Adults’ Services

Market Position Statement

October 2018
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Introduction

Bedford Borough Council’s Children’s and Adults Services are facing an increase in demand for services at a time of major financial constraint due to Central Government budget reductions. To help meet demand within available resources Bedford Borough needs a vibrant, diverse and integrated market for care and support. Local people need choice in how and where they receive care and support. The Council and partners need to encourage self-help and independence for individuals and communities.

The NHS Long Term Plan, published in January 2019, is a new plan for the NHS to improve the quality of patient care and health outcomes. Developed in partnership with frontline health and care staff, patients and their families will support the Council’s aims, embracing a holistic approach to enable communities to live and age well. The plan will encourage self-help and independence for individuals and communities.

The future for Bedford Borough involves using money differently to maximise the assets, skills, capacity and knowledge of individuals and the social capital of communities. We want to shift spending away from targeted and specialist services, and towards combined or integrated services that take a ‘whole person’ approach to meeting citizens’ needs.

To that end, the emphasis of our future commissioning will be on changing behaviours to promote independence, develop evidence-based early interventions to prevent peoples’ care needs increasing. We will be looking for new delivery models through integration with partners. We will achieve this through a particular focus on integrated commissioning and delivery, using available resources more effectively, and seeking to work with a more diverse range of partners including entrepreneurs and social enterprises.

This Market Position Statement is intended to help identify what the current and future demand for care and support looks like and to act as a starting point for discussions between the Council and service providers.

To feedback on any aspect of this document or identify key topics that you would like included in future versions please contact the

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All Local Authorities have a duty to improve the health of the population they serve. To help with this, we use data and information from a range of sources, including hospitals, to understand more about the nature and causes of disease and ill-health in the area.
Chapter 1 Facts and Figures about Bedford Borough

1.1 To find area profiles, census information and general statistics for Bedford Borough please visit this webpage: www.bedford.gov.uk/council_and_democracy/statistics_and_census.aspx

1.2 To see the Bedford Borough Health profile in full click here, and to access a report on what this means for the people of Bedford Borough please click here.

1.3 Other useful reference documents


The 2017 JSNA Executive summary can be found here: http://www.bedford.gov.uk/health_and_social_care/bedford_borough_jsna/jsna_summary_june_2017.aspx


Better Care Fund

1.4 During 2017/2019, Bedford Borough Council and Bedfordshire Clinical Commissioning Group committed to continue the momentum in partnership working to better manage and reduce the boundaries between health and social care where these hinder the integration of services around the needs of local people.

1.5 Focusing on developing a greater range and capacity in community based care and support we will deliver an improved health and care experience and use resources more effectively.

1.6 Much of the focus of the Better Care Fund (BCF) plan is on:

- Reshaping the model for prevention and early intervention – through an integrated approach to primary, secondary and tertiary prevention to stop or reduce deterioration in health
- Supporting people with long term conditions through multi-disciplinary working – focussing services around general practice in locality networks and helping people to manage their own conditions in the community
- Expanding the range of services that support older people with frailty and disabilities – integrating the range of housing, mobility carers and other services that wrap around older people with specific conditions and issues and helping to manage new demand including through the Care Act 2014
- Restructuring integrated care pathways for those with urgent care needs – ensuring that these are seamless, clear and efficient to help deliver the clinical shift
required to move care away from acute settings, where appropriate as well as building future resilience for the responsibilities of the council under the Care Act.

1.7 The plan focuses on the development of the above four points in the following:

(i) Continuation of the business as usual components of the 2016/17 BCF plan. This includes designated ‘protected services’ across adult social care and the NHS provision. Some will be improved in line with transformation plans

(ii) Expansion of schemes developed as part of the 2016/17 BCF plan

(iii) Implementation of new schemes which support the Primary Care home Model

1.8 The BCF plan takes into consideration the Health and Wellbeing Board Strategy, STP priorities, the large scale joint community services contract that went live on 1st April 2018, integrated health and social care out of hospital strategy, engagement with service users and stakeholders, evidence and the Joint Strategic Needs Assessment.

**Sustainability and Transformation Plan (STP)**

1.9 The STP is designed to help ensure that health and care services are built around the needs of local populations. Bedford Borough alongside Central Bedfordshire, Milton Keynes and Luton will produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency in Bedford Borough.

1.10 The STP plan is much broader than hospital care. The vast majority of care takes place outside hospital in the community, in GP and community clinics, in care homes or in a person’s own home.

**Local Plan 2035**

1.11 Bedford Borough Council is preparing a local plan that will set out how much growth there should be in the borough in coming years (housing, jobs and associated infrastructure) and where it should take place. Current planning policy documents look ahead to 2021 and this new local plan will extend the period that development is planned for beyond that date. It will also contain policies that will be used to make decisions on planning applications.

More detail about the plan can be found in the [Local Development Scheme 2016](#).

**2020 Programme**

1.12 The Medium Term Financial Strategy considered by the Executive in March 2016 highlighted a projected budget deficit of £21 million up to 31 March 2020, should we continue operating in the same way.

1.13 The Executive endorsed a programme of work to create a new Digital Operating Model (DOM) and transform the way we work. The DOM project aims to simplify the way we work by removing duplication and inefficient systems and using digital technology to create more customer focused services, making them easier to access for our residents whilst saving time and money.
1.14 There will be a number of work streams with the timescale of each work stream depending on the number of tasks and complexities relating to that work stream.

Project Management Office (PMO)

1.15 A programme team has been set up to drive the Council’s transformation programme forward. The programme is being led by the Chief Executive and Assistant Chief Executive (Business Transformation) Mark Stephens, who are responsible for strategically managing the programme and its deliverables.

1.16 The PMO is responsible for looking at the way we work, identifying how we could do things differently and how our technology could complement this. This will require a deeper level of engagement between and among commissioners and partners.

Transparency

1.17 As a public body, accountable to Council Members and the people of Bedford Borough, transparency is at the heart of how the Council works. The responsibility to safeguard and improve the health, wellbeing, resilience, and quality of life of our citizens means providing evidence of the effectiveness of our commissioning activity, and highlighting the areas where there is still more to be done. We want to work with partners who share this commitment to openness and accountability. We are keen to work with partners who publish independent performance reports against explicit quality standards and are prepared to work to an open book accounting approach.

Co-production & collaboration

1.18 We want to encourage more open dialogue between commissioners and partners, in particular:

- joint ideas generation and problem solving in terms of meeting the forecast reductions in budgets in an inclusive and progressive way
- identifying ways of simplifying the bureaucracy of procurement
- joint learning and engagement events to share knowledge and best practice on common priorities
- facilitating more alliance and partnership development to respond to the Council’s strategic priorities into their business models, in order to give citizens greater control over their care.

1.19 Co-production aims to democratise the production of health and social care, by enabling citizens to be full partners in the process of devising service specifications to best meet their personal outcomes and demonstrate value for money. Partner organisations will, in future, be encouraged to consider how they might build co-production

Community focus

1.20 We need to unlock the power and potential in communities to improve the lives of our citizens, and create thriving neighbourhoods where people have a sense of purpose and belonging. We need to shift our approach to one which focuses on the strengths of individuals and communities rather than deficits. We will create conditions for people to support each other to live healthy happy lives.
1.21 We aim to explore how currently disparate funding streams, including for carers, health and wellbeing, mental health and wellbeing and equalities, can be drawn together in order to ensure a more cohesive approach that will promote better outcomes. We will also explore how voluntary action, befriending and peer support can be invested in to complement statutory services, and deliver the social capital needed for communities to become more resilient and self-reliant.

Self-care

1.22 Self-care involves individuals taking personal responsibility for their own health and wellbeing, from the daily choices which they make about their lifestyle and behaviours, through to managing symptoms and long term conditions.

