Central Bedfordshire

NHS
Bedfordshire
Clinical Commissioning Group

Central Bedfordshire Better Care Fund Plan 2016/17

Narrative

Contents:

1. Introduction

This is the second Better Care Fund Plan for Central Bedfordshire. This Plan remains consistent with the priorities and outcomes of the Health and Wellbeing Board and is focused on the progressive integration of health and social care services through the Better Care Fund.

The 2016/17 Plan builds on the approved Better Care Fund plan for 2015-16.
It does not re-iterate all base-line information that formed part of the first plan. The Plan responds to the national requirements for Health and Care systems to produce a short, jointly agreed narrative plan including details of how the national conditions are being addressed.

In line with the 2015/16 BCF Plan, this narrative plan sets out:

- The local vision for health and social care services showing how services will be transformed to implement the vision of the Five Year Forward View and moving towards fully integrated health and social care services by 2020, and the role the Better Care Fund plan in 2016-17 plays in that context;
- The evidence base supporting the case for change;
- A coordinated and integrated plan of action for delivering that change;
- A clear articulation of how each national condition will be addressed;
- An agreed approach to financial risk sharing and contingency.

The Better Care Fund will create a pooled fund of £20.534m in 2016/17 to support the delivery of integrated care. This is made up of a contribution of £ 5.258m from Central Bedfordshire Council and £15,275m from Bedfordshire Clinical Commissioning Group.

This narrative plan does not restate information that is already satisfactorily provided in existing plans or previously set out in the 2015/16 BCF Plan. It however recognises the need for alignment of Plans across local health and care agencies and the national strategic drivers that influence them.

Cllr Maurice Jones
Chair
Central Bedfordshire Health and Wellbeing Board

2. The Vision for Integrated Care

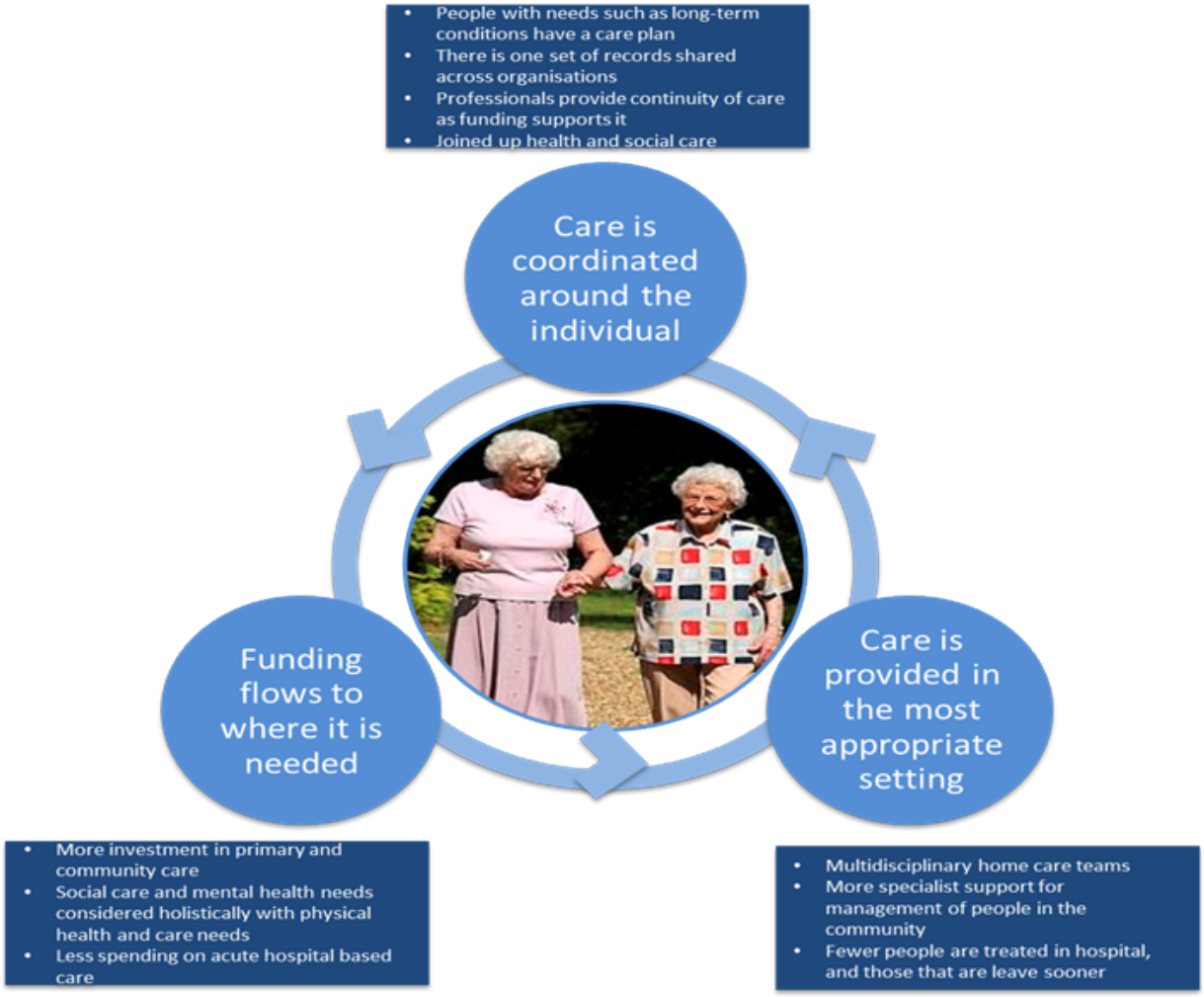
2.1 Vision for health and social care services

Our Better Care Plan is based on the overarching ambition to secure a fundamental shift in the ways in which care and support is provided to residents of Central Bedfordshire. It sets out a shared vision and ambition for transformational change across health and social care rooted in a locality based delivery model. Care should be coordinated around the full range of an individual's needs with prevention and support for maintaining and maximising independence remaining central.

We recognise the need to deliver these changes at some pace, underpinned by the following principles for integrated care with:

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

These principles are reflected in the diagram below.



2.2 Key Priorities

Central Bedfordshire's agreed strategic approach is based on four key priorities for delivering integrated care at scale and pace.

In setting out the four priorities below, we recognise the importance of reducing reliance on hospital services. By developing greater range and capacity in community-focused care it will be possible to deliver improved health and care experiences as well as more effective use of resources by:

1. **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.
2. **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.
3. **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.
4. **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 2014..

These are the overarching priorities which are central to the outcomes the local health and care economy wishes to achieve for the local population. Three key themes which will help to secure these outcomes in 2016/17 are set out in Section 4 below.

2.3 BCF Patient and Service User experience and outcomes

Our Better Care Plan themes will ensure, over time that the discrete silos of current health and care provision are replaced with a model of care aimed primarily at supporting patients to be self-caring, independent and less reliant on acute or specialist intervention. There will be better, more timely and accessible information and community services. The focus of this would be to enable people to have healthier lifestyles and manage their long term conditions more effectively.

Unplanned emergency admissions would be avoided. Quality of life would be improved and people supported to live independently in their own homes for as long as possible. By 2019, our journey from fragmented working to an integrated and person-centred approach will be fully embedded. These changes in the way services are organised will mean our population will:

- Experience **seamless access to a timely, coordinated offer of health and care support**.
- Have **access to a wider range of support to prevent ill-health**, with increased emphasis on early interventions supported by voluntary, community and long-term condition groups, enabling them to stay healthier for longer;

- Be **supported to remain independent with integrated GP and community multidisciplinary teams** delivering care directly **within their own home** wherever it is possible to do so;
- 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 lifestyle Hubs.
- Have access to **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**.

Central Bedfordshire Council is implementing the "Making it Real" Markers for change and is working across the health and care economy to secure the outcomes and values set out in the National Voices document.

2.4 Locality Based Integrated Health and Social Care Services

The local shared vision is for health and social care rooted in a locality-based delivery model. In Central Bedfordshire there are four existing and well-defined population centres based around the towns of

- Dunstable and Houghton Regis,
- Leighton Buzzard and Linslade,
- Ampthill and Flitwick,
- Biggleswade and Sandy.

These population centres form the basis of well-established localities (Chiltern Vale, Leighton Buzzard, West Mid Beds and Ivel Valley) that are to be the focus of developments in health and social care. The Council's older peoples and disabilities services are coterminous with these localities.

We have already established integrated health and social care locality arrangements in the Chiltern Vale area and experience gained is supporting the expansion of this approach across the rest of Central Bedfordshire.

Our Caring Together programme (formerly Demonstrator project) involves two pilot schemes across GP Practices in Chiltern Vale and West Mid Beds. We have introduced Multi-Disciplinary Team (MDT) working to provide an integrated response to those patients most at risk of admission and other people who would benefit from a more joined up response. Lessons from the pilots are also informing a current transformation of community health services as well future procurement.

Locality arrangements are central to responding to local demographic pressures and the increasing complexity of existing pathways within health and social care. The strategic review of healthcare services in Bedfordshire and Milton Keynes indicated that locality based integrated care hubs are fundamental to achieving sustainability in our local health and care system.

The Health and Wellbeing Board, Council and the CCG wish to ensure that the population of Central Bedfordshire has access to good quality, safe, local primary, community, health and social care across the towns and rural areas. The framework for achieving this is through a number of primary care led Integrated Care Hubs that are based, in the first instance on our four Localities.

2.5 An Integrated Health and Care Hub in each locality

The proposed initial configuration of hubs is set out in Figure One. Strategically, we recognise that the number of hubs would increase in line with housing and population growth.
The hubs would provide a range of medical, nursing and social care interventions to support their local population, providing access to full range of health and care needs, including:

- A wider range of primary health services ;
- Accommodation for groups of practices who wish to co-locate under one roof;
- Improved access to GPs through extended hours, out of hours and walk-in services;
- A focus for management of more complex long term conditions including dementia care;
- Clinically-led locality multi-disciplinary teams (MDTs)
- Access to community and mental health care services;
- Social care services, including occupational therapy, reablement, and children's support;
- Access to all out of hospital care services and hospital specialists;
- A single platform supporting information sharing across multiple organisations and providing access to integrated data sets for patients.

These would operate seven days per week and would prevent people, especially the elderly frail, making unnecessary journeys to hospitals. Only those requiring expensive diagnostic equipment or hospitalisation would need to be transported out of their local areas, freeing up the ambulance services to focus on those with very acute needs. We would want to explore the use of technology to help deliver our "hospital without walls" concept.

In each locality, it is anticipated that some Practices will co-locate within new hub facilities whilst the remaining practices will stay in their existing premises in a hub and spoke type model. In Dunstable five town-centre practices are signed up to co-locate in a hub type facility whilst five other practices will use the hub services listed above.

We are developing new models of delivery including: access to diagnostics, salaried GPs, specialised GPs, specialist nurses, geriatricians, therapists, social care staff, information and advice. We are considering including the assessment of housing needs and prevention of homelessness within this approach to provide a holistic approach. This would better meet the requirements of the Better Care Fund Plan which sees housing support, such as Disabled Facilities Grants for adaptations, as an important component of integrated outcomes. This would sit alongside access to community equipment and low level minor works to properties, which enables people to leave hospital early or delay the need for institutional care. We are aware of the developments in other areas around elderly medical units without inpatient beds and would want to see access to this type of support.

