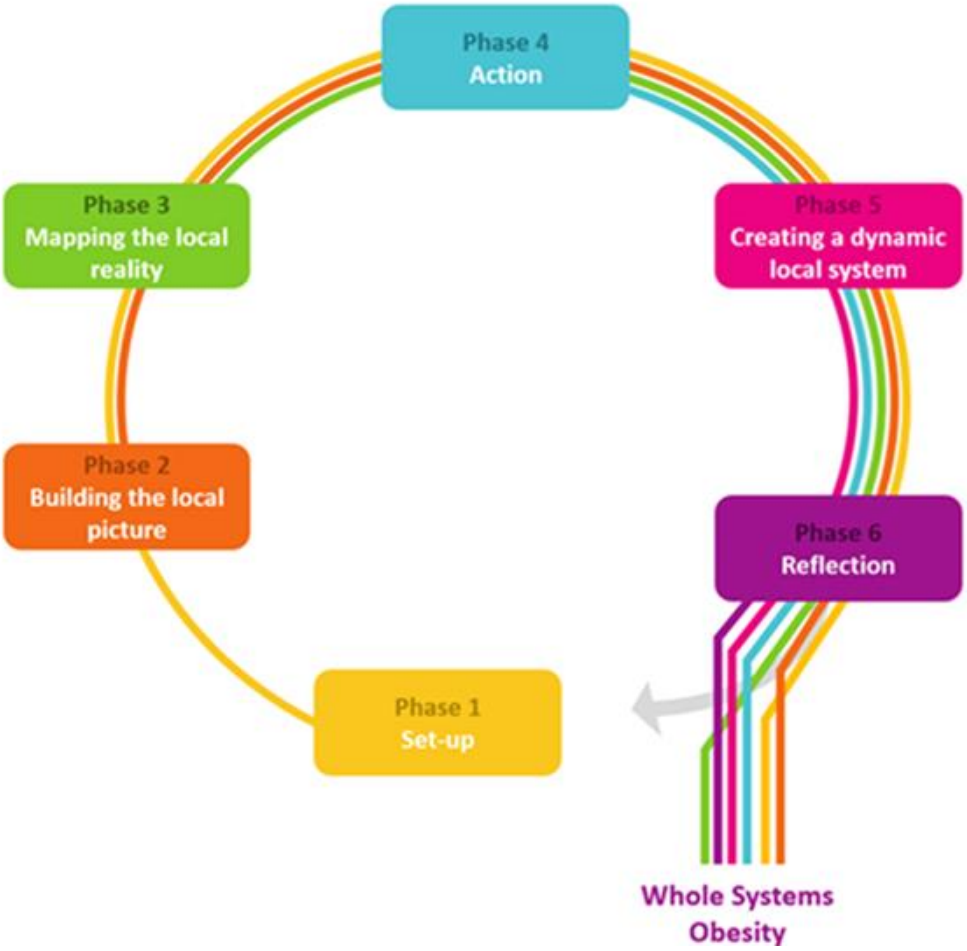

Figure 1. Public Health England Route Map; Whole Systems Approach to Obesity

21. In addition to the universal whole systems approach, we will focus efforts on a geographical area of higher need in Central Bedfordshire. This area will be identified using a range of indicators including deprivation and obesity data, and will be agreed by the Health and Wellbeing Board as part of a broader community-based approach to improving health and wellbeing. It is anticipated that this focused work should incorporate areas of established and new development. This will enable a wider range of planning, policy and asset-based interventions to be implemented.
22. After consultation with local stakeholders, principles from the European EPODE model will be applied. EPODE is a community-based approach which has been implemented in more than 500 communities across six countries and has achieved reductions in health inequalities related to nutrition and physical activity, and decreases in the prevalence of obesity.[2]

Step 1. Creating the conditions for change, January-April 2019

23. We will build on work so far to understand of the context of obesity in Central Bedfordshire and its impact. We have begun to collect and analyse relevant data to inform the programme, and meetings are scheduled to build on existing relationships with key stakeholders across the Council and its partners.

Step 2 - Understanding local causes and linkages, February-May 2019

24. Once preparation has been undertaken, interviews will be conducted with system partners and community stakeholders. This will help add to current understanding of issues and actions that are currently being undertaken in the local area. This system map will be the basis for the future action plans.

Step 3 - Identifying opportunities to disrupt the system, building and aligning actions around key objectives, targeted workshops delivered from July-September 2019

25. 'Disrupting the system' involves partners collectively identifying the most likely and productive areas of activity where the local health and wellbeing system in partnership with local communities can take action. It is anticipated that priorities will be creating a healthier food environment, working with children and young people as well as maternity services. These priority areas will relate to relevant resources and relationships, the extent of existing activities and the strength of the evidence base.
26. Collectively we will identify and develop actions around the identified areas. For example, if increasing healthy food consumption is a priority area of activity, actions would include incentivising local fast food outlets to provide a healthier food offering, tighter planning around fast food outlets, encouraging implementation of government buying standards for food and catering services across the wider public sector and catering guidance available to support this; working with schools to promote healthier school food approaches.

[2] EPODE, Ensemble Prévenons l'Obésité Des Enfants' (Together Let's Prevent Childhood Obesity).

27. The approach will be coordinated by the Senior Public Health Officer who will work across sectors and organisations to ensure that action in one area is not undermined by lack of action in another. The Officer will also coordinate the targeted, place based work.
28. It is also important to consider all local policies, programmes and activities that may impact on obesity. For example, strategies to promote road safety such as 20 mph speed limits in urban zones may also increase the number of children walking to school.