1.23 Supporting people to self-care involves empowering people with the confidence and information to manage their own health through education, information and community involvement. This means changing the way we identify, assess, and meet need with partners, and in so doing change the expectations and increase the independence and self-care capabilities of citizens who access our services. We will also explore how assistive technology can be used in enabling self care.

1.24 This will drive, and require, a change in commissioning approach from a deficit focus on illness and problems to an assets focus on strengths and abilities; this includes the skills, knowledge, resources and support available at an individual and community level. The broad aims of this are to promote personal and community resilience, to increase social connectedness and to empower people to take greater responsibility for their own health and wellbeing.

1.25 Enabling self care requires a partnership between providers of health and social care, patients and the public and community-based social enterprises and voluntary and community sector (VCS) organisations. We welcome partners who will work with us towards integrated service development across these sectors, to utilise their resources to promote independence and resilience.

Sustainability and Transformation Plan (STP)

1.26 The STP is designed to help ensure that health and care services are built around the needs of local populations. Bedford Borough alongside Central Bedfordshire, Milton Keynes and Luton will produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency in Bedford Borough.

1.27 The STP plan is much broader than hospital care. The vast majority of care takes place outside hospital in the community, in GP and community clinics, in care homes or in a person’s own home.

The Care Act 2014

1.28 The Care Act saw the introduction of the principle of wellbeing, as a key theme for local authorities in meeting the needs of people with care and support needs. How this happens will depend on a person’s individual circumstances, including the person’s needs, goals and wishes, and how these impact on their wellbeing.
1.29 Central to the shape of services is their accessibility and their capability of supporting people with disabilities. Unequal access to services can compound a person’s disability and leave them feeling lonely and isolated impacting negatively on their health and wellbeing. Therefore, this is a vital consideration in the shape of existing and future services and in direct relation to the prevention agenda. Providers will need to be innovative in the way that they respond to these service requirements.

**Better outcomes at lower cost**

1.30 All funding needs to focus on the outcomes that can be achieved for the money spent, and how it can drive increased independence over the long term. Therefore, we will work with partners to explore how we best measure outcomes, pay by virtue of those achieved, and where a service is subject to a local authority tender ensure our procurement processes are outcome focussed.

1.31 We will not be prescriptive about the approach partners take in delivering the desired outcomes, as long as they can evidence attainment of positive outcomes and demonstrate value for money.

**Social value**

1.32 Partners will need to demonstrate how they will offer social, economic or environmental benefits to the community over and above the provision of the commissioned service.
Chapter 2 What there is and what we need across the sector

2.1 In this chapter we look at the situation for different groups of people and indicate where we want to go next. It provides the starting point for discussions between the Council and service providers.

Learning Disabilities

Introduction

2.2 Bedford, like many areas, is experiencing an increase in the number of people with a learning disability. Demand on services is increasing at a time when budgets for care are being cut by central Government. This means that increasingly we are looking for more efficient and innovative ways of providing the support that people need, so that people can lead rewarding and fulfilling lives.

2.3 The 2012 investigation into criminal abuse at Winterbourne View Hospital initiated a national response known as “Transforming Care” to transform services for people with learning disabilities and/or Autism who have mental health conditions or behaviours that are challenging.

2.4 This national model of care aims to:
   • Change services for people with a learning disability and autism away from institutional models of care.
   • Close some inpatient provision.
   • Strengthen the support available to individuals in their local areas.

2.5 NHS England published Transforming Care for People with Learning Disabilities: Next Steps in January 2015. Building on the 2012 investigation it states that people with a learning disability and/or autism in hospital who could be supported in the community should get discharged into a community setting as soon as possible.

2.6 Further national policy documents, ‘Supporting People with a ‘Learning Disability and/or Autism who display behaviour that challenges’ Oct 2015 and the national plan ‘Building the Right Support’ Oct 2015, set out these expectations in more detail to transform care through:
   • Reducing numbers of in-patient admissions required for people with a learning disability and/or autism.
   • Managing effective discharge and transition for people in hospital.
   • Building resilient community services to support people to live as independently as possible in the most appropriate community setting.

Local Context

2.7 As well as the number of people with learning disabilities increasing in line with population growth it is expected that there will also be an increase in the complexity of disabilities due to:
   • Improvements in maternal and neonatal care.
• Increasing prevalence of foetal alcohol syndrome.
• Increasing numbers of adults from South Asian minority ethnic communities where prevalence of learning disability is higher.
• Improvements in general health care for adults which lead to increased life expectancy.

2.8 The Projecting Adult Needs and Service Information (PANSI) suggest that there are 1,032,531 people with a learning disability in England who are aged 18 and over.

2.9 The number of people with a moderate or severe learning disability in Bedford Borough who are likely to be in receipt of services is estimated to increase from 651 to 733 between 2017 and 2030.

2.10 By 2030 there will be an estimated 228 people aged 18-64 with a moderate or severe learning disability living with a parent in Bedford Borough with an estimated 50 people who are predicted to have a challenging behaviour.

2.11 By 2030 there are expected to be 858 people aged 64 and over with a learning disability, which compares to 618 in 2017.

2.12 As at the end of September 2017 Bedford Borough Council had 164 people with learning disabilities placed in residential care.

2.13 As an integral part of learning disability service provision, Bedford Borough continues working in partnership with statutory and non-statutory partners to facilitate people to live in their local communities. There will be a focus on people leading ordinary lives in ordinary settings and demonstrating the achievement of individual outcomes. This means providing support which helps people get involved in their local communities and accessing mainstream leisure, work and education opportunities where possible. To meet this need, providers will need to develop skilled services with stable staffing that can support individuals to settle and live within local areas.

2.14 The shift in expectation from caring for people to encouraging participation and independence will signify a significant change in commissioning in future years. Staff will need to have different attitudes and behave in different ways to improve outcomes for people. In turn, this has workforce recruitment, training and development implications across services from third sector support to mental health inpatient provision to care in the community, all of which will be focused on individual outcomes.

2.15 To address the ongoing health inequalities in people with a learning disability the national learning disability mortality review (LeDeR) 2015-2018 aims to guide improvements in the quality of health and social care service delivery for people with learning disabilities in response to one of the key recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD).

2.16 CIPOLD reported that for every one person in the general population who dies from a cause of death amenable to good quality care, three people with learning disabilities will do so.
Current provision

Employment

2.17 Bedford Borough Council has previously embarked on a day services modernisation programme which promoted new opportunities for paid and unpaid employment, training and work experience. Bedford Borough have a well-established Supported Employment Service that support individuals into voluntary and paid employment opportunities.

2.18 Other local providers have developed employment support schemes, including:

- Autism Bedfordshire are working with individuals and groups to support people on the autistic spectrum to access employment, training, CV advice and work experience opportunities. This involves working with local employers and providing support, guidance and training to employee and employer about the support needs of people with autism.
- European Social Fund funding also addressed the needs of unemployed or inactive individuals with learning disabilities who live within Bedford Borough by supporting them into work, or achievement of an appropriate positive outcome. The programme embraced Valuing People Now, real jobs for people with learning disabilities.

Housing Needs

2.19 All local authorities with strategic housing responsibilities need to plan to meet the housing needs of local residents. The Bedford Borough Council Learning Disability Accommodation Strategy, October 2016 sets out the Council’s aims in meeting the accommodation needs of people with learning disabilities through an integrated approach that makes the best use of the limited resources available to ensure that people are getting the right care in the right place:

‘Provide excellent, safe, sound, supportive, cost effective and transformational services for people with learning disabilities that promote independence, wellbeing, and choice and are shaped by accurate assessment of community needs.’

2.20 The key role of Adult Services has already been noted however, the following links are also important:

- Children’s Services work with young people with learning disabilities. An effective system must be in place for transition plans and year 9 reviews to inform future accommodation planning and commissioning.
- Bedford Borough Council does not hold a housing stock. Working with partners – particularly Housing Associations – is central to meeting housing needs.
- The Council’s Supported Housing Team fund housing related support services to enable some people with learning disabilities to live as independently as possible.