These hub services will be underpinned with a shared record system and informatics platform. An integrated shared care record accessed through a flexible web based portal will provide timely

access to information and enhance joint working between health and social care teams. We will be developing our digital roadmap as required by the national conditions. Although this is very much in the early stages and will require resources and support to secure this effectively across our health and care system

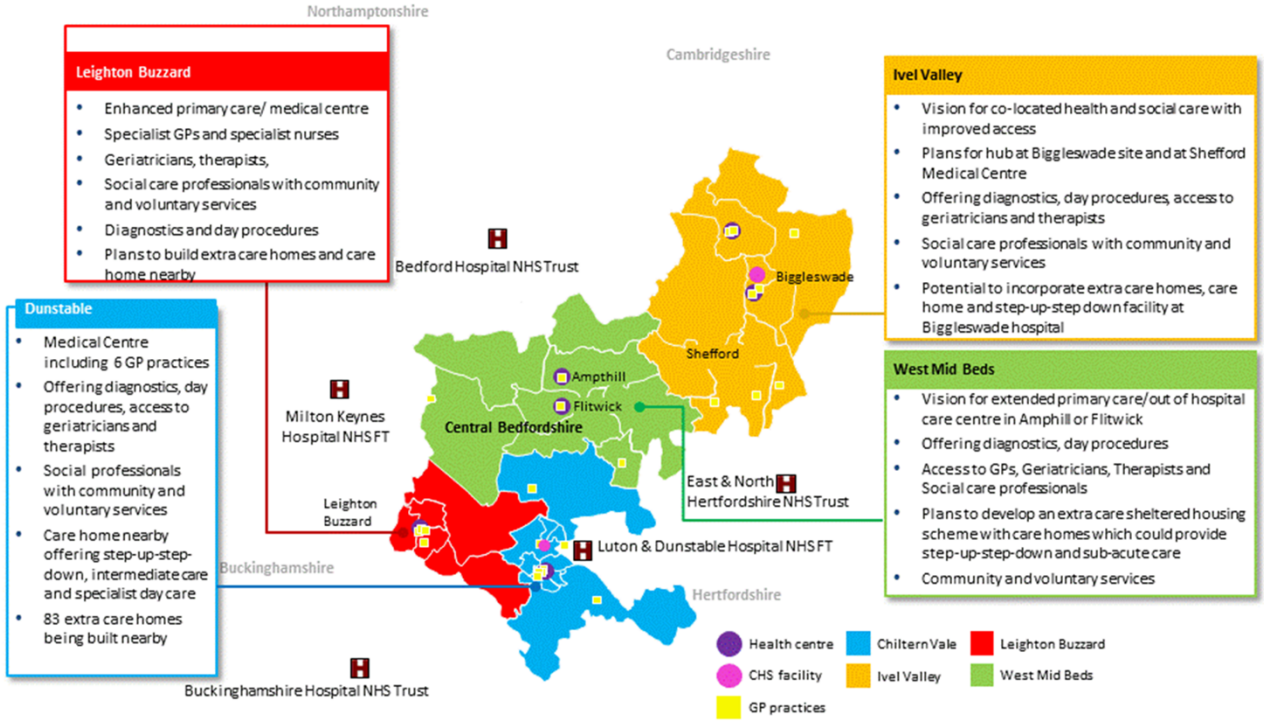
We are exploring the models available as announced in the NHSE Five Year Forward View and more recently the GP Forward View, to underpin the integration of services needed to make the most effective use of these hub facilities.

The configuration of hubs and services proposed across all of Central Bedfordshire are set out below. Business cases are currently being developed for two of the hubs.

Figure One

A

Proposed Model and Locations for Integrated Care Hubs in Central Bedfordshire



2.6 Progress on developing Locality based Integrated Care Hubs

Chiltern Vale (Dunstable) Integrated Care Hub :

Following a successful bid to the 2015/16 Primary Care Infrastructure Fund, work is now on going to develop the Outline Business Case (OBC) for the Dunstable Integrated Care Hub; this work is being undertaken by Capita. Work is focused on the development of progressive care models and accommodation requirements. All stakeholders across acute, primary, community and social care are involved.

A further options appraisal is being commissioned for the development of a 'spoke' to the Dunstable Hub, in Houghton Regis to meet a significant increase in housing growth.

The practices will develop closer working relationships (organisational form to be developed) over the next year so as the planning for co-location evolves to maximise resources, deliver seven day services and collaborative approaches to shared facilities, including IT and back office functions.

Ivel Valley (Biggleswade) Integrated Care Hub:

A Project Initiation Document (PID)to the Primary Care Transformation Fund in 2016/17 has been produced and is ready for submission once the NHSE 'portal' is open. In the meantime, work has also started on developing a strategic business case for the future of Biggleswade Hospital as an integrated care hub. This work is directly linked to the One Public Estate Programme across Central Bedfordshire. The Council has supported the refurbishment of a new Ivel Medical Centre which will host both health and social care staff and facilitate joint working as a precursor to MDT development. This provides an important template for co-location and multidisciplinary working and is in line with the GP Forward View.

West Mid Beds (Ampthill and Flitwick) Integrated Care Hub: The CCG has started an Estates Review for West Mid Beds. A feasibility study and options appraisal around the future configuration of GP premises in the Mid Beds Area, in particular addressing planned housing growth and also to consider feasibility of co-locating a number of surgeries into integrated Health and Social Care Hubs is to be commissioned.

2.7 Alignment of BCF with NHS Five year Forward View

Our Central Bedfordshire BCF Plan is directly aligned and contributes to the delivery of national health and care strategy, as set out in Delivering the Five Year Forward View, published in December 2015. https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf which sets out a new shared vision for the future of the NHS based around new models of care and national 'must dos' for 2016/17. Our BCF Plan aligns closely to other programmes of work including the new models of care as set out in the NHS Five Year Forward View and delivery of seven-day services and reinforces the ambition that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care.

We have established a programme of transformational change that focuses an out of hospital strategy around the needs of people with long term conditions and delivers a journey for the integration of health and social care services. Our local health and care system leadership is focused on securing a whole system approach from 2017-20 and a move on from existing BCF programme management.

2.8 System Sustainability and Transformation Plan and the Bedfordshire and Milton Keynes Healthcare Review

The Sustainability and Transformation Plan [STP] covers the period between October 2016 and March 2021. STPs will become the local whole system blueprint for accelerating the implementation of the Forward View, to deliver the triple aim of better health, transformed quality of care delivery, and sustainable finances.

A transformation footprint for the STP has been defined locally covering Bedfordshire, Luton and Milton Keynes. Place-based planning on this scale recognises the work being undertaken within the healthcare review of services in Bedfordshire and Milton Keynes. The footprint recognises significant patient flows across Bedfordshire to both Bedford Hospital and the Luton and Dunstable Hospital and reflects the planning footprint for the development of our learning disability transforming care programme.

As NHS planning guidance suggests, the STP will be an umbrella plan, with differing levels of shared planning. Transformational change for care pathways such as urgent and emergency care will be mapped across this broad footprint. Area specific plans for Primary Care and out of hospital services will be described at local authority and CCG level and set out within our Better Care Fund Plan and emerging Integration Plan. This is particularly relevant for Central Bedfordshire's population in view of patient flows to hospitals outside of the local STP footprint.

3. The Case for Change

3.1 Evidence Base - Population and Health Indicators

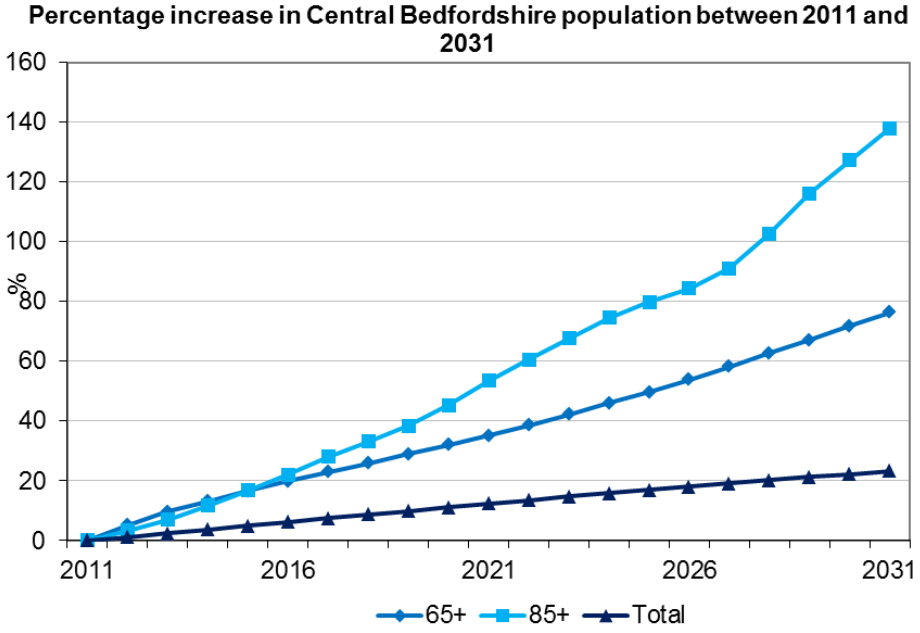
This section sets out the challenges facing our local NHS services, and the opportunities for transformation.

The Joint Strategic Needs Assessment (JSNA) provides a comprehensive picture bringing together about the health and wellbeing of the people living in Central Bedfordshire.
https://www.jsna.centralbedfordshire.gov.uk

A summary of the principal demographic and health characteristics are described below

- Growing population due to increasing life expectancy, a birth rate higher than deaths and inward migration
- In 2014 population of 269,000, with an increase of 6.3% by 2021. Older age groups will increase at a higher rate (65 + by 32.7%, 85 + 52.1%).
- Average life expectancy is 81.5 years for men and 83.8 years for women), better than the national average. Life expectancy is increasing at the rate of about 4.0 years for men and 2.1 years for women each decade.
- The main causes of death under 75 are cancer, heart disease and stroke.
- The largest towns in the area are Dunstable (33,805), Leighton Buzzard (32,753) and Houghton Regis (16,970).
- The population is 89.7% White British, with White: Other White (2.8%) and White: Irish (1.2%) being the largest minority groups.
- The number of people registered with Central Bedfordshire General Practices in early 2014 was 282,059

As the graph below shows, the overall population is expected to grow by over 23% between 2011 and 2031 compared to the number of older people aged 85 and over which will grow by 138% by 2031.



Central Bedfordshire is an area of significant opportunity with planned housing and employment growth and is a desirable place to live. Although Central Bedfordshire is a relatively affluent area with life expectancy that is greater than the national average, there are significant challenges resulting from an ageing population and pockets of urban and rural deprivation.