Step 4 - Creating and maintain a dynamic system to promote healthy weight, September 2019 onwards

29. Actions and efforts will be aligned, and action plans will remain flexible to accommodate changes in the local system, that may impact on the effectiveness of actions.
30. Stakeholders will meet regularly to discuss their progress towards the agreed goals and adjust activities where necessary.

Monitoring and Evaluation

31. Sufficient time will be allocated annually for partners to reflect on the functioning and effectiveness of the whole systems approach.
32. In the short term, the success of the approach will be monitored through a range of proxy measures, for example measures of stakeholder engagement and achievement of agreed actions, the reach of social marketing and the numbers of people receiving and successfully completing interventions.
33. In the long term, obesity levels and inequalities will be monitored via routine data collections, specifically the National Child Measurement Programme and the Active Lives Survey.

Financial and Risk Implications

34. It is anticipated that the majority of the work will be undertaken using existing local and national resources, however any additional funding will be sought through external sources for example, an application was recently made for the national Childhood Obesity Trailblazer programme.

Legal Implications

35. There are no direct legal implications arising from this report.

Governance and Delivery Implications

36. We will set up a clear structure to implement and monitor the WSA effectively; there will be a core working group who will meet regularly and will be responsible for initial implementation. There will be a wider systems network of stakeholders responsible for sustained implementation of the WSA.

37. Progress will be reported to the Health and Wellbeing Board.

Equalities Implications

38. 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.
39. Reducing health inequalities is central to the proposed WSA. There will be a combined universal and targeted approach, and the targeted work will be piloted in an area with a higher level of social deprivation and higher prevalence of obesity.
40. As well as considering inequalities between geographical areas, the targeted work will seek to understand and address the needs of groups who may experience worse health physical and mental health outcomes than the rest of the population. These groups will be identified during the community engagement phase.

Implications for Work Programme

41. An update to the Health and Wellbeing Board will be provided in phase 4 of the WSA in October 2019.

Conclusion and Next Steps

42. Obesity is a major public health challenge with complex causes and significant consequences for individuals and communities. The proposed ‘whole systems approach’ draws together and builds upon work to date, and provides the basis for achieving population-level impact on obesity in Central Bedfordshire.
43. The next steps, as described above, are to meet with local stakeholders and begin to create the conditions for change, identifying local challenges and opportunities.

Appendices

44. None

Background Papers

45. None

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Central Bedfordshire Health and Wellbeing Board

23 January 2019

Integrated Care System update
Bedfordshire, Luton and Milton Keynes

Responsible Officer: Richard Carr, Chief Executive
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Mark Thomas, Chief information Officer, BLMK ICS
Peter Howitt, Director of System Redesign BLMK ICS

Public

Purpose of this report.

1. To receive a progress update on the priorities of the Integrated Care System (ICS) in Bedfordshire, Luton and Milton Keynes (BLMK).

2. To inform the Board of the requirement for local health and care systems to produce a new five-year plan by autumn 2019.

3. To present the emerging thinking about the approach to the development of a person-centred five-year 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. **Consider the planning requirements and planned approach to the development of a five-year plan**
3. **Consider how the Health and Wellbeing Board can help to shape the plan for Central Bedfordshire**

Issues

1. Integrated Care System is now the term used to describe Sustainability and Transformation Partnerships that have greater control over the design and deployment of resources across local health and care systems. Integrated Care Systems comprise and bring together NHS commissioners, providers and local authorities to meet the needs of their local population.
2. BLMK Integrated Care System published a Single System Operating Plan for 2018/19, with continuing focus on five priority areas:
    i. Prevention
    ii. Primary, Community and Social Care
    iii. Sustainable Secondary Care
    iv. Digital Programme
    v. Systems Integration.
3. Progress against the priorities in Central Bedfordshire is monitored by the Transformation Board on behalf of the Health and Wellbeing Board.
4. Key areas of progress are set out in Central Bedfordshire Place Based Plan 2018/19 Progress Report. Appendix 1.
5. A letter from the Chief Executive of the NHS, in October 2018 required all STPs and ICS to produce a new five-year system operating plan, based on agreement of collective priorities and the parameters for organisational planning.
6. The ICS is required to develop and agree this strategic plan for improving quality and achieving sustainable (financial) balance which will be aligned to the NHS Long term Plan and the forthcoming spending review.
7. The five-year plan is to be developed by Summer 2019.

Approach to developing the five-year plan

8. It is intended that the emerging Five-Year Plan for BLMK will be person-centred and derived through a process of engagement and coproduction with residents. It will also take account of the socio-economic drivers that influence health experience and outcomes.
9. More emphasis will be placed on self-management, changing the narrative from ‘what is the matter with you’ to ‘what matters to you’.
10. It is proposed that the BLMK ICS Five Year Plan will build up from four longer term place plans. The Place plan will become the dominant wellbeing and health plan for each place, owned by the respective Health and Wellbeing Boards.

11. To facilitate discussion on the priorities and approach for developing the plan, the Health and Wellbeing Board will receive the following presentations:

    - key considerations for developing a person-centred five-year plan;
    - 'what matters to you' – The Wigan Experience (Video) https://www.youtube.com/watch?v=mYoepud2Azc&t=18s
    - digital solutions for delivering shared care records across the system,
    - key components and the programme for developing the five-year plan.