Specialist Health Services – secondary care mental health and learning disability partnership NHS Trust

2.21 The IST (Intensive Support Team) provides a predominantly community based
service for people with a learning disability and who have additional mental health needs or present with challenging behaviour. In addition to the community outreach support, there are 7 inpatient beds that are staffed as part of the service.

2.22 The Specialist Community Health Care Team provides a range of therapies to people with a learning disability. The service has a single point of access which then agrees a treatment pathway. The team includes speech and language therapy, dietetics, arts psychotherapies, psychology and sensory.

2.23 The Health Facilitation Team (HFT) provides support for people to access generic health care services. Staff are co-located with the Adult Learning Disability Team at Bedford Borough Council, and staff based in Bedford General Hospital.

2.24 The Specialist Medical Department team works as part of inpatient services, the specialist community health care team, and provides outpatient services to people with a learning disability.

2.25 Wood Lea Clinic is provided by East London NHS Foundation Trust (ELFT) as a regionally commissioned forensic (low secure) 10 bedded unit for people with a diagnosed learning disability who have committed an offence.

2.26 Care Treatment Reviews (CTR) have been developed as part of NHS England’s commitment to improving the care of people with learning disabilities with the aim of reducing admissions and unnecessarily lengthy stays in hospitals and reducing health inequalities.

2.27 CTRs aim to bring an individualised approach to ensuring that the treatment and differing support needs of the person with learning disabilities and their families are met. It focuses on four areas: is the person safe; are they getting good care; do they have a plan in place for their future and can their care and treatment be provided in the community.

Current Issues

2.28 Whilst progress has been made over the last two years the system remains fragmented in parts, with the integration of health and social care not yet at the desired level. Some of the issues that continue are:

- More people are presenting with a complex learning disability.
- Higher mortality rates amongst people with a learning disability than the general population.
- National requirement to reduce forensic inpatient beds for learning disability services.
- High cost placements for residential care, supported living and individual packages of support provided at home.
- Lack of flexible accommodation options to meet ongoing need.
- Low utilisation of Assistive Technology.
- Access targets for people with a learning disability to receive annual health checks not being monitored.
- More focus required on individuals’ progression.
- Insufficient system wide focus and lack of alignment needed between secondary, primary and third sector services to care for individuals in the community.
Bedford Borough Council Priorities from 2017

2.29 The aims and objectives of Bedford Borough Council working collaboratively with all Partners and Stakeholders are to:

- Reduce the current fragmentation between services and securing a more integrated approach to service delivery.
- Focus on improving the outcomes that services achieve, rather than on the detail of how they are structured.
- Provide clear care pathways through services, so that, irrespective of how people come into services, there is a shared understanding as to how people will be supported without being blocked or delayed by organisational boundaries.
- Improve access to services, with care and treatment based on assessed needs and good practice guidelines.
- Improve the service user’s experience of care and services.
- Ensure that all public services are supporting people to access and remain in employment.
- Move more health provision into the community.
- Educate, inform and involve the community in improving their own health and wellbeing.
- Ensure the system is safe, effective, efficient, affordable and sustainable.

2.30 Underpinning our local priorities is the requirement by March 2019 to close inpatient beds, starting with the national planning assumptions set out in Building the Right Support Oct 2015. These planning assumptions are that no area should need more inpatient capacity than is necessary at any one time to cater to:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

2.31 In reducing the inpatient capacity there will need to be an increase in community provision that provides person centred support and services to people and their carers that achieve:

- Improved quality of life.
- Services that support people to take positive risks whilst ensuring that they are protected from potential harm.
- Choice and control - working with people in their decisions about their health and care services decision must be made in their best interests involving them as much as possible and those who know them well.
- Support and interventions provided in the least restrictive manner.
- Equitable outcomes, comparable with the general population, by addressing the determinants of health inequalities outlined in the Health Equalities Framework.

2.32 The cohort of people affected by the implementation of the service model will include:

- Those currently living in the community, supporting them to lead independent lives including crisis prevention and management
- Those currently in in-patient and residential placements out of area who are able to be successfully transitioned back to the community.
2.33 The plans include the development and/or strengthening of service provision based on service user and carer feedback in the areas of:

- Employment service and supported employment strategy.
- Access to health services, specifically access and quality of health checks.
- Continuing health care for people with learning disabilities.
- Transport arrangements for people with learning disabilities.
- Respite care – what people like, what it should look like in the future.
- Charging for services.
- Housing – options, selection, accessibility, overcoming loneliness.
- Day opportunities – access, form, future.
- Transitions from children services to adult services.
- Budgets and savings the council need to make.
- Autism strategy.
- Winterbourne Report recommendations implementations.
- Reconfiguration and review of specialist learning disabilities services.
- Learning Disabilities Self Assessments.

2.34 In addition the LeDeR programme will enable local areas to meet their requirements as laid out in the NHS Operational Planning guidance 2017/18 includes the following “must do” for NHS England:

“Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism”.

2.35 There are many objectives and commitments in the national plan that aim to deliver improved access to high quality care and more integrated services. A common theme across many objectives is of building capacity within community based services to reduce demand and release capacity from the acute sector and inpatient beds towards a more ‘place based’ approach.

2.36 The Commissioning Intentions of NHS Bedfordshire Clinical Commissioning Group (CCG) are aligned to the Year 2 Mobilisation plans for ELFT and the required duties of Bedford Borough Council under the Care Act and include a review of specialist learning disability services with a recognition that safety, sustainability and shifting the balance of provision away from individual high cost packages is key in the development of more community based provision for people with a learning disability.

2.37 We also aim to strategically align and shape (using a co-production approach) housing related support provision across the Borough to ensure that there is a clear pathway and provision offer from acute settings to independent community living.
Older People

Introduction

2.38 The number of older people in Bedford Borough is projected to increase at a much higher rate than the rest of the population. The 65+ population is projected to rise by 16% from 2016-2023, and the 85+ population by 26%. Looking ahead to 2039 the projected increase is again, significantly higher in the older population with those aged 65+ increasing by 69%, and those aged 85+ by 142% (from 4,200 in 2016 to 10,200 in 2039).

2.39 The current overall joint financial model of health and social care is not sustainable taking into account the growth in the older population. Services need to be redesigned to provide better outcomes within reduced resources.

2.40 Bedford Borough Council and Bedfordshire CCG have the key leadership roles in driving change forward and helping all relevant public, private and voluntary organisations work more effectively together.

2.41 Individuals also have a role to play by maintaining, as far as they can, their health and well-being and making use, to the extent appropriate in each individual's case, of the services available to reduce, prevent or delay the onset of ill health in general.

2.42 Services will support older people to maintain their independence, and to take a more active role in directing their own care, promoting greater choice and control. People growing older can help themselves by adopting life choices to preserve good health and wellbeing.

2.43 The Borough’s Health and Wellbeing Strategy 2016-2020, places these themes at the heart of its expectations for older peoples services, where ‘helping older people to maintain a healthy independent life for as long as possible’ is a key strategic aim. This is underpinned by the prevention agenda, independence and the notion of self-care, which focuses on empowerment of the individual, enabling them to manage appropriate elements of their health.

2.44 This provides the direction of travel across Health and Social Care, with all our partners including those from voluntary, charitable and private sector organisations. Fundamental to our success in continuing to deliver quality services in this context is the ability of colleagues across all sectors to respond proactively and innovatively to the challenges which we face, together.

2.45 The shift in expectation from caring for people to encouraging participation and independence will signify a significant change in commissioning in future years. Staff will need to have different attitudes and behave in different ways to improve outcomes for people. In turn, this has workforce recruitment, training and development implications across services from third sector support to health and social care delivered in the community as well as that delivered in hospital. There will be a strong focus on rehabilitation and reablement support for older people as well as individual and service outcomes.
## Issues/Need for this client group

2.46 Services delivered to older people range from prevention and homecare services through to reablement and the management and support of long term conditions, Carers services and residential and nursing care.