Demands on services for older people with disability and frailty will increase. Mental health problems, particularly depression and dementia, are more common and have a worse outcome in the 60% of older people who suffer from long standing illnesses. The prevalence of dementia across the UK is estimated at over 700,000 and predicted to reach 3,600 in Central Bedfordshire by 2020. Only one third of sufferers receive any form of formal diagnosis at any point in their care or during the progression of the condition. Evidence suggests that early diagnosis and treatment is vital and can improve the quality of life for people and increase their independence as the condition progresses.

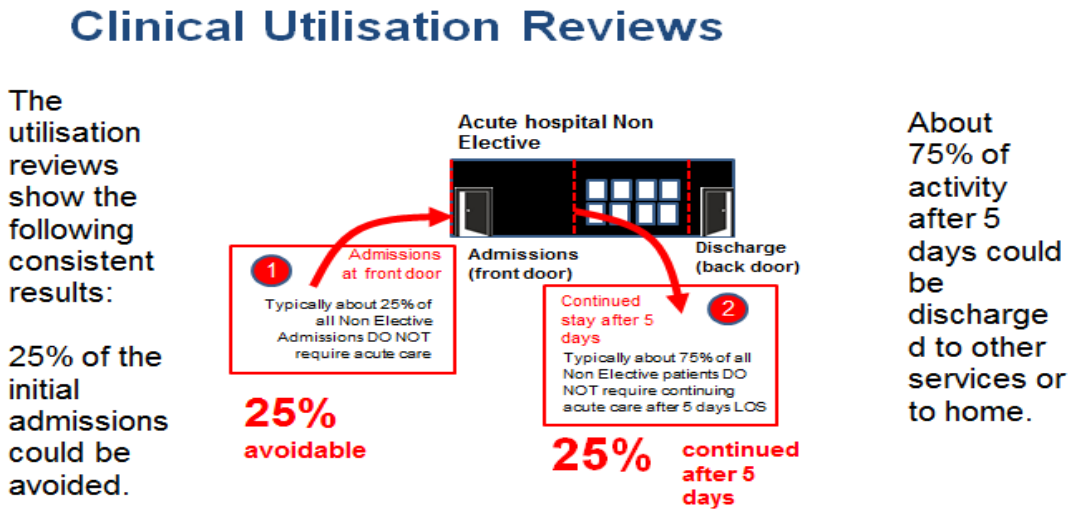
3.2 Future Changes in Demand for Health and Social Care

Key factors that influence potential changes in demand for health and social care in people aged 65 and over living in Central Bedfordshire:

	2011	2015	2020	2025	2030
People living with dementia	2,634	3,031	3,677	4,516	5,440
		15%	40%	71%	107%
People living with a limiting long term conditions	17,288	20,098	23,061	26,620	30,528
		16%	33%	54%	77%
People unable to manage at least one personal care task	13,131	15,077	17,578	20,648	23,936
		15%	25%	57%	82%
People unable to manage at least one domestic care task	16,010	18,379	21,530	25,294	29,240
		15%	34%	58%	83%

3.3 Reducing Reliance on Hospital Services for less Complex Care

A major challenge within our BCF Plan is to reduce Non-Elective Admissions, which has increased in 2015/16 as reflected in the BCF quarterly performance reports. Developing services that reduce reliance on the hospital sector for those with urgent but less complex care needs that could be provided in out of hospital settings, is a key priority in our Plan. To quantify the scale of the change that could potentially be made a clinical utilisation review has been undertaken on non-elective admissions to identify the proportion of sub-acute care that could be provided in community settings. This will be shared with providers and will inform plans to change patterns of care supporting future sustainability. Figure 2 below provides an outline of the scale of change anticipated.



Using internationally recognised clinical protocols, the Utilisation Reviews shows that up to 25% of current non-elective admissions do not require acute care and that up to 75% of those staying longer than 5 days in hospital could be more appropriately cared for in sub-acute settings.

Ongoing modelling will determine the proportion of patients that can be cared for at home and the proportion that would require step-up or step-down care.

The scale of change is potentially very significant but caring for people in the most appropriate care setting is key to sustainability in the system. It is anticipated that an overall programme to take this change forward will form part of our system Sustainability and Transformation plan which will be produced in July 2016. The Better Care Fund plan will be key in taking forward the transition to more local care.

3.4 Service User Feedback

As part of the review of healthcare services, there are ongoing comprehensive engagement activities with local people, clinicians, organisations, communities and a range of sectors. There is active engagement with local people and key stakeholders in helping to shape and understand what high quality, sustainable services will need to look like to support care needs into the future. Care closer to home has featured as a significant priority within the engagement we have undertaken in relation to the transformation of community health services.

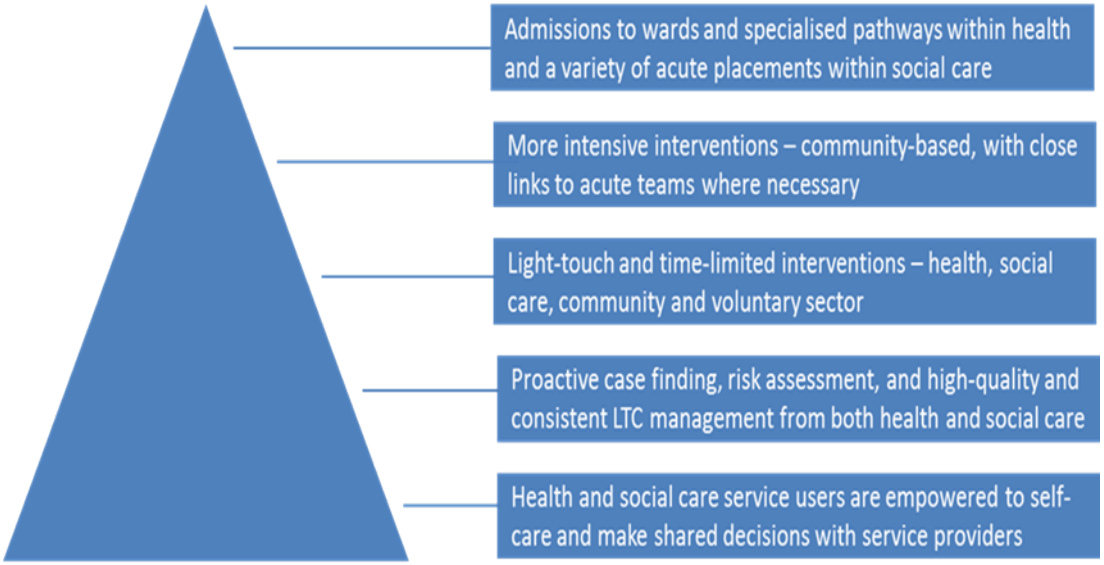
A strong theme in the conversations with patients and the public has been their wish to stay healthy and independent for longer and, to that end, to have more care provided closer to where they live, organised around their lives and available at times that suit them. In their discussions, clinicians describe how closer working between primary, community-based and hospital care can enable more care to be provided to patients without the need for hospital visits or inpatient stays. These feedback have influenced the focus for the BCF Plan, identifying what services could be delivered within the community and ensuring care closer to home becomes reality. Two further themes that emerged consistently were; more services offered out of hospital and GP practices, community services and social care providing one joined-up service, enhanced by greater networking across the NHS and the Council.
Further information on feedback from service users and our approaches on engagement are set at https://www.bedfordshireccg.nhs.uk/page/downloadFile.php?id=12381

Further information and evidence drawn from engagement on modelling community health services is attached.

AH_ BCF planning 16-17 - Engagement

3.5 Segmented Approach to Meeting Needs of Individuals

Our Care model is taking forward the following segmented approach (see below) to identifying and meeting the needs of individuals



Delivering this vision for integrated care means overcoming barriers between primary and secondary care, physical and mental health, and health and social care. Our Better Care plan brings resources together to address immediate pressures on services and establish a foundation for a much more integrated system of health and care delivered at pace. Our agreed model of care is underpinned by a new delivery framework for joint working across partners and client groups to deliver the full continuum of health and social care support. This includes prevention and early intervention, self-management, reablement and independence. For mental health this will focus on closing the gap between access to physical and mental health services
Key messages have been considered in shaping our whole systems response to the Case for Change, as part of the review of health care services in Bedfordshire and Milton Keynes, analysed alongside a range of pressures that currently challenge our local health and care services.

A full account of these challenges is described within the review midway report a Case for Change.
http://www.yourhealthinbedfordshire.co.uk/modules/downloads/download.php?file_name=37

3.6 Progress against BCF Plan 2015/16

In 2015/16, we committed to six key schemes within the BCF Plan. Performance against these schemes has been regularly monitored, through the Better Care Fund Commissioning Board and reported to the Health and Wellbeing board. Progress against key schemes in the 2015/16 plan are summarised as follows:

Scheme One Transforming Primary Care:

A Lifestyle Hub pilot was established in February 2015. Clients are pre-dominantly aged 46-55 and are referred for advice/support related to obesity. The benefit of this service is that it considers the health of the whole person. A full review of this pilot, including cost effectiveness, was undertaken and referral criteria extended. This will inform the future roll out across Central Bedfordshire localities in 2016/17.

Accountable lead professional – All patients over 75 have a named GP. A standardised approach to risk stratification (manual & electronic) is being introduced as part of multidisciplinary working across Central Bedfordshire localities

Long term conditions management in primary care - A more standardised means of collecting data in the four disease areas (asthma, diabetes, COPD, heart failure) using a LTC management template on SystmOne has been introduced.

Scheme Two Integrated Rapid Response:

A joint approach to the transformation of community health services has begun. Early discussion on integration of occupational therapy services is underway. A significant piece of work, reviewing the pathways for community beds has been completed. A key finding was that longer stay rehabilitation (slow stream) beds are an issue. We introduced a Multi-Disciplinary Team (MDT) working project to provide integrated response to those patients most at risk of admission and other people who would benefit from a more joined up response. The Caring Together pilot across two GP Practices in two localities, Chiltern Vale and West Mid Beds has been completed. Lessons from the pilot will be used to inform the ongoing review of Community Health Services and the roll out of MDT working across Central Bedfordshire. Dementia Health Needs Assessment completed. Dementia Friendly Communities programmes initiated. 280 CBC staff are dementia friends and nine Care Homes have gone through the CBC dementia quality mark process. A project on Paediatric Urgent Care aimed at reducing urgent care admissions amongst children and young people, and empowering parents to recognise and manage minor ailments, was completed. It also increased staff training to manage certain conditions in the community.

Scheme Three - Efficient Planned Care

Community services - A programme of work for a complete transformation of adult and children's' community services has now commenced. A Falls Project has commenced and is linked to facilitating a reduction in non-elective admissions. Fall prevention training is being delivered to Care Homes and Domiciliary Care providers. The Council's Urgent Homes and Falls Response Service is being piloted to provide support to Care Homes. A number of Care Homes have identified a Falls Champion. Five Step EOL training to Care Home staff, designed to not only improve EOL care but assist with best interest decision making on preferred place of death has been introduced. Training provided to Ambulance staff to support non-conveyance has by month eight resulted in 201 non-conveyances. The OT Service responds promptly to referrals for DFGs and has improved the average length of time from Occupational Therapy referral to DFG approval to eight weeks compared to a 2013/14 average of 10.9 weeks.