Financial and Risk Implications

12. The five-year plan must set out how local systems will improve services and achieve financial sustainability. The plans will need to be developed through engagement with all parts of the ICS and to provide "robust and credible" solutions for the challenges faced in caring for local populations over the next five years. The cost of developing the 5 year plan can be met from existing resources.

Legal Implications

13. There are no direct legal implications from this report.

Governance and Delivery Implications

14. The ICS is led by a Chief Executive Officer Group and has responsibility for ensuring resources are in place to produce the plan. The Chief Executive of Central Bedfordshire Council is lead officer for BLMK ICS and is the chair of Central Bedfordshire Transformation Board, a sub-group of the Health and Wellbeing Board. Each local authority area 'Place' in the ICS will also produce a five-year plan.

Equalities Implications

15. The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Consideration of equality implications will be built in to the development of the Place Plans and the 5 Year Plan.

Implications for Work Programme

16. The work programme will be developed to ensure that progress on producing and delivering the five-year plan is effectively monitored.

Conclusion and next Steps

17. The five-year plan will influence how the health and care needs of local people are met over the next few years. It is important that the plans take account of the challenges for Central Bedfordshire in meeting the needs of current and future populations.

18. The Health and Wellbeing Board is asked to consider the issues, following the presentations, which will shape the priorities for Central Bedfordshire.

Appendix 1

Central Bedfordshire
Better care locally

Central Bedfordshire Place Based Plan 18/19

Progress Update

November 2018

Central Bedfordshire

NHS

Overview of Place Based Plan

Place based plan in response to BLMK ICS priorities and challenges including:

- to drive better care delivery
- improve health outcomes
- reduce inequalities
- better integrated care
- make progress in ensuring a sustainable health and care system

To ensure patients and 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**.

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.

Summary of Progress Q1 and Q2 2018/19

Good progress has been made across all priority areas across Central Bedfordshire including:

- **Priority 1 Prevention**: launch of the social prescribing service
- **Priority 2 Primary, Community and Social Care**: 100% population coverage for extended access in primary care, launch of Urgent Treatment Centre, MDA roll out across all clusters, Programme for development of Integrated Health and Care Hubs progressing; implementation of Enhanced Health in Care Homes framework, a range of improvements in children's services including CAMHS crisis service and in respiratory and diabetes services
- **Priority 3 Acute sector**: Improvements in Maternity care
- **Priority 4 Digitisation**: Increased record sharing between practices and improving digitisation in care homes;
- **Priority 5:** Provider Alliance established; transfer of community services contract to ELFT; Strategic Commissioning Board for Central Bedfordshire established and will have its first meeting in November.

There have been notable challenges for example roll out of flu vaccinations to the elderly due to a national problem with distribution of vaccines and the delay in plans to merge BHT and L&D.

Key area of focus for Q3 anQ4 will include continued development of primary care home; agreeing an equitable clinical support model for care homes; further roll out of SystmOne , including access to multidisciplinary and care home modules and development of strategic digital solutions.

Detailed updates are provided in the remainder of the report.

Priority 1 – Prevention Actions Update

Lead: CBC Public Health

Aim	Actions	Progress	Outcomes
Reduce non medical demand on primary care	Implement social prescribing, social support, health coaching and navigation, wellbeing champions, Village Care, Good Neighbour schemes, information and guidance, digital solutions	Central Bedfordshire Community Wellbeing Champions have been appointed across the 4 localities and a Social Prescribing Service was launched in October. Asset mapping for community resources is underway. Inaugural BCCG self care group meeting in Nov and agreement to develop a BLMK self care / management network.	The social prescribing service is also an integral part of a multidisciplinary approach within localities and will support initiatives targeted at High Intensity Users. External evaluation is planned.
Reduce levels of smoking and harmful alcohol and substance misuse	Stop smoking re-design to improve access to services Effective delivery of prevention and treatment services for drugs and alcohol Implementation of risky behaviours CQINN in acute and community providers	Re-design at consultation phase with implementation of quit-line service and targeted interventions for vulnerable groups in April 2019 Health Needs Assessment complete with recommendations for further improved outcomes	Smoking quitters 72% of target in July 2017 Outcomes for successful completions of drug and alcohol treatment in top quartile in all categories
Reduce flu in vulnerable groups	Seasonal flu vaccinations to be completed by Dec 18	There have been delays in some practices receiving their flu vaccine orders. This has been mostly resolved and the programme is underway.	Admissions to hospital due to flu for vulnerable groups including older people will be monitored and evaluated in Spring 2018
Reduce incidence of cardiovascular disease (CVD)	Review of the CVD Rightcare pack revealed considerable variation in practice and outcomes. Promotion of HeartAge Tool	The pilot of opportunistic screening for AF/ HT has had limited take up by community pharmacies, limiting evaluation Proposals to address variation will be taken to the Clinical Executive Group to review and address these	The second phase of the AF/HT pilot is being scoped including further evaluation
Ensuring that growth delivers improvements in health and wellbeing for current and future residents	Improve understanding of people's experiences of recent local growth. Use this and evidence from elsewhere in the country, to identify specific changes or interventions to create 'healthy places'	Commissioned customer insight for delivery in Q3 2018	The outputs of the survey will be available in Q4 2018/19