2.47 Bedford Borough is home to an estimated 2087 people living with dementia. Numbers of people living with dementia are increasing and will continue to rise in the future. At the same time we face a need to reduce the rate of people moving into residential and nursing care, and ensure that as many older people as possible are able to receive good care in their homes or communities.

2.48 Older people are now becoming known to us, in increasing numbers, at a later stage in life and enter the system with more complex care needs.

2.49 Deprivation amongst older people is located within the urban areas of Bedford Borough with 13.5% of older people considered to be experiencing income deprivation. It is known that people from income deprived backgrounds experience a higher incidence of poor health and long term conditions, whilst simultaneously, accessing preventative services in lower numbers than the rest of the population. Increased access to services is one of our key strategic aims as part of the prevention agenda.

### ‘As is’

2.50 Care is provided through older people’s services such as home care and day care but also through the provision of extracare schemes as well as residential care homes, rehabilitation and reablement services. There is also a range of specialist provision provided by health partners and voluntary and community services.

### Current issues:

2.51 There are significant challenges for the local authority within the care industry. Recruitment and retention of care staff with the right skills, presents an ongoing concern.

2.52 Across adult social care there is a shortage of staff with the right skills, both of qualified social workers and unqualified staff.

2.53 Older people are entering the system at a later stage with more complex care needs. Increasing numbers of older people requiring access to reablement or enhanced reablement.

2.54 Diagnosis targets for dementia.

2.55 Sections of health, social care and housing need to collaborate more effectively, avoiding working in isolation.

### Recent developments in response to the current context:

2.56 A new Home Care Framework has been designed and commenced in October 2016. The framework incorporates the introduction of three geographical areas, in an
attempt to address the following issues:

- Finite numbers of carers spread too thinly across too many agencies.
- Reduce the gaps between home care and community and primary health care.
- Focus on reduction to hospital admissions.
- Reduction in inefficiencies with providers picking up packages dotted about with no critical mass in a particular geography.

2.57 Dementia services have been re procured to meet the changing needs of the population and will be delivered in partnership.

2.58 Carer’s services have been re procured and reorganised to meet the needs of the changing demographic, targeting resources on prevention and those in crisis as well as supporting those not in crisis but with ongoing needs.

2.59 The Bedfordshire and Luton Community Equipment Service has been re procured in line with our strategic objectives with customer and partner feedback including health, central to the specification redesign but also incorporating increased access to services.

Aims and objectives

2.60 Continue to reduce the current fragmentation between services, securing a more integrated approach to service delivery;

2.61 Target our work with people with life limiting conditions such as stroke by redesigning and coordinating the stroke pathway across social care, health and the third sector.

2.62 Ensure that older people and providers have the skills, knowledge and confidence to self-care or enable self-care across an integrated health and social care pathway.

2.63 Reshape our reablement model for older people providing enhanced reablement for people with more complex reablement needs.

2.64 Provide clear care pathways through all older people’s services, so that, irrespective of how people enter services, there is a shared understanding of how people will be supported to move through those services from hospital discharge to reablement or rehabilitation, or to the community, without being blocked or delayed by organisational boundaries;

2.65 Deliver planned extracare schemes according to the delivery programme.

2.66 Review existing extracare schemes to ensure the provision meets the increasing complex care needs amongst the elderly.

2.67 Refresh the Joint Commissioning Strategy for People with Dementia in Bedford Borough, and work with partners to develop community dementia initiatives which raise the profile of dementia and create dementia friendly communities.

2.68 Explore with health the possibility of broadening our telecare offer.

2.69 Work with providers to meet the increasing needs of older people in the community
and deliver the volume of care packages required.

2.70 Improve the service user’s experience of care and support services;

2.71 Deliver outcomes that meet rising demands within available budget.

2.72 Focus on improving the outcomes that services achieve, rather than on the detail of how they are structured, encouraging greater innovation;

2.73 Move more health provision into the community;

2.74 Educate, inform and involve the community in improving their own health and wellbeing by addressing issues;

2.75 The Draft Older Persons’ Accommodation Strategy sets out the Council’s aims in meeting the accommodation needs of older people in the Borough and is being consulted on during Autumn 2018.

www.bedford.gov.uk/council_and_democracy/consultations/older_persons_acc_strategy.aspx

### Mental Health

#### Introduction

2.76 Bedford, like many areas, is experiencing an increase in the number of people with mental ill health. Demand on services is increasing at a time when budgets for care are being cut by central Government. This means that increasingly we are looking for more efficient and innovative ways of proving the support that people need, so that people can lead rewarding and fulfilling lives.

2.77 We know that 1 in 6 people will experience a mental illness (including anxiety and depression), that equates to nearly 28,000 people in Bedford Borough.

2.78 As an integral part of mental health service provision, Bedford Borough continues working in partnership with statutory and non-statutory partners, across the mental health stepped model of care from prevention and early intervention through to community and inpatient provision and aftercare where people with enduring mental illness will be helped to live in their local communities. There will be a focus on people leading ordinary lives in ordinary settings and demonstrating the achievement of individual outcomes. This means providing support which helps people get involved in their local communities and accessing mainstream leisure, work and education opportunities where possible. To meet this need, providers will need to develop skilled services with stable staffing that can support individuals to settle and live within local areas.

2.79 The shift in expectation from caring for people to encouraging participation and independence will signify a significant change in commissioning in future years. Staff will need to have different attitudes and behave in different ways to improve outcomes for people. In turn, this has workforce recruitment, training and
development implications across services from third sector support to mental health inpatient provision to care in the community, all of which will be focused on individual outcomes and recovery. To address the ongoing health inequalities in people with mental illness, primary healthcare needs to be improved along with support for older people.

2.80 Earlier this year a three-year campaign called Five Ways to Wellbeing was launched in partnership with Bedfordshire Clinical Commissioning Group to help people take practical steps to improve their feelings of wellbeing.

Aims and Objectives

2.81 The aims and objectives of Bedford Borough Council working collaboratively with all Partners and Stakeholders are to:

- Reduce the current fragmentation between services and securing a more integrated approach to service delivery;
- Focus on improving the outcomes that services achieve, rather than on the detail of how they are structured;
- Provide clear care pathways through services, so that, irrespective of how people come into services, there is a shared understanding as to how people will be supported to move through those services into recovery, without being blocked or delayed by organisational boundaries;
- Improve access to services, with care and treatment based on assessed needs and good practice guidelines;
- Improve the service user’s experience of care and services;
- Ensure that all public services are supporting people to access and remain in employment;
- Move more health provision into the community;
- Educate, inform and involve the community in improving their own health and wellbeing;
- Ensure the system is safe, effective, efficient, affordable and sustainable.

Current - Issues

2.82 Whilst progress has been made over the last two years through the retendering of mental health services, the system remains fragmented in parts, with the integration of health and social care not yet at the desired level needed to improve outcomes. Some of the issues that continue are:

- More people are presenting in mental health crises.
- Pressure on local inpatient beds and a lack of specialist accommodation has led to out of area (high cost) placements being used rather than alternative community based models of care.
- Access targets are not being met for psychological therapies (IAPT) or Dementia Diagnosis.
- Lack of recovery focus resulting in some service users remaining in residential accommodation and day opportunities for longer than necessary.
- Insufficient system wide focus on early intervention, prevention and employment.
- More alignment needed between secondary, primary and third sector services to care for individuals in the community.
Current – Recent Developments

2.83 The Bedfordshire Primary Care Mental Health (PCMH) service provides clinics based in the associated GP surgeries to which each Link worker is aligned. It also works with health visitors supporting young mothers with mild to moderate mental health issues.

2.84 The purpose of PCMH service is to work with individuals (aged 16yrs & over) who present at GP surgeries with complex, common mental health disorders at the upper level of stepped care. This will include those that do not require specialist secondary care and can be effectively treated in the primary care setting. PCMHL workers are specialist and experienced mental health practitioners.