Scheme Four - Supported discharge

Discharge facilitation pilot in West Mid Beds – pilot completed. Learning from the pilot will be used improve patient pathways as part of the transformation programme for community services. A carers' lounge has been opened at the L&D to mirror that at Bedford Hospital. A multi-agency

partnership for prevention and promoting independence was established. Programmes for physical activity and exercise for frail older people are being commissioned.

Scheme Five - Care Act

Duties set out in Phase One of the Act have been embedded into local practice. Phase Two implementation has been deferred.

Scheme Six - Better Care Fund Implementation

A Better Care Fund Plan Commissioning Board was established, together with an Operational delivery group. A Provider Alliance was set up. Links with CCG Locality Boards established. Pooled budget established and S75 agreement signed. Performance and finance monitoring framework agreed and reviewed monthly, with quarterly reporting to NHS England. NHS number is now used predominantly as primary identifier across all agencies and systems.

3.7 What lessons were learned and what will change?

A review of the 2015/16 Schemes was undertaken by the Health and Wellbeing Board and based on the findings, made the decision to take a more focused approach to the 2016/17 Plan. **http://centralbeds.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=829**

It is clear that there are now real challenges within the health and social care system in Central Bedfordshire for delivering an ambitious BCF Plan, particularly in relation to reducing unplanned admissions to hospitals. Although there has been important progress in all scheme areas, there have been a number of factors that have impacted on the overall pace of delivery of the BCF Schemes. The Clinical Commissioning Group's financial recovery and changes in leadership has also had an impact on the delivery of the BCF Plan and schemes.

Uncertainties regarding the re-procurement of Community Health Services contract have also had an impact on delivery. Community health services provision is central to the BCF Plan. The majority of the schemes set out in the BCF Plan require new ways of working and in particular integrated services to facilitate seamless and timely care pathways for frail older people. These uncertainties in the system have undermined the delivery of the BCF Plan

The ongoing review of community services now means that a number of BCF Plan projects are subsumed into the scope of the review and being taken forward initially as part of the transformation of community health services in 2016/17.

In recognition of the financial challenges within our local health and care system, there is a clear focus across the system on achieving financial stability and sustainable health and care services, through transformation and integration. Our BCF Plan for 2016/17, as earlier stated is consistent with the ambitions of the CCG's Operational Plan 2016/17 and the Council's Five Year Plan. Our 2016/17 BCF Plan takes forward the following developments that will make a significant contribution towards delivering the vision set out in the Five Year Forward view and are reflected in our Schemes.

To meet the immediate challenges, within our local health and care system, our BCF Plan for 2016/17 is focusing on three key schemes to help deliver improvements, cost efficiency, more streamlined pathways of care and to meet the national conditions. There is local recognition and agreement that a focus on these areas would deliver more significant benefits to the target population.

Although there have been some successes, in 2015/16, the review of the schemes have shown that there are a number of key areas that would benefit from a greater focus and these have been scoped to ensure a more effective and achievable plan for 2016/17. The prevailing challenge is reducing non-elective admissions and the key projects have been mobilised to mitigate this. Additionally, the transformation of community services with introduction of multidisciplinary working and enhanced care into care homes should have an impact on this. A risk share agreement will be set out in the Section 75 Agreement. Performance will be monitored and reviewed by all key partners through the Systems Resilience Groups, the BCF Commissioning Board and the Health and Wellbeing Board.

4. BCF Plan 2016/17 Delivery

The transformation of community services, based on GP clusters within localities will be a key trigger for our journey towards integration. Our case for change is predicated on the increasing levels of non-elective admissions which are evidenced in our quarterly submissions for BCF 2015/16. New ways of working will be required to deliver changes and ensure the sustainability of our health and care system in the face an ageing population with increasing complexity of needs. The GP Clusters with MDTs will offer proactive care to high risk patients, reducing admissions as well facilitating reduced length of stay in hospital. These and a key focus on the following seven projects will underpin our approach in 2016/17:

1. Improving the Falls Service
2. Transforming Community Services - Multi-Disciplinary Team Working
3. Transforming Community Services - Maximising Independence through Supportive Technology (MIST)
4. Improving End of Life Care
5. Improving outcomes for stroke survivors
6. Enhanced Care in Care Homes
7. Delayed Transfers of Care (DTOCs)

Details of the projects, objectives, and deliverables and how they align to the national conditions and metrics are set out respectively in Appendix 1. The seven projects, which build on the 2015 /16 BCF Plan, fall into three themes as follows:

4.1 Theme One - Out of hospital care.

This scheme is focused on transformation of community health and care services. Our vision for a local model for community based services is likely to result in the need for substantial change in the way services are currently modelled and delivered. It is likely that investment in new ways of working and capacity will be needed. Jointly commissioning health and care services will improve patient experience, help to provide efficiencies, improve the quality of care and create opportunities to address local workforce challenges. The total BCF financial allocation against this scheme is £12.984m in 2016/17 compared to £12.019m in 2015/16.

In 2016/17, the transformation of community services will reinforce the MDT model for proactive care (Caring Together) which is focused on those patients at risk of admission. It is anticipated that this approach will advance to a rapid response to avoid hospital admission. This will be achieved through better cohesion and joint working across existing teams, such as the current rapid intervention teams, Urgent Homes and Falls Response Service and the Emergency Duty Teams.

The scheme will facilitate integration of services, development of multidisciplinary teams across Central Bedfordshire localities and a common intermediate care pathway for joint assessments, care planning and provision.

Principles for the design of community services are:

- To provide care closer to home
- Simplify services and remove unnecessary complexity, through integration and collaboration.
- Design services that are patient and family centred
- Develop teams and services to provide support to patients as an alternative to admission or hospital stay.
- Designed in line with evidence of best practice

The overall scope of this scheme will also include redesign of intermediate and rehabilitation services, improving access to community beds and delivery of seven day services. This will respond to the requirements of the national conditions for joint assessments, care planning and accountable professional.

4.2 Theme two – Prevention

There are important opportunities to influence, empower and reshape how people in Central Bedfordshire experience health and care services. The need for a system wide response to wider system issues around prevention and early intervention is recognised. There needs to be an integrated approach to primary, secondary, and tertiary prevention to stop or reduce deterioration in health. The total BCF financial allocation against this scheme is £4.962m in 2016/17 compared to £4.687m in 2015/16.

The overall scope of the scheme will address: patients being enabled to self manage; the use of assistive technology; disabled facilities grants and adaptations; paediatric admissions; falls prevention; accommodation and support to carers. This will ensure the most progressive, evidence-based prevention and early intervention programmes are available to our population. Local investment in prevention initiatives are set out in the template and builds on the key initiatives commenced as part of the 2015/16 BCF Plan.

A key initiative planned for 2016/17 is Maximising Independence through Supportive Technology (MIST). This will introduce systematic support for patients to self manage. The concept is a population based approach to prevention, targeted at particular segments of the population and is based around proactive health care coaching through telephone and outreach services. The self-management support service will help people to be independent through proactive interventions which enhance an individual's confidence and by coordinating health and social care as and when they need it. It will consist of four elements:

1. A proactive health care coaching (through telephone, outreach and assistive technologies such as telecare, telehealth etc.) service for patients identified by MDTs as being at risk of admission.
2. A reactive rapid response service for patients in care homes where care home staff can access expert support and information from dedicated Senior Nursing staff in a centralised hub to avert an emergency admission and gain access to community nursing or GP access/visits.

3. A single point of access for the new integrated community care and support service (currently in operation across SEPT provided by One Call)- linked to each of the nine operational integrated cluster care teams- providing support and referral management for staff and patients (including community and commissioned care home beds).
4. A service to provide direct care coordination for patients in the last year of their life (currently provided by PEPS) to support patients to die in their preferred place and provide patients, carers and professionals with a single point of contact for advice and support for palliative care.

The service will combine nurse-led telephonic management using electronic evidence based protocols which assess and case manages individuals on a multi domain holistic model. The target group will be high risk, high cost patients. A full business case is in development to support procurement for 2016/17.

The 2016/17 BCF Plan continues the focus on mental wellbeing. A number of self help guides have been introduced as part of the mental health and wellbeing campaign. The five ways to wellbeing encourages people to take actions which are proven to improve mental health. The guides contain useful hints and tips on self care and also signposts to professional help if required.

4.3 Theme three – Protecting Social Services

This scheme will ensure the Council is able to respond to increasing demands and complexity of care needs, in a timely and appropriate manner. There is a real challenge in reducing delayed transfers of care, supporting Care Homes to deliver more complex care for people in their usual place of residence and delivering timely and integrated care packages, including domiciliary care. This scheme will focus on key areas which will help to reduce unplanned admissions, including rapid home care response – enabling people to remain at home longer. The total BCF financial allocation against this scheme is £2.588m in 2016/17 compared to £2.001m in 2015/16.

Within this scheme, there will be a focus on implementing an integrated model of multi-disciplinary health and social care working that provides care in the patients' usual place of residence. Enabling care to be accessed through a network of support focused on meeting individual needs and supporting people's independence.

This scheme aims to transform care both in terms of new developments and for the key enablers that will underpin integration and joint working, for example workforce and data systems and shared records.

The Council has a programme for managing the accommodation needs of older people (MANOP). This programme is focused on delivering an expansion of independent living accommodation for Central Bedfordshire residents and in particularly securing alternatives to reliance on care homes. People with varying levels of care, can have access to extra care housing with support.

Pathways for coordinated discharge from hospital will ensure that people leave hospital with support to maximise their independence back in their own home. The discharge pathways will incorporate integrated rehabilitation and reablement with access to equipment and adaptations as required.

These schemes will complement the priorities areas set out in the Bedfordshire Plan for Patients 2016/17.

5. An agreed approach to Financial Risk Sharing and Contingency

The total BCF Pooled Fund is £20.533m and has been allocated across the three Themes as follows:

Theme	2016/17 Allocation £m	2015/16 Allocation £m
Out of Hospital Services	12.984	11.465
Prevention	4.962	4.687
Protecting Social Care	2.588	2.555
Total	**20.534**	**18.707**

New investment in 2016/17 has been allocated to support new Falls prevention activity £0.180m, Liaison Psychiatry £0.135m and Primary Care Mental Health Liaison of £0.144m. In addition a contingent sum of £0.389m has been set aside to mitigate the impact of failure to reduce non-elective admissions by 1%. Furthermore, an under-spend from the 2015/16 BCF Pool of £0.044m revenue and £0.482m capital has been carried forward into 2016/17 to support the programme.

As indicated above new investment has been made available to support the new Falls Prevention activity sitting within the seven transformation projects. The remainder, Multi-Disciplinary Team Working, Maximising Independence through supportive technology (MIST), End of Life Care, Improving outcomes for stroke survivors, Enhanced Care in Care Homes and Delayed Transfers of Care (DTOCs) will be supported by using existing resources across the Council, the Clinical Commissioning Group and Providers. Much of this work is focussed on driving improvement to service configuration and operations and will identify how to use existing investment in more effective and efficient ways to prevent unnecessary admissions to hospital and improve discharge arrangements from hospital.