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

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

Aim	Actions	Progress	Outcomes (achieved so far and planned achievements)
Primary Care Home To support and accelerate the development of primary care networks with a focus on population health management.	Clusters to: • demonstrate Level 1 of NHS E ICS Primary Care maturity matrix by end of 18/19 • 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, have developed transformation project and development plan to work collaboratively • PMS scheme for 18/19 to expand multidisciplinary approach • continue delivery of GPFV commitments and primary care home model • align local investment opportunities.	Six clusters of GP Practices are signed up to NAPC Programme. Current cluster maturity assessment: West Mid Beds F Leighton Buzzard F Ivel Valley North F Ivel Valley South F Chiltern Vale F Increased the number of clinical pharmacists, Emergency care practitioners and AHP roles in primary care Next steps are to: • develop Population Segments to identify priority groups and update cluster development plans • Continue to develop multidisciplinary team working to support complex patients and High Intensity Users of services • Evaluate the benefits of the cluster transformation schemes	Improved access to primary care appointments via Extended Access services introduced in Sept 18 Cluster transformation schemes now benefiting patients and the system: Joint Frailty nurse in WMB cluster providing support to patients in their own homes to reduce possible risks of admission to hospital Ivel Valley complex care team approach with nurse and pharmacist input have supported patients to potentially avoid 37 admissions Chiltern Vale have recently appointed a Frailty nurse to provide on the day home visits LB practices are collaborating to use technology via Footfall website to provide more timely information to patients and reduce need to face to face appointments

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

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

Aim	Actions	Progress	Outcomes (achieved so far and planned achievements)
To develop 5 **Integrated Health and Care Hubs** as focal points for Primary Care Home model	Development of Business Cases for Integrated Health and Care Hubs. OBC/FBC for Dunstable and Biggleswade Hubs. Development of Strategic case for remaining Hubs – WMBs, LB and HR	Programme plan to develop OBCs for Dunstable and Ivel Valley Hubs on track – expected completion February 2019. SOCs for West Mid Beds, Leighton Buzzard and Houghton Regis Hubs being finalised – completion November 2018.	Integrated Health and Care Hubs as a focal point for access and delivery of primary care and out of hospital services. **Planned:** Improved access to sustainable primary and community care and securing integrated outcomes residents. Reduced demand for planned and urgent secondary care services
To proactively support complex care patients	Residents with complex needs and those at high risk of deterioration are identified and supported within a multidisciplinary framework. • Multi-disciplinary approaches implemented across all localities • Implementation of CHS transformation	MDTs rolled out across all clusters from July 18 Proactive case management including social prescribing for High Intensity Users starting Nov 18 CHS Transformation Plan to be agreed at Nov contract meeting CHS Single Point of Contact implemented 1st Oct	**Planned:** Prevent rising health care risks, Improve primary care access for patients Reduce inappropriate or preventable crisis demand on the acute sector.
To improve outcomes for frail older people and better complex care management in the community.	Delivering **enhanced health in care homes (EHICH)** and implementation of a frailty index	EHICH Framework in place. Red Bag scheme, Trusted Assessor, Training, *6 111 scheme, WHZAN remote baseline monitoring pilot underway Implementation of tele-monitoring support to Care Homes. Complex Care Team support to Care Homes in Ivel Valley; WMB Frailty nurse Clusters starting to use frailty scores	**Planned** Reduced admissions for complex patients including from care homes. Alignment of GP support to care homes. MDT and Geriatrician support to Care Homes.

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

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

Aim	Actions	Progress	Outcomes (achieved so far and planned achievements)
To improve access to urgent care and primary care services to avoid unnecessary A&E and inpatient admissions.	• Extended Access to Primary Care • Urgent Treatment Centre (UTC)	Integrated discharge team at L&D Extended access started 1st Sept 18. 100% population coverage UTC opened 1st Oct 18	Reduce A&E attendances and non elective admissions Extended access delivering c 410 appointments per week in CBC The UTC has seen 715 patients since going live on the 1st October 2018, of which 221 were via 111 into a pre-agreed booked appointment
Reduce non electives for Children and Young people	• Transformation of CAMHS • 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 s/t 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.	CAMHS ; 7 day CAMHS crisis service embedded ./ community specialist eating disorders services fully recruited /schools- CAMHS link workers covering all secondary schools across Bedfordshire . New models of care business case for reducing in patient admissions to tier 4 beds in progress . Community : Bronchiolitis training rolled out to primary care / oxygen saturation monitors purchased and provided to primary care and community nursing teams . Rapid response team being developed in community model	Reduction in admissions Reduction in LOS

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

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

Aim	Actions	Progress	Outcomes (achieved so far and planned achievements)
FYFV aim to improve mental health **outcomes including parity of esteem for MH**	• Implementing early intervention programmes; • 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.	Mental Health Social Worker now contributing to Multidisciplinary team meetings. Four Housing Officers appointed to to support mental health patients	Update: the development of a Dementia Intensive Support Service (DISS) has been approved. Awaiting business case from MH provider with launch date to be confirmed but anticipated to be January 2019.