2.85 A range of interventions are provided based on need and may include the following:
- Triage, assessment (including risk) and review, where appropriate
- Psycho-education
- Self Help Literature - Advice on books, leaflets and websites that will help people to help themselves
- Brief Intervention – symptom management i.e. anxiety management, distress tolerance, behaviour activation, goal setting, relaxation, stress management, medication management, motivational interviewing, problem solving, goal setting etc.
- Signposting - Referral to other voluntary & statutory services as appropriate.
- Primary Care Liaison and education - Advice and support to primary care professionals and consultation with secondary care colleagues.

2.86 The Bedford Psychiatric Liaison Service ensures that all patients at Bedford Hospital who require mental health input or assessment will be referred to the Psychiatric Liaison Service (A&E Liaison Nurses within the Crisis Team).

2.87 The Recovery College is part of The Mental Health Academy formal partnership with East London NHS Foundation Trust (ELFT) and The University of Bedfordshire, offering educational workshops and courses which focus on mental health recovery and wellbeing. The workshops are co-produced in partnership with people with lived experience and professional experience. The comprehensive range of courses and workshops are open to all service users and carers, family, friends as well as those in the wider community outside of secondary services becoming a valuable inclusive community resource which supports the ‘Break The Stigma Initiative’.

2.88 The workshops are delivered in local, accessible venues across Bedford and support people to manage their own recovery journey. By offering choice, hope, control and self-determination an increasing number of service users, having attended recovery college workshops are now in the process of training to become involved in co-production initiatives within ELFT and the University of Bedfordshire.

2.89 The Break the Stigma Campaign lead was appointed in February 2016. Achievements have been made in raising mental health awareness and reducing stigma across Bedfordshire. The ‘Break the Stigma’ message boards are a great success and are recognisable throughout the county and are in place in all ELFT wards. Connections and collaborative work has reached many and varied organisations and people including; local services, local residents of Bedfordshire via
public events, MPs, Businesses, Police, University, Colleges, Schools, Minority Groups. A key recent outcome is that Thameslink have agreed to have Break the Stigma Boards sited at Bedford railway station that will include information about where to get help and support. In addition, the campaign has an ever increasing social media following and local media interest.

2.90 Mental health housing support through the Bedford Borough Council funded tenancy sustainment officer post. Initial focus on Community Mental Health Teams (CMHTs) caseloads and supporting a number of service users to maintain tenancies and prevent eviction / potential homelessness to facilitate:

- Discharge protocol in place for mental health in-patient units. Ensures early identification of homelessness/ housing need and avoids delays in discharge plans.
- Supporting people - working with the Borough to continue to develop a range of supported living opportunities.
- ELFT participation in the Bedford Supported Housing forum, CHIP.
- Homelessness bid- ELFT supporting and looking at homelessness outreach posts.

2.91 The CAMHS Transformation Plans to support early help is also progressing; with the successfully appointed dedicated CAMHS clinicians into early help teams in both local authorities. The focus is to be involved in the rapid access to targeted interventions for children which will be facilitated at an early stage of need. This will include joint health and social care assessments and consultation for the ‘Team Around the Child’, focusing on the principle of strong, collaborative partnership working between agencies. Recruitment for these staff is currently underway.

Bedford Borough Council Priorities from 2017

2.92 The ‘Five Year Forward View for Mental Health’ is one programme but contains different elements across the health and social care system for all ages:

- Strategic priority 1: more people will have good mental health
- Strategic priority 2: more people with mental health problems will recover
- Strategic priority 3: more people will have improved mental health and physical health
- Strategic priority 4: more people will have a positive experience of care and support
- Strategic priority 5: fewer people will suffer avoidable harm
- Strategic priority 6: fewer people will experience stigma and discrimination
- Strategic priority 7: Equality

2.93 Underpinning this is the Transforming Care Partnership (TCP) for Learning Disability Services and the Sustainability and Transformation Plan (STP) programme which are designed to ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England has produced a multi-year STP, showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

2.94 There are many objectives and commitments in the national plan that aim to deliver improved access to high quality care, more integrated services and earlier interventions. A common theme across many objectives is of building capacity within community based services to reduce demand and release capacity from the acute
sector and inpatient beds, whilst in parallel moving the commissioning model for inpatient beds in mental health towards a more ‘place based’ approach.

2.95 The Commissioning Intentions of BCCG are aligned to the Year 2 Mobilisation plans for ELFT and the required duties of Bedford Borough Council under the Care Act and form the basis for the priority areas for system wide local development:

1. Reviewing the Community Mental Health Services model
2. Developing Community Perinatal services
3. Enhancing Primary Care Liaison
4. Enhancement of Mental Health Street Triage
5. Enhancement of the Bedfordshire Academy
6. Roll out of the Recovery College
7. Review of Rehabilitation Units
8. Implementing a Carer’s charter
9. Implementation of CAMHS Transformation Plan
10. Enhancement of dementia assessment services
11. Review of Specialist Learning Disability Services
12. Developing Social Work framework
13. Developing a People Participation Strategy for Bedfordshire
14. Review of Crisis care concordat – Suicide prevention

2.96 It is envisaged that the full scale of this work will continue well into the delivery of the 7 year Contract with ELFT.

2.97 There is a need to move or prioritise funding (where possible and appropriate) to services that promote wellbeing for all Bedford citizens. Key to this is safely, and sustainably, shifting the balance of provision away high cost packages of care to early intervention and alternative types of community based support and living.

2.98 We also aim to strategically align and shape (using a co-production approach) housing related support provision across the Borough to ensure that there is a clear pathway and provision offer from acute settings to independent community living.

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**Physical Disabilities & Sensory Impairment**

**Introduction**

2.99 Bedford Borough Council, like many other Local Authorities is operating in challenging times. The Adult Services Directorate is facing an increase in demand for services at a time of financial constraint, due to Central Government budget reductions.

2.100 Our challenge is to deliver on specific physical disability and sensory impairment requirements ensuring they are included in the delivery of mainstream health and social care services. This will require an integrated approach across all agencies with a role in the health and wellbeing of the Borough.

2.101 Bedford Borough Council and Bedfordshire CCG have the key leadership roles in driving change forward and helping all relevant public, private and voluntary
organisations work more effectively together.

2.102 The current joint strategy, between Bedford Borough Council and Bedfordshire Clinical Commissioning Group demonstrates a continuing commitment to delivering services in an integrated way whilst supporting people with physical disabilities and sensory impairments, to live their lives the way they want to. The strategy complements the Borough’s Sustainable Community Strategy, the Joint Health and Wellbeing Strategy and the Bedford Borough Adults Services Plan.

2.103 This strategy is for all adults in the Borough with physical impairments and/or sensory impairments, whether the condition is congenital, acquired or progressive.

2.104 The Disability Discrimination Act (DDA) defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.

2.105 According to 2011 Census data, just over 16% of the Borough’s population reported having a long term health problem or condition which limited their daily activities (ONS, 2011).

2.106 The Borough is currently home to 1124 people with one or more sensory impairments. Of these, 93 people were registered deaf, five people were registered deaf/blind and 308 people were registered hard of hearing. There are 374 people registered blind in addition to those registered deaf/blind in the Borough and 344 registered partially sighted as at 30th November 2016.

2.107 It is worth noting that the prevalence of physical disability increases with age. In Bedford Borough in 2011, 50% of the population with a long term condition was over 65. (ONS, 2011)

2.108 Therefore, with our growing and aging population, this fact must be a central consideration in the commissioning and delivery of all services across sectors, requiring an innovative approach to the design and delivery of services. The current overall joint financial model of health and social care is not sustainable. The number of people with physical disabilities is likely to rise significantly, in line with the growth of the older population, requiring all service providers to think innovatively and provide better outcomes within reduced resources. For example, we know that the fastest population increases are in the numbers of those aged 85 and over (ONS, 2012). This is the age group most at risk of eye disorders causing vision impairment. There is a clear economic case for early and effective intervention (Boyce, 2011a; Access Economics, 2009) to prevent vision impairment and to overcome barriers experienced by people with sight loss.