Appendix two (a&b) shows how the BCF financial resources in the Pool in 2016/17 compares to the 2015/16 BCF and aligns with the three Central Bedfordshire Themes and national scheme types. Also see BCF 2016-17 Planning Template

5.1 Risk Share

Our Plan is focused on Integration and the improvements in quality of life for people with long term conditions and older people with frailty. For each of our schemes we will measure the impact on non elective activity. For the 2016/17 Plan we will continue to build on the work started in 2015/16, which we believe will stabilise current levels of admissions.

As a system we recognise that failure to meet the BCF targets will have an impact on the quality of life and experience of our population, when they need to make use of health and care services. This failure would lead to an increasing reliance on use of institutional care and non-elective admission. In addition, failure to increase use and effectiveness of Reablement and intermediate services could impact on the recovery and ability to regain important life skills following an episode of ill health.

Key performance and quality outcomes have been articulated with providers as part of the local CQUIN targets, and these will be further developed in 2016/17 to form part of contractual obligations. In addition to this, the Council has included the requirement for prevention and promotion of wellbeing, within council commissioned care services.

Both the Council and the Clinical Commissioning Group have a clear understanding of the challenges of reducing non-elective admissions and are in a better position to manage the trend currently being experienced. However, it is proposed that the financial risk presented by the failure to reduce non-elective admissions by 1% will be positioned against the whole BCF pool of £20.5m and shared according to the proportion of spend from the BCF pool. A contingent sum of £0.388m has been allocated to mitigate the non achievement of the 1% target in the first instance although local agreement has been reached that the risk share will be shared on a 50/50 basis.

The 1% risk share recognises the challenge of reducing non-elective admission which has continued to increase in 2015/16 against the BCF baseline. An analysis of the drivers for the increasing Non-Elective Admissions has been undertaken and is predicting activity at 2015/2016. (Attached)

BCF emergency admissions paper Fina

5.2 Risk log

Overall BCF Plan and project specific risks are described.

There is a risk that:	**Mitigating Actions**
Finance. Due to underperformance of the schemes or delays in realising benefits, there is a risk that the ring fenced sum for Out of Hospital Services has limited impact on reducing non-elective admissions in the current year.	1. All key providers signed up to their contribution to achieving a reduction in non-elective admissions. 2. All schemes will have business cases detailing evidence base, effectiveness, finance and activity. 3. Robust performance framework to ensure monitoring of performance and prompt action to mitigate under performance including discontinuing those not realising expected benefits. 4. A risk share agreement is in place
Due to the increased complexity and demand for services on adult social care and additional responsibilities resulting from the Care Act as well as the new national living wage requirements, there is a risk of financial pressure on care delivery.	1. Focus on early intervention and prevention to moderate progression to severe need. 2. Robust monitoring of performance and continuous revision of care packages 3. Development of more integrated approaches within the care market 4. Acceleration of integrated and joint working across all agencies. 5. Greater involvement of the Voluntary sector

There is a risk that:	Mitigating Actions
Reputational Risk Reputational risk to all partner organisations in the event of failure to meet statutory duties occurs.	1. Appropriate governance and system leadership structures in place with provision of regular, timely and accurate information to support monitoring of services ongoing. 2. The BCF Plan development has involved all our key providers, including Private, Voluntary and Independent (PVI) sector who have signed up to the plan.
Project Specific Risks	
Improving the falls service:	
• Luton CCG is the lead commissioner for the L&D hospital. As a result of the Fracture Liaison Service not being supported by LCCG there is a risk that development of an FLS at L&D isn't viable which may result in a FLS service not being developed in south Bedfordshire. • As a result of interventions being targeted at specific patient cohorts and the limitations of standard datasets to identify these, there is a risk that impact of the project may not be accurately measured due to coding and data recording issues.	• Work with LCCG to develop the financial model and understand benefits. Work with L&D to explore the practicalities of commissioning a CCG specific service. • Discussion with provider to address coding and recording issues, recognising the impact may not be visible in wider population level data and ensure that there are metrics to measure the impact of discrete interventions at a cohort level.
Multi-Disciplinary Team Working	
• As a result of the current CHS workforce there is a risk that there is not sufficient workforce capacity to deliver a new model of care	• Current workforce capacity obtained from SEPT • New models of care are proposing the use of multidisciplinary health and social care teams to provide more holistic care. The model will also include self-management as a key element, telecare to reduce reliance on professionals and the voluntary sector to increase capacity. • Work is underway by CBC to map and model the workforce between health & social care, as part of Beds and Herts Workforce Development Programme. • More effective care will be provided by personalised care planning of individual client needs. • Continuing discussions and investment with SEPT who will implement an aggressive recruitment campaign and consider additional skill mixing of staff to ensure maximum coverage

There is a risk that:	Mitigating Actions
Maximising Independence through supportive technology (MIST)	
• As a result of the sign off and funding for the project not yet being confirmed, there is a risk that the investment required for MDT working may not be available to support the additional workforce needed by SEPT to implement changes • As a result of a lack of dedicated project management resources for transformation there is a risk that transformation projects will not be managed effectively resulting in lost opportunities both in financial and patient benefits • As a result of the current CHS workforce there is a risk that there is not sufficient workforce capacity to deliver a new model of care • As a result of the national challenges of recruiting nursing staff, there is a risk that the recruitment element of the project plan will be affected and that mobilisation will be delayed.	• Process and timescales is being monitored and support by the Community Health Services Steering Group and risk is escalated by SRO. • New models of care are proposing the use of multidisciplinary health and social care teams to provide more holistic care. The model will also include self-management as a key element, telecare to reduce reliance on professionals and the voluntary sector to increase capacity. • MIST is closely aligned to MDT working which is part of the in-year transformation programme. • Requirement for additional project support has been escalated. A recruitment process is underway • Current workforce capacity obtained from SEPT • Work is underway by CBC to map and model the workforce between health & social care, as part of Beds and Herts Workforce Development Programme. • Continuing discussions and investment with SEPT who will implement an aggressive recruitment campaign and consider additional skill mixing of staff to ensure maximum coverage
Improving the End of Life Service	
• As a result of data submission not being in providers' contracts there is a risk that data may not be provided or not be provided on time. This may result in not being able to evidence the benefits of training. • As a result of trained staff not being able to put into practice the full content of the training there is a risk of inconsistent outcomes which may result in benefits not being realised.	• Providers are keen to continue this training as it provides benefits to staff therefore they are committed to evidencing the benefits of the training. • The training has now been running for one year, continued learning from reflective practice continues to inform course content.

There is a risk that:	Mitigating Actions
Improving Outcomes for Stroke Survivors	
• National gaps in recruitment of some therapy areas i.e. speech and language therapy mean that we might not be able to recruit the necessary staff • Limited availability of integrated pathways will delay securing the desired outcomes.	• Work with Health Education East on workforce development • Multidisciplinary neuro-rehab team established and developing integrated care pathways for stroke care.
Delayed Transfer of Care	
• As a result in an agreement not yet being reached by stakeholders across the system, there is a risk that there will be a delay in the sign off of the DTOC Policy which may result in a delay on progress • As a result of an agreement not being reached by stakeholders across the system for recognised priority areas of work, there is a risk that there will not be sufficient focus on areas that need to be addressed, which may result in the continuation of ongoing issues.	• A DTOC sub group has been established, as a sub group of the System Resilience Group. Much work has been undertaken as part of this with system partners, in order to ratify the localised DTOC policy. It is anticipated that this will be done by 30/9/16. • The DTOC and 7 day services SRG sub group meet monthly to progress work on priority areas, to prioritise the work to improve the self-assessment position as per ECIP recommendations.
Enhanced Care in Care Homes	
• Ability of care homes to recruit and retain appropriately qualified staff	• On-going work with Beds & Herts Workforce development partnership on transformation programme, focusing on recruitment and retention, training, support for existing staff and news ways of working. Including generic worker and Super Carer roles. • Ongoing work to making Caring profession a career of choice

6. The National Conditions

6.1 Plans to be Jointly Agreed

As previously indicated, the 2016/17 BCF Plan builds on the 2015/16 Plan. It reflects the more focused approach adopted by the Health and Wellbeing Board and takes account of local system-wide issues which have had an impact on overall success of the 2015/16 plan. The Health and Wellbeing Board has overall responsibility for both operational and financial delivery of the Better Care Fund, totalling £20.534m and will maintain oversight of the outcomes. **http://centralbeds.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=829** In addition the CCG and the Council through existing, robust governance mechanisms will ensure there is appropriate oversight and decision making.

The Central Bedfordshire BCF Plan has been jointly agreed. All key partners are represented on the Health and Wellbeing Board and both the CCG and the Council are agreed on the BCF Plan 2016/17 and are represented on the Joint BCF Commissioning Board which will monitor progress and report to the Health and Wellbeing Board. From 2015-16 BCF funding has been underpinned by a Section 75 pooled budget arrangement jointly governed by the LA and CCG under an existing overarching arrangement. This will continue for 2016/17. The Health and Wellbeing Board will approve the Scheme of delegation for the Pooled Budget and Section 75 agreements.

There is ongoing engagement through Healthwatch, as a member of the Health and Wellbeing Board, and systematically through service development initiatives, such as community services review and the strategic review of health and care services in Bedfordshire and Milton Keynes. Our Better Care Plan is strongly aligned to the Bedfordshire CCG Operational Plan for Patients, 2016/17 and the current Five Year Strategic Plan of the Clinical Commissioning Group which reference locality based approaches for health and care services. The Council's Five Year Plan has a strategic vision for integration and shifting the balance of care from institutional to personal solutions and the development of integrated care hubs. There is a programme for Meeting the Accommodation Needs of Older People which is part of the Council Five Year Plan.

Assessment of workforce requirement to support the BCF Plan

The general consensus in terms of future workforce is that there will need to be a shift away from specialism to more generic and transferable skills together with a shift of skills into the community. In terms of future care models, there is a focus on integrated workforce across health and social care, particularly for non-professional staff. There is now a much clearer picture of the size and shape of this workforce, and again this can be explored to a level of granularity to explore the implications of developing integrated roles.

Central Bedfordshire Council is leading a group of local commissioners and providers in a Bedfordshire and Hertfordshire Workforce Partnership project, which is mapping and modelling the Workforce. The project, which concluded in March 2016, gathered health and social care workforce information across Bedfordshire and Luton, to quantify current staffing levels, current staffing needs and future staffing needs, in order that joint solutions across adult health and social care can be modelled to support a process of addressing identified gap in future workforce capacity. The findings from the project was shared with National Better Care Support Team, who commented that the work "helped to bring things to life a little more for them with a practical example of the challenges involved in

understanding the current health and social care workforce and then using that to model the future workforce size, shape and skills against population needs and different models of care" and have subsequently used the data as evidence to support discussions at the integrated workforce working group, where membership included colleagues from the Department of Health who are working on policy papers on workforce integration.