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

Lead and partners(who). GP Clusters; L&D/BHT ICOPD Service, ELFT /CBC , BCCG and Community and Voluntary sector

Aim	Actions	Progress	Outcomes (achieved so far and planned achievements)
To improve health outcomes and reduce unplanned episodes of care for people with **Respiratory Conditions** Rapid response service/ early supported discharge. Community Epilepsy pathways. Community respiratory pathways. Long term conditions management in the community/ complex case management. Therapies remodelling – SCLN / Physio / OT sensory.	• 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 to Practice Nurses. • Joint initiative with NSHI delivering paediatric asthma management guidelines targeting high referring GP practices rolling into Yr2 delivery. • Provision of Paediatric Community Nursing support, in line with what is already available in Luton and MK Adults: • Structured preventative care in primary care • Proactive recall of patients at risk of COPD for spirometry • Enhance delivery of community based services.	<u>Children</u> Bronchiolitis pathway developed and use Pulse Oximeters CAKES training being rolled out NSHI nurses – Asthma mentoring for age 5 and above – guidelines being developed Paediatric community nursing services supports complex needs and acute care in community <u>Adults</u> • Training of workforce to make accurate diagnosis of respiratory symptoms (Protected Learning Time events) • British Lung Foundation 'Information Event' - October • Promote use of Bedfordshire Community Health Services 'Rapid Intervention Service' • Breathlessness symptom pathway to inform accurate diagnosis • Adult asthma – one page guide to management of mild/moderate problems in primary care • One page pathway for COPD • Specialist psychologies for respiratory commenced October	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 <u>Children</u> CAKES training – KPIs and outcomes developed for reporting form Q3 2018/19 Promote clinical guidelines – bronchiolitis, asthma Plan to: Reduce non-elective hospital admissions for children aged 0-4 with bronchiolitis / Viral Induced Wheeze (VIW) by providing safe care closer to home <u>Adults</u> 1) Reduce A&E attendance and non-elective admission for adults with respiratory disease mainly COPD, Asthma and influenza/pneumonia 2) Increase the capability and confidence of Primary and Community Care to manage respiratory conditions in very young children 3) Empower patients and families to self-manage conditions at home 4) Standardising patient pathway

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

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

Aim	Actions	Progress	Outcomes (achieved so far and planned achievements)
Cont..	Cont..	• Shared Decision Making - CCG is part of a collaborative. CCG has used the national framework and a logic model to help inform the work. Continue work to help embed into business as usual. • Respiratory: Introduction of GOLD Guidelines - Launched guidelines back April 2018. Secured funding for two respiratory nurses for two years. Start in January 2019. Review patients at practice level, auditing, inviting patient in to have discussions ensure patients are on correct drug therapy, which will help to avoid admissions. • Community-based case finding with quality assured spirometry • FeNO – equipment and training in primary care. Plan for scoping. • Flu and pneumonia vaccinations - • Promotion and awareness with at risk group – Green book reminder of eligible patients • Timely access to pulmonary rehabilitation • Access to specialised Services – Development LTC IAPT programme and operationalise the offer and recent introduction of 2 x Clinical Phycologists. (Prioritised COPD and Diabetes).	

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

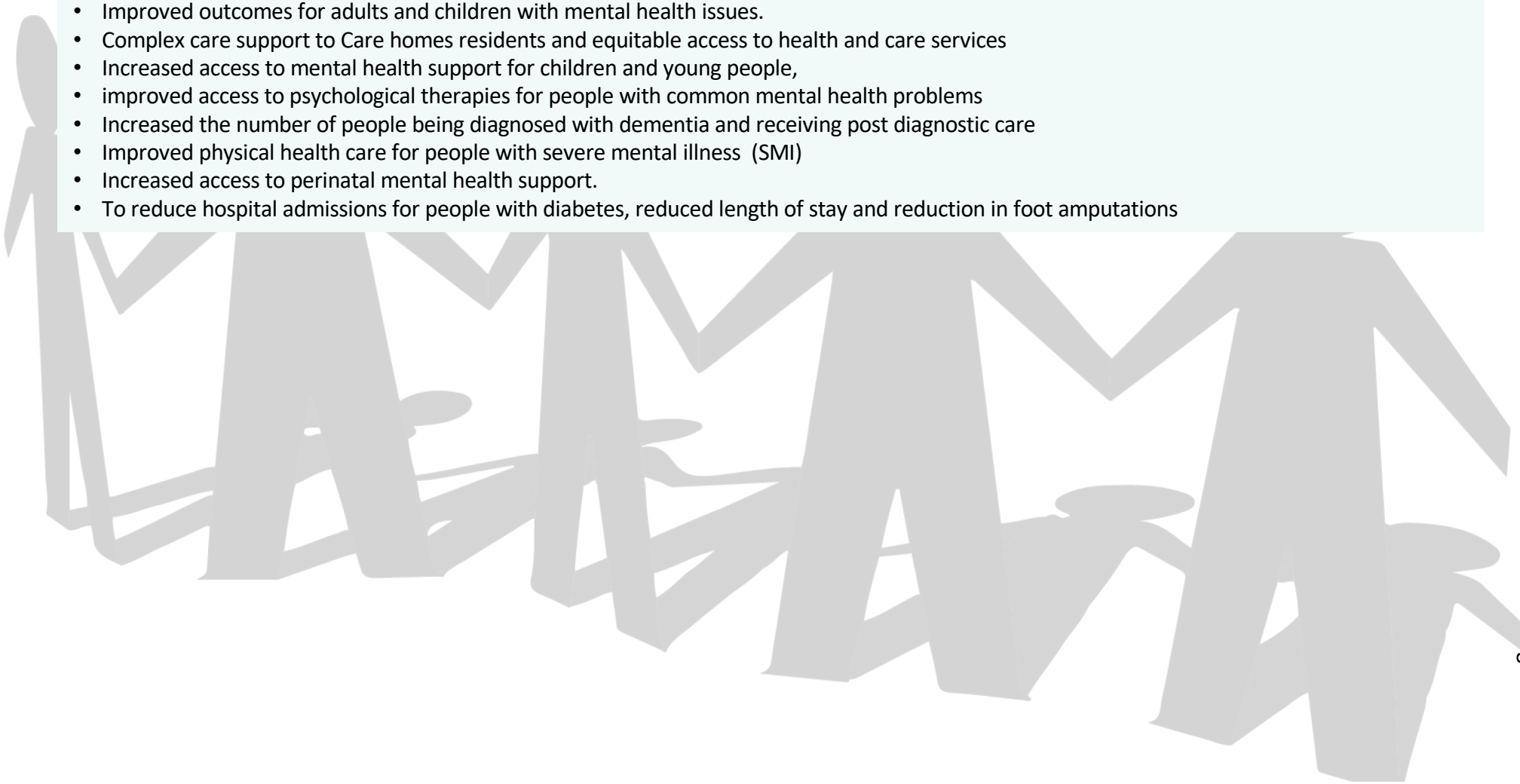
Lead and partners(who). GP Clusters; ELFT /CBC , BCCG, BHT & LDH community diabetes services (ICDS), and Community and Voluntary sector