2.109 As with older people we know that when there is a breakdown of care at home this can mean someone going into hospital or another higher cost alternative, unnecessarily. The prevention agenda is focused on ensuring, through services like those for Carers, advocacy services, and domiciliary care, that the right information, advice and support is provided to prevent the breakdown of care.

2.110 NHS Bedfordshire Clinical Commissioning Group’s, Commissioning Intensions, show their priorities supporting this direction of travel as follows:
• Targeting Prevention
• Care in the right place and right time
• Primary care development
• Transforming integrated community services
• System resilience
• Streamlining urgent and emergency care pathways

2.111 Individuals also have a role to play, within this context, by maintaining, as far as they can, their health and well-being and making use, to the extent appropriate in each individual's case, of the services available to reduce, prevent or delay the onset of ill health in general.

2.112 This represents a change in approach to care delivery. Services will support people with physical disabilities to maintain their independence, and to take a more active role in directing their own requirements and or care, promoting greater choice and control. People with disabilities will identify the outcomes that are important to them to preserve good health and wellbeing with the aim of making a positive contribution in their chosen way.

2.113 The Borough’s Health and Wellbeing Strategy has a keen focus on independence, emphasising the need for services to be accessible to all, with factors including geography, opening hours and access for people with disabilities as central to provision. As the prevalence of disability increases with age, so helping older people with physical disabilities to maintain a healthy independent life for as long as possible, as detailed in the strategy, must be a crucial consideration in service design. This is underpinned by the prevention agenda, and the notion of self-care, which focuses on empowerment of the individual, enabling them to manage appropriate elements of their health.

2.114 This provides the direction of travel across Health and Social Care and subsequently, with all our partners including those from voluntary, charitable and private sector organisations. Fundamental to our success in continuing to deliver quality services in this context is the ability of colleagues across all sectors to respond proactively and innovatively to the challenges which we face, together.

2.115 The shift in expectation from caring for people to encouraging participation and independence will signify a significant change in commissioning in future years. Staff will need to have different attitudes and behave in different ways to improve outcomes for people. In turn, this has workforce recruitment, training and development implications across services from third sector support to health and social care delivered in the community as well as that delivered in hospital. There will be a strong focus on rehabilitation and reablement support for older people as well as individual and service outcomes.

‘As is’

2.116 Care is provided through the Physical Disabilities team for people aged 18 to 65 years old, with the aim of helping people to live safely and independently. Dependent on need, a person may be offered one or more of the following options: A Direct Payment, Home Care, Day Care, equipment including telecare, meals at home, Residential or Nursing Care. Referrals for Sheltered Housing may also be supported. The team work closely with other community services provided by our health
colleagues such as Doctors, Nurses, Occupational Therapists, Physiotherapists, Care Agencies and other specialist services in the community including voluntary sector services. The Sensory Impairment team also provides a range of services including: Early intervention services such as mobility and orientation, Assistive Technology, Advice and Information, Welfare Advice, Personal Budgets and adapting spoken and written English for BSL users.

Current issues:

- Sections of health, social care and housing do not collaborate effectively, working in isolation.

- People who are diagnosed with sight impairment are not always certified and registered and therefore are not always aware of available service and support they can access. There can be blockages in the system preventing relevant sight loss data flowing through the whole eye health and sight loss pathway, in turn impacting on the ability to put preventative measures in place.

- Whilst good progress has been made in relation to the review of equipment provision in the community, there remains room for improvement. Equipment items need to be reviewed more systematically by all partners involved in its allocation, decommissioned and recycled as appropriate to better manage resources.

- Bedford Borough is home to an estimated 2087 people living with dementia. Numbers of people living with dementia are increasing and will continue to rise in the future. At the same time we face a need to reduce the rate of people moving into residential and nursing care, and ensure that as many older people as possible are able to receive good care in their homes or communities.

- The government’s dementia diagnosis target of 67% is not currently being met for the region, which means that post diagnostic support is not being accessed. This number needs to be increased in collaboration with our health and third sector and voluntary providers.

- We know that the prevalence of disability increases with age. Deprivation amongst older people is located within the urban areas of Bedford Borough with 13.5% of older people considered to be experiencing income deprivation. It is known that people from income deprived backgrounds experience a higher incidence of poor health and long term conditions, whilst simultaneously, accessing preventative services in lower numbers than the rest of the population. Increased access to services is one of our key strategic aims as part of the prevention agenda.

- Older people are now becoming known to us, in increasing numbers, at a later stage in life and enter the system with more complex care needs many of which will incorporate a physical disability. There is a need to engage and improve access to services to enable prevention interventions to take place.

- There are significant challenges for the local authority within the care industry. Recruitment and retention of the necessary levels of care staff with the right skills, presents an ongoing concern.
• Increasing numbers of older people requiring access to reablement or enhanced reablement.

Recent developments in response to the current context:

2.117 Bedford Borough’s telecare provision underwent a thorough review in March 2016. The review found that the current service offered is of a good standard and demonstrated that it has a significant impact on increasing and maintaining the safety and independence of those using it. This, in turn, has reduced adult social care costs, as a direct impact of measures put in place to enable people to maintain greater control over their lives.

2.118 Report recommendations: The review highlighted the considerable benefits of:

• An integrated approach to telecare, working with health
• Expansion and promotion of telecare services in different ways,
• Targeting difference audiences, with greater precision.
• Access to services should be varied, providing different entry options to meet the needs of different customers including service users, private users and the broad range of professionals accessing telecare.

2.119 A paper has been submitted to the Better Care Fund Board to explore the possibility of advancing the above recommendations.

2.120 Carer’s services have been re procured and reorganised to meet the needs of the changing demographic, targeting resources on prevention and those in crisis as well as supporting those not in crisis but with ongoing needs.

2.121 The Bedfordshire and Luton Community Equipment Service are commissioned by a consortium between Bedford Borough Council, Bedfordshire Clinical Commissioning Group, Luton Clinical Commissioning Group, Central Bedfordshire and Luton Borough Councils.

2.122 The service has been re procured in line with our strategic objectives with customer and partner feedback including health, central to the specification redesign.

2.123 Access to service provision has been improved and now incorporates support from a qualified clinician (employed by the provider) for specialist equipment. Clinical assessments can now also be held at the depot. This contract includes an option to develop telecare services in the future.

2.124 Bedford Borough Council was awarded the International Glaucoma Association award for commitment to raising awareness of glaucoma in 2015.

2.125 The Bedfordshire Eye Care Working Group is a partnership of eye care professionals including BBC Sensory Impairment team, Moorfields Eye Hospital, and a number of voluntary and third sector organisations specialising in eye health. The group has held a numerous prevention led eye health awareness raising events including: glaucoma awareness, sight testing for children, as part of a long term prevention strategy following children into adulthood and similarly, worked in partnership with Moorfields Charity to deliver the Eye Heroes programme in Bedford Borough with
Health Watch Bedford. This took place in many of the borough’s schools and targeted children and their adults, highlighting the importance of regular sight tests and eye health.

2.126 Bedford Borough Council is working in partnership with the newly formed Dementia Action Alliance to further develop the independence of people with dementia aspiring to work with the local community and local business, to develop dementia friendly communities.

2.127 Joint Dementia Strategy review is underway.

2.128 The procurement of advocacy services is in process.

2.129 A new Home Care Framework has been designed and commenced in October 2016. The framework incorporates the introduction of three geographical areas, in an attempt to address the following issues:

- Finite numbers of carers spread too thinly across too many agencies.
- The approval process now reflects new policy pressures, for example, the Better Care Plan, prevention agenda and staff conditions.
- Reduced the gaps between home care and community and primary health care.
- Focus on reduction to hospital admissions.
- Supported the joint vision of the Council and the CCG as described in the Better Care Plan for Bedford Borough.
- Reduction in inefficiencies with providers picking up packages dotted about with no critical mass in a particular geography.