In addition to this, work is ongoing to develop new multi-skilled generic worker roles. A 'super Carer' role has been developed in conjunction with University of Bedfordshire. Upskilling of staff will commence in May 2016.

The CCG and the Council have also mapped the workforce model for the transformation of Community Health Services. The work which was undertaken by a Health Economics Consortium sets out a model for rebalancing approach to shift greater emphasis on community based and out of hospital services. A clinical model associated with Multidisciplinary teams has been developed. MDTs are based on a cluster of approximately 40,000 people for keeping care close to home.

A Cross Sector workforce partnership group will be re-established and will take forward the framework for local workforce development in conjunction with Health Education England and importantly wider STP footprint.

6.2 Maintenance of Social Care Services

The Council recognises the need to continue to develop effective solutions for the provision of social care support to adults and older people assessed as having moderate, critical, or substantial needs. This is particularly relevant given the increasing complexity of need and an ageing population, with people 65 and over representing 19% of all people by 2021, compared to 12% in 2011.

An amount of £4.977m has been assigned out of the CCG minimum allocation for the protection of adult social care services. This level of spend is an increase on 2015/16 allocation. A total allocation of £10.223m has been made to support adult social care services which include a further sum of £5.258m from the Council. This allocation will mitigate the demographic pressures from the increasing ageing population and greater complexity of need in the frail and elderly; and for people with learning disabilities
This level of protection covers the costs of a range of services, including step up/step down provision, equipment, telecare, integrated hospital social work teams and care packages where residential care admissions are directly from hospital or respite.

Compared to the national minimum criteria which is set at Substantial, Central Bedfordshire Council's eligibility criteria is set at moderate and offers timely care and support to more people and is consistent with our local health and care economy's joint approaches to prevention and early intervention. This will ensure access to appropriate care and support before reaching crisis and thereby avoid unnecessary institutional care. Access to reablement services is consistent with the Care Act regulations which require intermediate care and reablement to be provided for up to six weeks with access to aids and adaptations to promote independence and help sustain people at home.

This will continue through reablement, additional funding for Disabled Facilities Grants (DFG) minor works, targeted provision of community equipment, community alarms, and

other telecare solutions, as well as investment in support to local communities to increase social capacity, such as, good neighbour/village care schemes. Progress will be measured through both Adult Social Care Outcomes Framework and other customer experience indicators which are reviewed by the BCF Commissioning Board.

Embedding the Care Act
A total sum of £599,000 is allocated for the Care Act and will enhance the ability to meet the additional duties and inherent cost pressures for adult social care. The Care Act 2014 requirements are now embedded into practice and remain an integral part of the delivery of our BCF Plan. Requirements of the Act include provision of universal assessments for all those in need of care and for carers. The provision of enhanced information and advice, signposting, and promotion of wellbeing and independence is central to our approach as well as a focus on identifying and supporting carers. Our approach to implementing the Care Act was set out in the 2015/16 Plan.

Provision of Carer-specific support
The value of the fund directly allocated to Carer Support is £532,000. Carers will also benefit from a wide range of investments through the fund activities.

The totality of our theme three is focused on services that will protect and enhance the quality of social care services for Central Bedfordshire population.

6.3 Seven day services

Appropriate seven day services are in place to facilitate effective hospital discharge. Services such as Reablement and the Urgent Homes and Falls Response Service have been expanded to seven days through investment from the Better Care Fund.

The Luton and Dunstable Hospital has defined a project to deliver the "seven day service offering" that supports both the Trust's five year business development vision and the overarching aspiration for the future new hospital. Seven day services currently in place include imaging, therapies, social care, community services, pharmacy, and diagnostics and home care provision. This range of seven day services facilitates early assessment and discharges. The Trust is mid way through a three year project assessing appropriate lengths of stay for different patient groups. This includes developing short stay capacity with seven day consultant-led wards rounds to facilitate early discharge.

Bedford Hospital is 87% compliant against the standard that patients should be seen within 14 hours by a consultant (based on CQUIN data 2014/15). There is seven day access to the following diagnostic services - biochemistry, chemical pathology, CT, haematology, MRI, microbiology, radiology, endoscopy, ultrasound and X-rays. Consultant directed interventions is available on site 24/7, including access to critical care facilities, emergency general surgery and interventional endoscopy. Networked arrangements exist for the other services: cardiac pacing and percutaneous coronary intervention (Papworth), interventional radiology (Addenbrookes), renal replacement therapy (Lister), thrombolysis (Luton and Dunstable) and urgent radiotherapy (Addenbrookes). Network arrangements for interventional radiology services are currently being formalised with Addenbrookes. Twice daily ward rounds are being reviewed across all principal ward areas.

Central Bedfordshire Council operates a seven day service via the Hospital Social Work Team at the Luton & Dunstable Hospital. This service is also provided at by Bedford Council

at the Bedford Hospital for Central Bedfordshire residents. This Duty/First Point of Contact Team are responsible for the screening, assessment and support planning process. Cases are referred to reablement, and the identification of potential complex cases which will require timely intensive work. The team liaise with wards and community partners. The Duty/First Point of Contact Team is managed and led by the Advanced Practitioner as the Duty Manager. There is an agreed rota with practitioner providing cover over the weekend and on Bank Holidays. This ensures the continued high level of support with discharges and provision of appropriate packages of care

SEPT Community Health Services currently offer comprehensive seven day services through the community nursing; Clinical care at home nursing and therapy clinicians and access to on call Macmillan advice and support. New referrals are received via One Call and accepted according to the standard commissioned specification for each service.

ELFT Mental Health Services are now implementing the new stepped model of mental health care described in the CCG's mental health strategic objectives and as part of this ELFT have rapidly mobilised a service improvement plan, including priority projects for the CCG; Street Triage: Working in partnership with GP's, Acute Hospitals, Ambulance Trusts, Local Authorities and the Police to provide a service which can rapidly respond to people experiencing a mental health crisis delivering rapid treatment and intervention and ensuring any ongoing needs or support takes place in the most appropriate environment. Liaison Psychiatry: To fully integrate a liaison psychiatry service at Bedford Hospital and the Luton & Dunstable Hospital based on a Rapid Assessment Interface and Discharge (RAID) model to improve both patient and carer outcomes. Ensuring all patients attending A&E with mental health needs are seen with no exclusion criteria being applied. Providing a same day assessment (within one hour for urgent referrals) for all inpatients, irrespective of age.

Going forward the plan is to secure evidence of progress towards implementation of the four key seven day services standards through engagement with all the key care providers.

The SRG has undertaken a self assessment which confirmed that some services are available seven days a week, however some services, were more limited at weekend. The SRG work on delayed transfers of care and the BCF Project will aim to increase the levels of discharges from hospital and community services at the weekend to achieve the national targets (80% of weekday average and 35% respectively).The BCF Plan has key deliverables and milestones for 2016/17 – see Appendix 1.

6.4 Better data sharing between health and social care, based on the NHS number

Local Health Providers use the NHS number through using SystmOne. The Council has reinforced the collection of NHS numbers as part of the implementation of the Zero Based Review from April 2014. NHS numbers is routinely collected as part of the assessment framework and recorded within the adult social care system (SWIFT). We are committed to using the NHS Number as the primary identifier for correspondence. Currently 91% of social care records have NHS Number as primary identifier and are continuing to do number matching to achieve 100%. We will also be reviewing options for developing common and shared systems across health and social care to facilitate data sharing.

Work is ongoing to enable data sharing and risk stratification using pseudonmyised data sets based on the Mede-analytics pseudonymisation at source (P@S) tool, which enables high risk patients to be identified and to improve care pathways. This tool will facilitate

joining of datasets across primary, community and social care, particularly for MDT working. A Bedfordshire wide steering group has been established to drive this work forward and will develop the digital roadmap for data sharing.

The CCG and the Council are committed to pursuing interoperable Application Programming Interfaces (APIs). Local systems and standards are compliant with Health & Social Care Information Centre (HSCIC) Information Governance Statement of Compliance (IGSoC) and Interoperability Toolkit (ITK).

The vision set by the Better Care Fund will need to be supported by robust IM&T; in addition to all systems currently being compliant with IGSoC and ITK2.0, any systems implemented under the BCF going forward, will meet the same levels of compliance as the current. The proposed integrated Multi-Disciplinary Team (MDT) approach to patient care is dependent on integration of two systems, TPP SystmOne and Northgate Public Services SWIFT. Support will be required to progress this integration and will be taken forward as part of the Local Digital Roadmap.

Both the Council and the CCG have completed the Information Governance toolkit and are compliant. All staff undertake annual IG training along with confidentiality clauses written into their contracts. Both organisations have designated Caldicott Guardians. Information sharing agreements are in place and submitted as part of the Section 75 agreement.

MM_ Bedfordshire information sharing pl

Local people are advised on how their data is used. The Caring Together programme has produced a consent leaflet which advises people that their data will be shared for care purposes. Whoever consents the patient for Caring Together is responsible for ensuring the patient is aware of this.

The Council is participating in the Social Care digital maturity self assessment. This and the recent digital maturity self assessment carried out by providers will be used to inform the local digital roadmap. A key focus for this will be integrated record and care plans and the use of assistive technology for community based support and self management. The Roadmap will also align with the wider STP IM&T programme.

6.5 Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

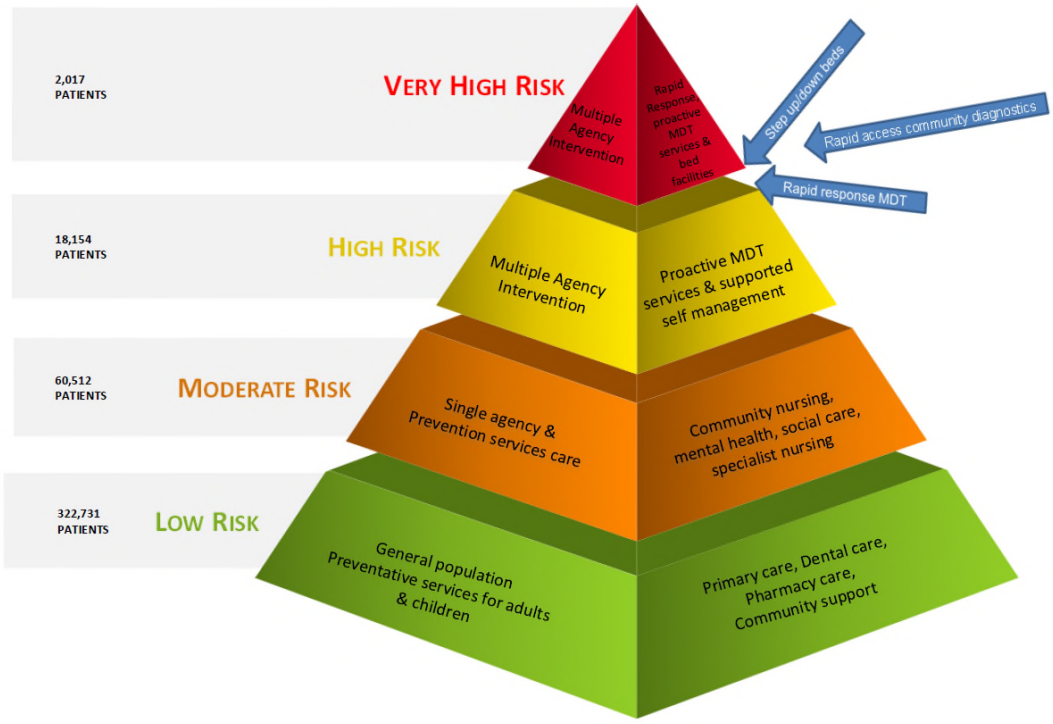
Integrated teams currently support people with learning disability and mental health in Central Bedfordshire. A model of multidisciplinary working and joint approach to assessments and care planning for older people is emerging. Our model for multi-disciplinary working in teams is based around primary care practices and clusters. (see figure 3) This is a key part of the transforming community health services programme and a key deliverable for the BCF Plan in 2016/17.