Aim	Actions	Progress	Outcomes (achieved so far and planned achievements)
To improve health outcomes and reduce unplanned episodes of care for people with **Diabetes**	**NHS Diabetes Prevention Programme (NDPP) – commenced June 2017** • Two-year Programme providing education and support for people at risk of diabetes to help prevent or delay onset **Diabetes Treatment & Care Programme** • 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 for Integrated Community Diabetes Service (ICDS) to support patients who are struggling to optimise control of their diabetes and tailored support to practices where indicated by current outcomes and performance.	**NDPP – to date** • 4087 patients referred to programme (across BCCG) • 33% referred attended Initial Assessment (IA) • Re-procurement underway for further 3 year programme from August 2019 **Diabetes Treatment & Care Programme** • 47/48 practices signed up to local incentive scheme for care planning as part of diabetes annual review – attended personalised care planning training • Expansion in structured education (SE) capacity in choice of local venues and flexible days including Saturdays • Promotion of access to well-being services (weight management, IAPT, smoking cessation) • Podiatrist training for practice staff to undertake footchecks • Community Foot Protection Service and hospital Multi-Disciplinary Footcare Team implemented • Additional posts in ICDS to support practices including use of new IT tool to identify individual patients not achieving treatment targets (HbA1c, cholesterol & blood pressure) • Webinars for practices – SE, use of purpose designed IT template	**NDPP – to date** • Reduction in mean weight of patients after 6 months on programme – 3.9 kgs (178 patients to date) • Ongoing monitoring of impact of programme **Diabetes Treatment & Care Programme** April-September 2018 • 3000+ personalised care plans • 10,000 + foot checks in practices • 280 additional SE places compared to same period 2017/18 • 944 referrals to structured education (35% attendance) • 165 Diabetes referrals to IAPT 2018/19 Year-end targets 10,000 care plans delivered 20,000 foot checks delivered 1800 referrals to SE and increase attendance rate All practices referring diabetes patients for weight management and/or SE Reduction of 12 major foot amputations (75%) Reduction of 14 minor foot amputations (53%) Note: Information provided is for all BCCG patients

Priority 2 – Impact

Impact

- 100% coverage of self-identified primary care networks, mitigating primary care workforce recruitment and retention issues
- Access to fully integrated teams in primary care
- 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

Lead and partners(who) Acute Trusts; ICS PMO

Aim	Actions	Progress	Outcomes (achieved so far and planned achievements)
To deliver high quality and sustainable secondary (hospital) care services.	To support merger of the L&D and BHT Working with Acute hospitals to support delivery of out of hospital services in Integrated Health and Care Hubs. **Cancer** BCCG as lead STP CCG for Cancer continue to work with the Cancer Alliance to develop the EoE Cancer ambitions focusing 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	Ongoing The Transformation team have successfully rolled out a new primary care test to detect Colorectal Cancers earlier. The Faecal immunochemical test (FIT) was launched early October across the STP. Each project has a pan STP working group There are 9 projects included in the Transformation Plan focusing on Early Diagnosis and Living With and Beyond Cancer. 7 of the 9 projects are well established as part of the year 1 programme with work underway to scope the 2 new 18/19 projects.	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 BCCG has retained Patient Experience score of 8.7/10 in the annual National cancer Patient Experience Survey BCCG has retained Good rating in the annual NHSE Improvement and Assessment Framework. Year 2 funding to support the programme for 18/19 has been approved by NHS England.

Priority 3 – Sustainable Secondary Care

Lead and partners(who) Acute Trusts; ICS PMO

Aim	Actions	Progress	Outcomes (achieved so far and planned achievements)
To deliver high quality and sustainable secondary (hospital) care services.	**Maternity** Delivery of Local Maternity Services Plan priorities including 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. Alignment of Local Maternity Services in Integrated Health and Care Hubs.	A newly developed Maternity dashboard to monitor progress against Better Births Standards has been added to BHT contract this year .	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.