Aims and objectives

2.130 The NHS QIPP Programme (Quality, Innovation, Productivity and Prevention) is a large scale transformational programme for the NHS, involving all NHS staff, patients and partners and involves improving the quality of care the NHS delivers whilst delivering significant savings. The Borough Council continues to work closely with Bedfordshire Clinical Commissioning Group implementing the QIPP Plan locally and is particularly supporting the re-design of services for people who have had strokes, people who have fallen or who are at risk of falling, people who are at the end of their lives and people who live with long term conditions and is looking at the potential to align certain social care services more closely with NHS services.

2.131 This involves the revision of commissioning intentions associated with the following work streams (this list is not exhaustive) which support the Joint Commissioning Strategy for Physical Disabilities and Sensory Impairment:

- Stroke Development Programme
- Telehealth
- End of life care
- Falls and fragility
- Rehab and Enablement
- Expansion of personal health plans
- Expansion of personal health budgets
- LTC for COPD
- LTC for Diabetes
• Problems with vision
• Target our work with people with life limiting conditions such as stroke by redesigning and coordinating the stroke pathway across social care, health and the third sector.

• Ensure that people with disabilities are part of and have access to mainstream health and social care services.
• Reshape our reablement model for people with physical disabilities providing enhanced reablement for people with more complex reablement needs.
• Reduce the current fragmentation between services, securing a more integrated approach to service delivery;
• Provide clear care pathways through physical disability services, so that, irrespective of how people enter services, there is a shared understanding of how people will be supported to move through those services from hospital discharge to reablement or rehabilitation, or to the community, without being blocked or delayed by organisational boundaries;
• Refresh the Joint Commissioning Strategy for People with Dementia in Bedford Borough, and work with partners to develop community dementia initiatives which raise the profile of dementia and create dementia friendly communities.
• Explore with health the possibility of broadening our telecare offer include telehealth services increasing the independence of people with physical disabilities.
• Improve the service user’s experience of care and support services;
• Deliver outcomes that meet rising demands within available budget.
• Focus on improving the outcomes that services achieve for people with physical disabilities and sensory impairments, rather than on the detail of how they are structured, encouraging greater innovation;
• Move more health provision into the community;
• Educate, inform and involve the community in improving their own health and wellbeing by addressing issues;

Strategic Priorities of Bedford Borough Council

• Strategic Priority 1: Improving the employment chances of people with Disabilities and sensory impairments
• Strategic Priority 2: Improving the provision of equipment and Telecare / telehealth
• Strategic Priority 3: Improving access to personalised services in the Community, so that people with disabilities can have the same choice and Control over their lives as people without disabilities.
• Strategic Priority 4: Improving the provision of suitable accommodation in the community.

‘Making choice a reality for disabled people’

2.132 Continue the focus on promoting choice and control for disabled people, when designing and commissioning future provision with recognition of the lack of choice and control that disabled people have compared with non-disabled people. Service providers across all sectors should be mindful that this is partly due to support needs often being met in ways that do not put disabled people in control.
UK Vision Strategy

- Strategic priority 1: Everyone in the UK looks after their sight and their eyes.
- Strategic priority 2: Everyone with an eye condition receives timely treatment and if permanent sight loss occurs, early and appropriate services and support are available and accessible to all.
- Strategic priority 3: A society in which people with sight loss can fully participate.

2.133 Bedford Borough Council and Bedfordshire Clinical Commissioning Group’s 2016/17 Better Care Plan identified a number of system challenges and constraints. In order to address some of these challenges and deliver the improvements emphasised by our patients, providers and stakeholders, our 16/17 BCF Plan focuses on three key themes to help deliver improvements. The three themes contribute to the overall programme of change for Bedford Borough and build on last year’s progress to look forward, in line with the Five Year Forward View, to integration by 2020.

2.134 The three key themes are:
- Improving out of hospital care
- Prevention
- Protecting social care

Within these themes we have identified specific projects and developed plans for delivery.

These specific projects are:
- Multi-Disciplinary Team Working
- Maximising Independence through supportive technology (MIST)
- Improving outcomes for stroke survivors
- Improving delayed transfers of care
- Improving the End of Life Service
- Improving the falls service
- Enhanced reablement

Public Health

Issues/Need for this client group

2.135 The health of people in Bedford Borough has improved in recent years, with falling death rates from stroke, cancer and heart disease. Life expectancy for both men and women is higher than the England average, and is increasing. However, women from the most deprived areas of Bedford Borough are predicted to live on average 10.1 years less than those from the least deprived areas. For men, the gap is 7.1 years.

2.136 Currently in England, the average number of years a man can expect to live in good health is 63.3 years, compared with an average life expectancy of 79.5 years. Bedford Borough was above midway in the ranking of 149 upper tier local authorities in England from 2014 to 2016, where men could expect to reach just over 63.8 years in good health, compared with an average life expectancy at birth of 80.1 years. Women could expect to reach 64.4 years of age in good health, compared to an
average life expectancy of 83.4 years.

As is

2.137 Universal public health services are commissioned to improve health and wellbeing overall, taking the Council’s statutory responsibilities and the Public Health Outcomes Framework as a starting point.

2.138 A number of public health services are targeted to ensure that they are most appropriately supporting vulnerable groups.

2.139 Where possible services are integrated into existing mainstream services and delivered at neighbourhood level, taking public health work into the heart of local communities.

Priorities

2.140 Bedford Borough’s Health and Wellbeing Strategy identifies the top priorities for improving health and wellbeing in the Borough. The overarching ambition of the Health and Wellbeing Board is to improve the health and wellbeing of our residents and reduce health inequalities. To achieve this we will maintain a life course approach by ensuring our plans are targeted at critical points throughout life, thereby:

1. Giving children and young people the best start in life
2. Enabling adults and older people to live well and remain independent

As health is also shaped by the conditions in which we live, the extent of our social connections, and whether we have stable and supportive work, the so-called wider determinants of health, a third priority has also been included:

3. Promoting strong, safe and healthy communities.

Three cross-cutting themes run through the three priorities of our Joint Health and Wellbeing Strategy. First, we recognise the need to embed prevention and early intervention throughout our services, in order to reduce the burden of ill health and need for costly health and care services. Second, we know there can be no health without mental health and so we will work to ensure lifelong mental wellbeing and resilience. Third, we understand that in order to reduce health inequalities, we must target our resources proportionately towards the most disadvantaged and be mindful of the likely impacts of our plans on our most vulnerable groups.

2.141 Public Health currently commissions the following public health services:

- An integrated weight management service which includes children, young people and their families, and adult weight management
- An integrated contraception and sexual health service for people of all ages
- An integrated drug and alcohol early intervention and treatment service for adults; specialist support, advice, mentoring and advocacy service (SAMAS) for individuals, carers and families recovering from drug or alcohol misuse; and support for young people having problems with their own, or others, drug and/or alcohol use
- Level 2 (Primary Care) and Level 3 (Specialist) Stop Smoking Services
- NHS Health Checks
• The 0-19 Healthy Child Programme, incorporating the Health Visiting Service and the School Nursing Service

Homelessness and Supported Housing

Issues/Need for this client group

2.142 Like many urban areas, Bedford Borough has a growing problem with homelessness. In 2015/16 there was a doubling of the number of rough sleepers and a 44% increase in the number of homeless households presenting to the Council. This trend has continued into 2016/17 with further increases in homelessness and rough sleeping. We know that as a council we can’t tackle this alone which is why we are involving all the partners to play a part in helping address the difficult challenges of homelessness in our area. In October 2016 we launched a revised homelessness strategy 2016-2021 which outlined the plans for tackling homelessness and rough sleeping in Bedford in partnership with all relevant stakeholders.