In 2015/16, we piloted the Caring Together proactive care project in the Chiltern Vale and West Mid Beds Localities. The project developed a risk stratification process based on the GP 2% of patients most at risk of emergency hospital admission. The work was led through an MDT with a Care Coordinator. The project is currently being evaluated and will feed into the planned approach for management of high risk patients based on a proactive case

management which will be rolled out across Central Bedfordshire as part of the transformation of community health services in 2016/17.

Three main tools have been made available to all GPs, a MedeAnalytics risk stratification tool, and two methodologies developed by local GPs. Agreement has also been reached across all providers for information sharing for risk stratification using pseudonmyised data sets based on the Mede-analytics pseudonymisation at source (P@S) tool. This enables high risk patients to be identified and to improve care pathways. This tool will facilitate joining of datasets across primary, community and social care, particularly for MDT working.

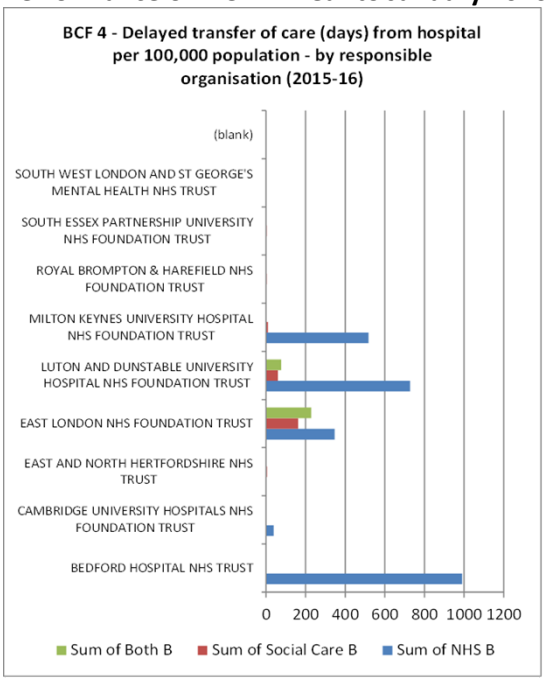
Figure Three

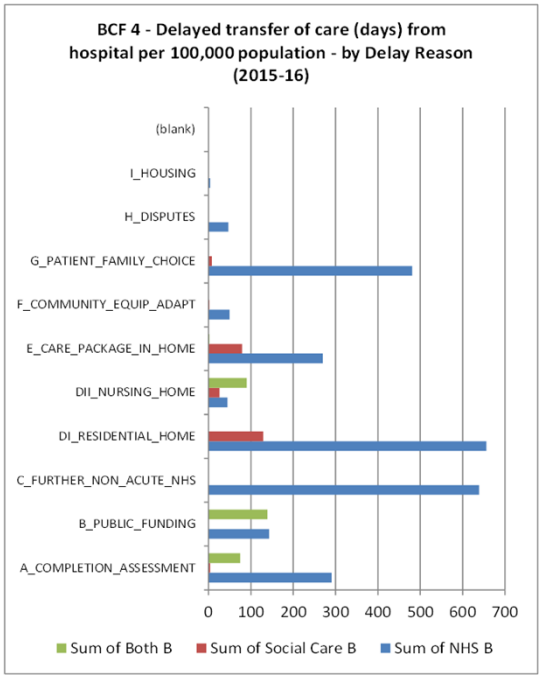


6.6 Agreement on local action plan to reduce delayed transfers of care (DTOC)

DTOC is regularly monitored through the SRG and the BCF Commissioning Board with regular reporting on performance to the HWB Board. Central Bedfordshire is represented at two local SRGs for Bedford Hospital and the Luton and Dunstable Hospital. There is now engagement with other hospitals outside the area that care for Central Bedfordshire residents. To date the overall performance against the 2015/16 BCF target is green although the last three months have shown a dip in performance however; we anticipate the outturn will still be green. We also expect to see some improvements from the projects that focus on DTOC and Enhanced Care in Care Homes during 2016/17.

Performance on BCF4 – Year to January 2016.





Source: DTOC NHS England

An Operational Group for DTOC has been established and a draft multi-system DTOC policy developed. The group will oversee a self-assessment of services in Bedfordshire against current services and ECIP eight high impact interventions as per the model below and the results of the self assessment will be used to develop a local plan for managing DTOCs. This will include setting a stretch target for DTOCs. The underpinning principles and aims for DTOC across the Bedfordshire system are as follows:

- Partners to work together to ensure that there are no delays across the whole system and that patients are moved safely through the discharge pathway, thereby improving efficiencies and patient experience
- Improving services for patients by avoiding situations where, patients are put at risk by remaining in the acute sector when they no longer need acute care.
- Partners to work together to improve current DTOC self-assessment against the eight ECIP recommended interventions, to prevent delays occurring in the first place.
- Retain and continue to build positive partnership working across all departments and organisations.
- Drive a better system of discharge planning encouraging the development of proactive planning for discharge to “pull” patients from acute beds
- From admission manage patients and their relatives/carers expectations and ensure that all patients receive a letter and booklet explaining discharge processes and possible discharge destination on admission.
- Trust clinicians are not expected and should not make recommendations or decisions about the discharge destination. This is a Multi- Disciplinary discharge pathway decision.
- Full assessment of need should not be undertaken while a patient is acutely ill or

still has potential for improvement

- Ensure there is consistency in the notification of Expected Discharge Date (EDD) to partner organisations as part of the assessment notification and proactively manage patients to ensure discharge on EDD is optimised and thereby improve patient flow
- Prioritise use of step down as well as step up beds.
- Continue to review against lessons learnt and best practice in order to ensure quality improvement.


Bedfordshire DTOC Policy Draft EHS 22 0


Winter SLI Model v3 LS.PPTX

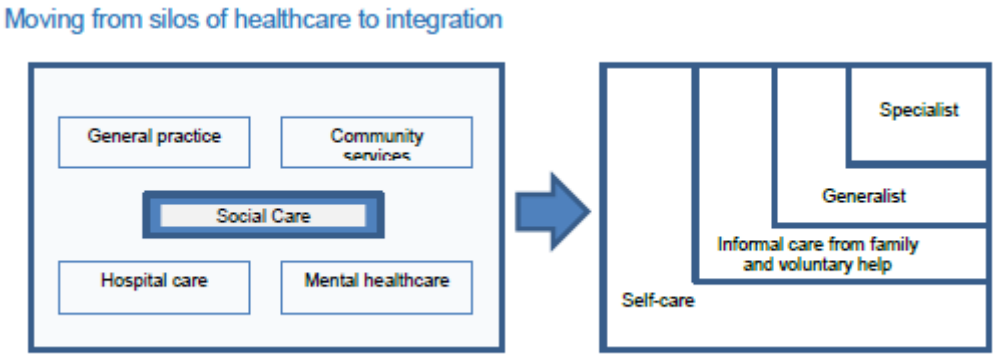
The Plan will be used to address DTOCs across the health and social care system, in relation to demand, capacity and quality. It will also help to plan future provision with the aim of developing seven day services across Bedfordshire to meet the needs of the population and to ensure that work is undertaken jointly across organisations to support. The key deliverables for the group are aligned to the BCF Project in Appendix 1.

In addition to the foregoing, as a Unitary Council, the disbursement of DFGs forms part of the overall approach to prevention and early intervention to promoting independence and ensuring people can remain at home and in their communities. DFGs will be used, in conjunction with the Council's housing assistance policy, to secure early discharge from hospitals and reduce non-elective admissions.

6.7 Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

The vision for Central Bedfordshire is for a whole system, person-centred and outcome focused community service which provides care closer to home, reduces reliance on hospital based care and ensures that people have access to good quality, safe, locally delivered health care services including primary care and health and social care across both towns and rural areas.

A programme of transformational change that focuses an out of hospital strategy around the needs of people with long term conditions and delivers a journey to integration of health and social care services has been established. In alignment with the CCG's Bedfordshire Plan for Patients which describes significant investment in Out of hospital care. The Better Care Plan provides the overarching vision and framework for integration and joint commissioning for adult services, described below.



Investment in NHS Commissioned out of hospital services will increase in 2016/17. Although the focus of this investment is in the transformation of community health services, all key projects mobilised by the 2016/17 BCF Plan will contribute to the overall ambition to reduce non-elective admissions, reduce delayed transfers of care and provide timely and proactive care for people with long term conditions and other vulnerable groups. By implementing transformational changes in 2016/17 such as realignment of community services to our proposed cluster modelling BCCG will be commencing an admission avoidance strategy (as detailed by HCD economics) and eventually aiming to effect up to 25% of all non-elective admissions (full implementation of the proposed model of care).

Transformation (realignment of services with a greater focus on prevention and proactive case management) with the use of clinical utilisation/management tools and additional investment from Social care (domiciliary care provision) as recommended by HCD economics, is hypothesized to impact on approximately 1.5% of all non-elective admissions. There were approximately 34,000 attendances in 2014/15 (based on SUS data, source MedeAnalytics) in Bedfordshire. Trends in admissions are set out in our BCF quarterly returns.

Additional projects mobilised as part of the 2015/16 BCF Plan around management of long term conditions, end of life care, Falls and Care Homes are beginning to have an impact on non-elective admission. This work will continue as part of the BCF 2016/17. The overarching ambition remains reduction of non-elective admissions in line with targets set for 2015/16.

Furthermore, in accordance with 2016/17 planning guidance, system resilience plans are now aligned across hospital, community/out of hospital provision, primary care and mental health services to ensure sufficient capacity is planned to cope with surges in demand for services.

6.8 Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

There is currently in place a Systems Leadership Group which has oversight of local strategic and operating plans to ensure alignment and cohesion. Key Providers have been engaged in the development of the BCF Plan 2016/17 and involved in delivery of the projects.

Two meetings to secure agreement on the consequential impact of changes took place on 24 March 2016 and 21 April 2016. The meetings, convened by the CCG and Central

Bedfordshire Council were attended by representatives from

- Luton and Dunstable Hospital
- Primary Care – representing GPs
- Bedford Hospital
- East London Foundation Trust – Mental Health Services Provider
- South Essex Partnership Trust – Community Health Services Provider
- East England Ambulance Services Trust
- Central Bedfordshire Social Care Services – Provider services lead.