System Enablers – Priority 4 Digitisation

Lead and partners(who) P4 Board and ICS PMO

Aim	Actions	Progress	Outcomes (achieved so far and planned achievements)
Place based implementation in conjunction with Digital Transformation workstreams	**Shared Health and Care Record:** Continued N3 replacement across STP; Continued Wi-Fi roll out in Practices and Care Homes; EHR Core mobilisation at BHT (Q1), rollout of S1 to ELFT PC link workers, Clinical System Reviews and template alignment for BCCG member practices; Data sharing agreements and IG agreements between Practices and with STP Providers supporting development of shared care records across clusters and place. Care Homes undertaking IG toolkit readiness and assessment to expand on the LGA funded pilot. Social care workforce primed for agile working. **Technology:** SMS messaging in practices rolled out across STP; Development and procurements for online consultations; Telehealth monitoring pilots begin in Care Homes. Whole population health analytics: Tactical Business Intelligence solutions being explored. Central Bedfordshire commissioning case management system (SWIFT replacement) Whole population health analytics Continue to commission Civica SLAM **Information Governance:** BLMK information sharing agreements reconfirmation in Q1; Data-sharing model to continue to be developed; Assurance of compliance with GDPR across STP.	**Progress to date:** - Monitoring the improvement against Universal capabilities and Interoperability across providers - Procurement of replacement N3 services via a BLMK / Herts STP procurement supported by HSCN - Increased rollout of SystmOne as tactical shared record solution across BLMK - Project established and well underway to roll out robust WiFi, NHSMail, IG training and SystmOne access to all BLMK Care Homes - Procurement of online consultation solution - Remote monitoring pilots mobilised in each CCG area - GP Collaborative Working Toolkit produced and disseminated - Clinical Systems Reviews at BLMK practices to ensure consistency, template alignment work is ongoing - BLMK IG model developed and overarching ISA's signed - Extended access technical solution developed for all BLMK CCG areas - Options appraisal and Outline Business Case for strategic Interoperability Architecture solution completed - Engagement events held to support this strategic programme - HSLI Bid submitted for funding of the Interoperability Architecture - BLMK Maternity Programme provided with Digital Transformation Support	Strategic solution developed Increased record sharing via SystmOne Increasing enablement of collaborative working

System Enablers – Priority 5 System Redesign

Lead and partners(who) P5 Board and ICS PMO

Aim	Actions	Progress	Outcomes (achieved so far and planned achievements)
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.	• Implementation of new CCG Leadership arrangements that support greater integration of commissioning at scale and at place • Build ICS infrastructure • Consolidate the Provider alliances/partnerships and networks to progress greater integration between health and social care • Establish an understanding of 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 • Implement whole population health management capability as a key enabler to the ICS becoming operational; • Develop potential risk/gain share mechanism related to the management of non-elective activity in the Bedfordshire system.	Joint CCG Accountable Officer and CFO take up posts in November Transformation Board established in Central Bedfordshire and is sub group of the Health and Wellbeing Board. Transfer of adult and children's community health services to East London Foundation Trust completed and transformation in progress. Central Bedfordshire has established a Provider Alliance, which includes the PVI sector. A Strategic Commissioning Board for Central Bedfordshire has been established and will have its first meeting in November.	**Planned**

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Central Bedfordshire Health and Wellbeing Board

23 January 2019

Integrated Health & Care Hub Programme Update

Responsible Officer: Julie Ogley, Director of Social Care, Health & Housing, Central Bedfordshire Council
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Nikki Barnes, Head of Infrastructure & Integration
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Public

Purpose of this report.

1. To receive a progress update on delivery of the Integrated Health and Care Hub Programme.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. **Note the progress within the programme underpinning delivery of the Hubs, since the full update to the Health & Wellbeing Board in October 2018.**

2. **Note the planned actions for the next few months.**

Issues

1. Central Bedfordshire has a population of 280,000 (2017 mid-year estimates), of whom more than half live in rural areas. The population is expected to increase to 325,000 by 2031, with a projected increase of 44% in the over 65s. The rate of increase is even higher for those aged 75+, at 63%.

2. New Housing developments will further increase demand on existing health and care services. The draft Local Plan for Central Bedfordshire anticipates growth of 43,000 new homes by 2035.

3. Failure to reconfigure health and care services in anticipation of demand will put significant pressure on already vulnerable hospital services and fundamentally undermine the quality of care provision.

4. One of the ways in which this can be achieved is by enabling the development of more local and appropriate health and social care services that are less dependent on acute hospital provision.

5. Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group (BCCG) have the shared ambition to enable appropriate, health and care services to be based in local communities, with integrated multi-disciplinary teams working together. This enables services to be more locally accessible to people, especially in predominantly rural areas, and to meet the requirements for delivering health and care services to an expanding and ageing population.

6. With the significant expected growth in housing and increased population, the Council has an important role as 'Place Shaper' to influence how health and care services are delivered to better meet the needs of its population. Making better use of public assets to deliver new models of care and the co-location of health and care teams in fit for purpose facilities is central to managing demand and ensuring the future sustainability of our health and care systems.

7. Integrated Health and Care Hubs are a key enabler for securing high quality, resilient, integrated primary, community, mental health and social care services in each locality in Central Bedfordshire. The Council and BCCG have a well-established programme of work underway to deliver Hubs in accessible locations for all localities.

Progress Update

8. The Health & Wellbeing Board received a full update on progress and challenges within the programme, underpinning delivery of the Integrated Health and Care Hubs in October 2018. This report provides a summary of progress in the last two months.

Chiltern Vale (Dunstable)

9. Following extensive engagement, the requirements for all the potential occupants of the proposed Hub in Dunstable have now been fully mapped and a draft “Schedule of Accommodation” has been produced.
10. The Schedule of Accommodation is being used to shape the specification for commissioning the design work for the Hub. Central Bedfordshire Council will go out to procurement for the specialist design input in January, and this work will commence in March 2019, with a view to having detailed designs and costings available by May 2019. The Hub element of this design work is being funded via the NHS.
11. Consultation plans which will feed into the business case are also being developed. The consultation which will last eight weeks will commence on 28 January 2019.
12. All other elements of the business case for the Hub are being collated, with the expectation of completing this work on schedule by February 2018.