2.143 The Homelessness Strategy 2016-21 has 3 themes which follow those set out in the 2006 Code of Guidance. These are:

• Prevention - the prevention of homelessness.
• Support - the provision of effective support to people who are homeless or those at risk of homelessness.
• Supply - to ensure that there is sufficient supply of accommodation for those at risk of homelessness and those who are homeless.

2.144 The Supporting People Strategy 2017-22 sets out the vision for housing related support services in Bedford Borough:

‘To provide accessible high quality and cost effective housing-related support for vulnerable people that promotes independence, social inclusion and complements other services. Working in partnership with stakeholders and in consultation with service users, we will ensure services respond to local need, are accessible, equitable, flexible and provide the best possible outcomes for those who use them.’

2.145 Housing related support services in Bedford compliment the homelessness and rough sleeper provision and are an essential part of the solution to tackling homelessness and rough sleeping.

Context

2.146 People approach Homelessness services for a variety of reasons, including possession or eviction, loss of lodgings (family, friends or relatives are no longer able or willing to accommodate them); relationship breakdown or domestic violence.

2.147 Domestic abuse remains a significant reason why households are accepted as homeless in Bedford Borough with 25% of acceptances in 2015/16 being attributed to domestic violence. Between 2014/15 and 2015/16 there has been an increase of 55% of people presenting with complex needs (this includes physical disability, mental illness or disability, drug and alcohol dependency).

2.148 Although the 2015 Homelessness Review indicated many positive developments, the
most recent statutory rough sleeper headcount in November 2016 showed that 59 people were sleeping rough on the night of the count in Bedford Borough. This is an increase on the count in November 2015 of 51. It continued the upward trend since November 2014 when there were 25 rough sleepers counted in Bedford. This demonstrates a 136% increase in rough sleeping in two years.

2.149 The criteria for the count are such that this is likely to underestimate the true total numbers of rough sleepers, and many homeless people do not actually sleep rough, the so-called ‘hidden homeless’ who may be sofa surfing or living in unsecure accommodation. During the operation of the Severe Weather Emergency Protocol over the winter of 2015/16, 79 people accessed emergency overnight cold weather provision.

2.150 In 2014/15, the Council’s homelessness service had 366 applications of which 164 were accepted. In 2015/16, there were 529 applications, with 292 accepted as homeless, representing a 44% increase in homeless presentation and a 78% increase in acceptances on the previous year. At the end of December 2016 there were 84 homeless households who have been assessed as being owed a full rehousing duty under the Housing Act 1996, and were being accommodated in temporary accommodation. There were a further 93 households who were homeless at home as at the end of December 2016.

2.151 The Council has focused upon the prevention of homelessness and there were a significant number of households placed directly into housing related support that were accommodated and supported without having to go through the homeless process.

2.152 The Council currently commissions 167 bed spaces in a range of housing related support schemes including specialist accommodation for rough sleepers, people with mental health needs, young people, and people fleeing domestic abuse.

Priorities

2.153 Tackling the increase in homelessness and rough sleeping by improving the provision and support available is a major priority for us. We recognise that this requires a collaborative approach, sharing investment, through a broad range of partnerships including business, higher education and faith and voluntary sectors.

2.154 The growing number of rough sleepers gives rise to a need to ensure that commissioning priorities and any additional investment are focused on activity which reduces the numbers of people sleeping rough and supports move-on pathways. To this end the Council has led and been successful in obtaining funding from central government to develop a rough sleeper outreach service with embedded mental health support over 2017-19. This will be delivered over the Sustainable Transformation Partnership area of Bedford Borough, Central Bedfordshire, Luton and Milton Keynes Councils with the respective Mental Health Trusts.

2.155 The Council has long recognised the need for a jointly commissioned complex needs unit to assist individuals who have multiple needs and are often accessing inappropriate high cost care and health facilities. The complex needs unit is now in development and will be completed at the end of 2017 providing 12 units of complex needs support and a further 19 units of medium to high needs accommodation.
2.156 The total 2016/17 spend for housing-related support, which includes both accommodation and floating support is £2,410,460. In addition to this the Council directly spends £1 million per annum on discharging its statutory duties providing emergency and temporary accommodation as well as loans and deposits to prevent homelessness. Of this spend around £600k per annum is recovered as income. The Council is continually assessing how to effectively use these resources to assist homeless households and rough sleepers and will look at innovation that is being developed in other local authority areas.

2.157 Bedford Borough’s Homelessness Strategy 2016-21 highlights the linkages to other key strategies; including Bedford Borough’s tenancy, Housing, and Supporting People strategies as well as broader reform programmes and new ways of working, such the Early Help approach.

2.158 The Homelessness Strategy outlines a range of objectives for improving outcomes for households who are homeless or at risk of becoming homeless in the area:

- To continue to prevent homelessness and help people sustain their tenancies by early intervention and providing good quality advice and support services.
- To ensure that there is sufficient supply of temporary accommodation for those who are homeless.
- To commission support services for people who are homeless or those at risk of homelessness.
- To support an appropriate range of hostel and specialist accommodation including the provision of a Complex Needs Unit.
- Continue to take a proactive and innovative approach to dealing with the impact of welfare reform to ensure its potential to impact on homelessness is minimised.
- To encourage the provision of debt and welfare rights advice services.
- To work to inform expectations surrounding housing availability and tenure particularly among young people.
- To provide continuing support for young people at risk of homelessness.
- To look for new and innovative ways to prevent homelessness and help tenants remain in their homes.
- To continue to work with owner occupiers at risk of mortgage repossession.
- To maintain a pro-active approach to reducing rough sleeping.
- Continue to support families who have suffered domestic abuse.
- To improve information sharing regarding release programmes for people leaving Care and institutions’ such as the Hospital, Prison and the Armed Forces.
- To ensure that the homelessness services offered by Bedford Borough Council are available equally to all members of the community.
- To continue to support the Mental Health Partnership to re-house single people with mental health problems, and provide ongoing support from mental health professionals to help maintain tenancies created.

2.159 The Council will commission services that support and directly contribute to meeting the objectives set out in the Homelessness Strategy 2016-21 and set out in the Supporting People Strategy. Furthermore commissioning activity around homelessness services will be underpinned by the following key principles:

- Enables resources and investment to be aligned to specific outcomes across strategic partners.
- Based on a robust analysis of need and intelligence, focused on evidence based interventions, and guided by early help and prevention.
- Puts citizens at the centre of commissioning.
- Assures high quality provision by specifying outcomes and using effective financial mechanisms.
- Will be underpinned by social value and local benefit.
- Demonstrates a strategic linkage to national, regional and local levels.
Working with us

For further discussion you and your organisation can book a personal appointment to discuss how we can work with you as a potential care partner. We particularly wish to meet with:

• Partners who are keen to pursue new and innovative ways of co-producing and delivering public services within the community.
• Organisations which are keen to form strategic alliances or consortia with others, either locally or across a wider area.
• Partners interested in developing extra care housing for sale and lease
• Partners interested in developing specialist supported residential models for people with Learning Disabilities and/or autism
• Residential care partners who wish to diversify their care offer
• Home care partners who feel they could take on a wider range of services, including extra care and early intervention and prevention –based services
• Community-based partners for close-to-home learning disability support
• Community organisations that wish to extend their work in dementia care
• Organisations keen to diversify (i.e. utilise more Assistive Technology, or children’s service partners providing services for adults and vice versa)
• Schools and other community hubs interested in contributing to early intervention and prevention efforts to improve children’s outcomes

Contacting and Connecting with Commissioners

Enabling Services

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## Useful Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>URL</th>
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<tbody>
<tr>
<td>Clinical Commissioning Groups (CCGs)</td>
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<tr>
<td>Adult Services and Health Overview and Scrutiny Committee</td>
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