A summary of the discussions is attached.

summary of provider impact meetings april

Key comments have been taken on board and as appropriate reflected in this revised version of the narrative plan. Key projects, such as MDT, MIST, DTOC and Enhanced Care in Care Homes seek to address some of the points raised.

In addition to these meetings, there has been further engagement with general practitioners through locality boards. Further engagement will be undertaken with Care Homes and the Community and Voluntary Sector Providers.

The Community Health Services Provider was slow to engage on the 2015/16 plan, which has had impact on key delivery areas. The CCG and Council have engaged with SEPT and a shared vision for transformation has been agreed.

The Transforming Community Health Services programme which is central to the success of the Out of Hospital scheme has been agreed with the current community health services provider. This has formed part of the contract negotiations for an in-year transformation. We will be embedding stepped changes with our community provider South Essex Partnership Trust (SEPT) in 2016/17, to implement improvements for multidisciplinary team working (MDT), complex care rehabilitation pathways and utilisation of community bedded units. A Community Health Services Transformation Programme Group has been established and a risk register specific to the transformation of community health services has been produced and is updated regularly by the Group, which includes the Provider (SEPT).

The approach and focus on integrated locality based delivery of health and care services align with other local plans and strategies. Implementation of schemes and new initiatives will be influenced through service user representative groups, e.g. Healthwatch Central Bedfordshire, and through our Making it Real Action Group. These groups currently agree with the strategic direction of both the CCG and Council and are working with local health and care agencies to provide a whole systems response to the challenges faced.

A Provider Alliance for integration has been established and there is a shared vision and

understanding on the future needs for health and care services. Discussions for a five-year Sustainability and Transformation plan for our local system involving all Providers is also helping to secure the agreements needed to deliver the ambitions of the Central Bedfordshire BCF Plan. The local Provider Alliance includes all key Acute, Community, Mental Health and Care Services Providers for Central Bedfordshire residents.

Shared System Leadership Group has been established to ensure alignment of plans and ambitions across the health and care system and is leading the development of the STP. The BCF Plan will form part of the future 2017 Integration Plan as well as influencing the emerging STP.

7. BCF Metrics and Performance Framework

Delivery against the BCF national metrics remains challenging. A description of the targets for 2016/17 and the rationale and key drivers are set out in appendix three.

7.1 Non Elective Admissions

A target of 1% reduction has been set. This represents a reduction of 261 admissions in the year 2016/17. Number of non-elective admissions has increased, as reflected in the quarterly submissions, due largely to the ageing population. We carried out review of non elective admissions (attached) and work has begun in areas with higher rates of emergency admissions with a focus around proactively managing people with long term conditions. A risk stratification model is also been used to support the work of multidisciplinary teams as part of the Caring Together Project.

7.2 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

Although on track for improved performance, we recognise that the 2015/16 target for this measure is not likely to be met. As such the 2016/17 target has been set based on the 2015/16 outturn. As at quarter 2 in 2015/16, there were 153 new placements into residential and nursing care against a target of 106 with frailty and dementia as the most common diagnosis for admissions. Overall outturn for 2015/16 will be undertaken as part of the Short and Long Term Support statutory submission.

Packages of care are being scrutinised through a panel process to ensure that all alternatives have been explored and that the focus remains on helping people to remain in their own homes. Work is on going to improve hospital discharge coordination and reduce reliance on residential care. Crisis prevention plans with carers are also being put in place. The Council's development of more independent living (extra care) accommodation will help to mitigate admissions into residential care.

7.3 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

This measure currently reports only on the Council's reablement service and does not include outcomes data in relation to rehabilitation/intermediate care provided through Community Health Services. Central Bedfordshire Council's figures show an improving trend and performance is currently above the national average. This has influenced the target set in the BCF template. An information sharing agreement with the community

health services provider has been reached which will allows for the follow of dataset with patient identifiable data to enable a more complete reporting on this measure. It is however not known what the impact of this will have on the target. We will monitor and discuss performance with the provider.

7.4 Delayed transfers of care (delayed days) from hospital per 100,000 population

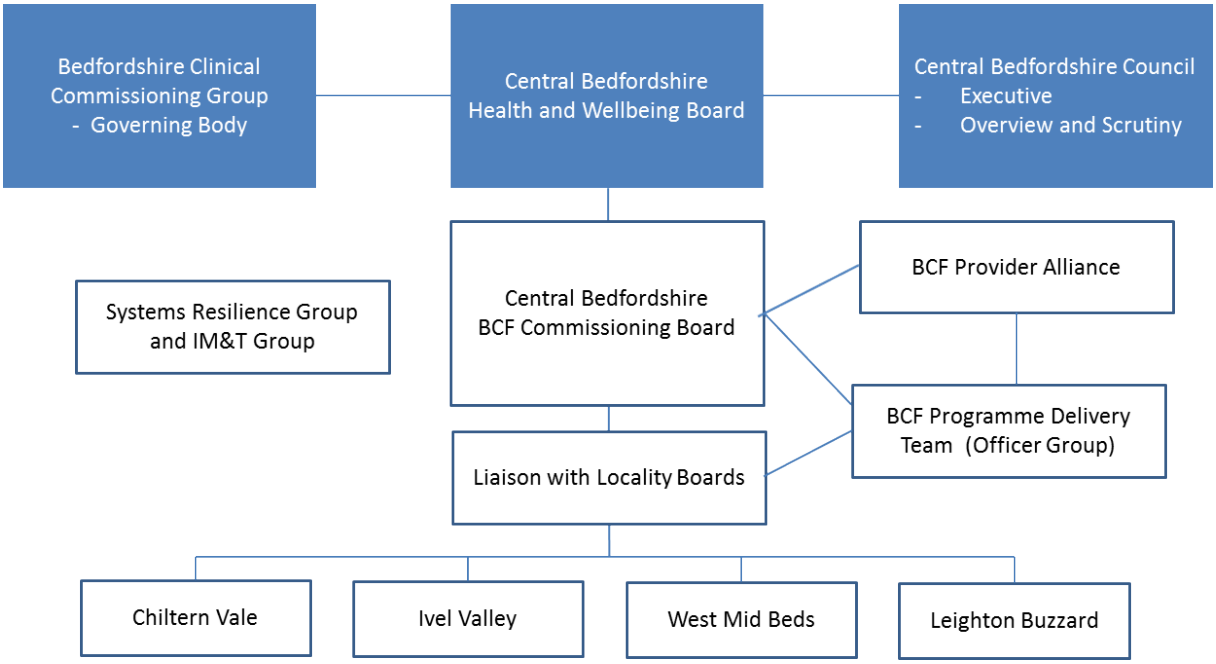
Overall for 2015/16 the actual performance is in line with the planned figures for 2015/16. Our review of the SITREP reports show that the main reasons for delay are attributed to patient and family choice and completion of assessment. Delays due to social care related reasons reduced. Central Bedfordshire has several hospitals which discharge patients into the area, none of which are within its boundaries. Support for early discharge planning and coordination through joint working with providers has been established. The 2016/17 target is based on a 2% reduction set by the Clinical Commissioning Group.
A specific project on delayed transfers of care is included in the BCF Plan and the Systems Resilience Group is producing a multi-agency DTOC Plan.

Our performance framework and dashboard, which also includes local measures, will be further developed based on the 2015/16 outturn and is attached for information (Appendix three). Performance will be monitored by the BCF Commissioning Board and the Health and Wellbeing Board. Monthly monitoring reports are also circulated to the Council's Corporate Management Team, Political Leadership and the CCG's Governing Body

8. Governance and Joint Approach

The BCF plan and overall integration programme for Central Bedfordshire is overseen by the **Health and Wellbeing Board**. The HWB membership includes the executive member for Health, Social Care and Housing and the Chief Officers of the CCG and Council.

The overarching accountability and governance structure remains with the Health and Wellbeing Board.



8.1 Management and oversight

Directly accountable to the Health and Wellbeing Board is the BCF Commissioning Board. This is a Chief Officer Group comprising

- BCCG Director of Strategy and Service Redesign
- General Practitioner Chairs of the Locality Groups for Ivel Valley, Chiltern Vale, West Mid Beds, and Leighton Buzzard;
- Director of Social Care Health and Housing
- Assistant Director of Public Health
- Finance Leads.

This Commissioning Board has overall responsibility for integrated care and BCF delivery and provides joint accountability and oversight of the strategic direction of the Better Care Fund Plan, pooled budgets and performance. Lead commissioner for the project areas have been identified and shown in the BCF Planning Template. A performance framework has been developed and aligns equally to the Council and BCCG performance monitoring processes. (Appendix 4)

A programme management approach is in place, see appendix five. A Delivery Programme Group comprising locality leads has been set up and works closely with the four locality Boards to support the delivery of the key projects and the BCF Commissioning Board. The Delivery Group reports progress on projects monthly to the BCF Commissioning Board. Our emphasis in devising these arrangements is to mainstream BCF governance to the greatest extent possible in order to achieve the maximum alignment of the programmes involved into existing change programmes.

8.2 Supporting Integration and Transformation

Successful integration requires strong foundations of stable organisations, clear governance and effective partnership working. Bedfordshire's local health and care governance is not as unified as it needs to be if we are to deliver a fundamental change in the way we commission and deliver our health, social care and public health services.

Work is ongoing with input from the Kings Fund to explore the potential for an Integrated Care Partnership, across emerging local health and care footprints which will take forward the strategic approach to securing wider integration and transformation across our health and social care economy. Central Bedfordshire Council, Bedfordshire CCG, and Bedford Borough Council with support from the Kings Fund, are working collaboratively to:

- develop a joint vision for integration
- secure senior leadership commitment to the vision including members and Health and Wellbeing Boards
- agree in principle to develop the foundations for integration, namely:
    - unified governance
    - joint commissioning and funding arrangements
    - shared information systems
- set out a clear road map for achieving integration across Bedfordshire by 2020.

As part of the focus on integration between health and social care, a joint CBC/CCG leadership group, which includes the local authority Chief Executive and Chief Officers of the CCG, has also been established. This leadership group will continue to have oversight on the vision and programmes and performance which will influence the outcomes from the BCF. The BCF Commissioning Board provides a focal point for the wider integration and transformation agenda, supporting output from the Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan in the context of Central Bedfordshire. Consideration will be given to the governance structure to reflect the role of the STP in the emerging place-based approach.

Our ambition is that within the next five years, services will be coordinated and service users will say:

'My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes'

9. Additional Documents

- BCF Planning Template
- BCF Narrative Plan 2015/16 http://www.centralbedfordshire.gov.uk/Images/plan_tcm3-12383.pdf
- Appendices
    - *Appendix 1 – Boscards – Key Projects and Deliverables*
    - *Appendix 2 (a&b) - Financials against BCF National Conditions and Schemes*
    - *Appendix 3 – Performance Metrics*
    - *Appendix 4 – BCF Performance Dashboard*