Ivel Valley (Biggleswade)

13. Following similar engagement activities to those in Chiltern Vale, the draft Schedule of Accommodation for the proposed Hub in Ivel Valley is also in the process of being finalised.
14. The design input for this Hub will be commissioned by the Council once the negotiations around the proposed site have been satisfactorily concluded.
15. Further constructive discussions have taken place between BCCG, the Council and NHS Property Services (the owners of the Biggleswade Hospital site). Detailed information about the likely size of the Hub building is required to finalise these discussions – which will be available once the Schedule of Accommodation has been completed.

Scoping Work for Further Hubs

16. Scoping work is underway for the proposed Hubs in Leighton Buzzard, West Mid Bedfordshire and Houghton Regis.
17. It was reported to the Health & Wellbeing Board in October 2018 that this work was behind track due to significant personnel changes within the consultancy delivering this work. The new team are now making good progress, and the Strategic Outline Cases for these three Hubs are expected to be complete by March 2019.

Financial and Risk Implications

18. Funding for two hubs has been included in the Council's Draft Capital Programme which is being considered by Executive at its January meeting. The affordability of the revenue implications for the Hubs (for potential occupants) will be determined once the detailed costings are available and as the Heads of Terms are negotiated. Other key risks include: ensuring enough stakeholder capacity to engage with programme, while faced with competing priorities; availability of the capital to deliver the full programme; and the risk that Council and NHS Property Services will be able to reach a satisfactory position in relation to Biggleswade Hospital site.

Legal Implications

19. There are no direct legal implications from this report.

Governance and Delivery Implications

20. This programme is overseen by the Hub Development Steering Group, comprising of directors from BCCG and Central Bedfordshire Council. The Steering Group is supported by a Programme Group comprising colleagues across the Council; in Adult Social Care, Assets, Major Projects, Children Services, and strategic leads from BCCG.

Equalities Implications

21. 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. Consideration of equality is being built into the development of the integrated health and care hubs.

Implications for Work Programme

22. The Programme is on track to deliver against the timelines described in the full update to the Health and Wellbeing Board in October 18. The Board may wish to continue to receive regular updates around progress in relation to this programme.

Conclusion and next Steps

23. The key activities planned within the Programme for the next few months include:

    i. Procurement and commencement of the specialist design work for the Hub in Dunstable

ii. Commencement of negotiations with potential occupiers of the Dunstable Hub in relation to their Heads of Terms (lease terms) for space in the facility.

iii. Completion of Schedule of Accommodation for the Ivel Valley Hub, and conclusion of negotiations with NHS Property Services in relation to the Biggleswade Hospital site.

iv. Subject to the outcome of negotiations with NHS Property Services, procurement of the specialist design work for the Ivel Valley Hub.

v. Establishment of local Delivery Groups for Chiltern Vale and Ivel Valley to oversee the development of the designs and delivery for the Hubs in these localities.

vi. Completion of the Strategic Outline Cases for the proposed Hubs in Leighton Buzzard, West Mid Bedfordshire and Houghton Regis.

24. The Hub Development Programme is a complex, long-term programme. Partners are working together to ensure that good progress is being made against delivery of the programme plan, with a particularly busy and key period expected throughout 2019.

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CENTRAL BEDFORDSHIRE HEALTH AND WELLBEING BOARD

Date of Meeting 23 January 2019

WORK PROGRAMME 2019/20

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 2019/20.

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 2019/20.

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)
Integrated Care System	To receive an update on the progress of the priorities of the Integrated Care System (ICS) in Bedfordshire, Luton and Milton Keynes (BLMK)	10 April 2019	Richard Carr, Chief Executive, CBC Contact Officer: Patricia Coker, Head of Partnership and Performance, CBC
Digital Strategy and Target Architecture	To receive an update on the digital architecture for the BLMK	10 April 2019	Pam Garraway, BLMK STP Programme Director, Luton Borough Council
Improving outcomes for people with Diabetes	To receive an update on improving outcomes for patients with Diabetes	10 April 2019	Dr Sanhita Chakrabarti, Clinical lead, BCCG
Central Bedfordshire Place Based Plan	To receive an update on the Central Bedfordshire Place Based Plan	10 April 2019	Patricia Coker, Head of Partnership and Performance, CBC
Driving change to improve mental health and wellbeing for children and young people	To receive the latest Local Transformation Plan and other actions being taken to improve emotional wellbeing and resilience of children and young people.	10 April 2019	Anne Murray, Director of Children's Services, BCCG Contact officers: Karlene Allen, BCCG, Sarah James, Public Health Senior Practitioner
Ensuring that growth delivers improvements in health and wellbeing for current and future residents	To receive a presentation on the changing population and the implications for the Joint Health and Wellbeing Strategy.	10 April 2019	Muriel Scott, Director of Public Health, CBC Mark Yeardon, Director , Public Health Perspectives. 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	

Issue for Decision	Description	Indicative Meeting Date	Lead Director and contact officer(s)
Integrated Care System	To receive an update on the progress of the priorities of the Integrated Care System (ICS) in Bedfordshire, Luton and Milton Keynes (BLMK)		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