Central
Bedfordshire
Council
Priory House
Monks Walk
Chicksands,
Shefford SG17 5TQ

TO EACH MEMBER OF THE
HEALTH AND WELLBEING BOARD

07 January 2014

Dear Member

HEALTH AND WELLBEING BOARD - Thursday 9 January 2014

Further to the Agenda and papers for the above meeting, previously circulated, please find attached the following reports which were marked as 'to follow' in the Agenda:

Item 5 Improving Mental Health and Wellbeing in Adults
Item 6 Better Care Fund
Item 9 Bedfordshire Plan for Patients

Should you have any queries regarding the above please contact Sandra Hobbs on Tel: 0300 300 5257.

Yours sincerely

Sandra Hobbs
Committee Services Officer
email: sandra.hobbs@centralbedfordshire.gov.uk

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	**Improving Mental Health Outcomes for Adults**
Meeting Date:	9 January 2014
Responsible Officer(s)	Julie Ogley (Director of Social Care, Health and Housing, Central Bedfordshire Council (CBC)) Dr Diane Gray (Bedfordshire Clinical Commissioning Group (BCCG))
Presented by:	Dr Judy Baxter (BCCG) Elizabeth Saunders (CBC)

Action Required:

1. **the Board to note progress against the key mental health outcome measures;**
2. **to note progress made on measuring customer and carer experience of mental health services; and**
3. **to advise the Board of recent developments in respect of mental health services.**

Executive Summary	
1.	At its meeting on the 18 July 2013, the Health and Wellbeing Board considered a progress report outlining actions underway to improve the position relating to three Mental Health Indicators. The Board requested a report reviewing progress against these indicators and further information concerning other Key Performance Indicators. This paper reports on progress to date, as well as advising the Board of recent developments that have a potential impact on mental health services.

Background	
2.	The update on the three original indicators:

	Increasing Access to Psychological Therapies (IAPT)
2.1	The national target is to increase access to Psychological Therapies for people with depression and/or anxiety to 15% (of the prevailing population) by March 2015. The BCCG plan is to increase access to 10% (of the prevailing population) by March 2014, and 15% by March 2015. Significant work has been undertaken in this area. BCCG has provided training for 95% of GP based counsellors to enable them to be IAPT compliant and have now introduced a generic data tool to capture IAPT activity for all trained staff. A Q2 report is appended (Appendix 1) which suggests that action taken to increase capacity will result in these targets being achieved. The recommendation for procurement of Steps 1 – 3 of the Stepped Care Model, covering IAPT and counselling will be taken to the Governing Body in February 2014.
	2012/13 Adult Social Care Outcomes Framework (ASCOF) Outturn Measures
2.2	The two measures concerned are: **IF-Proportion of adults in contact with secondary mental health services in paid employment** **IH-Proportion of adults in contact with secondary mental health services living independently, with or without support.** For both these measures there had been a significant drop in performance for 2011/12 when compared to the out turn in performance for 2010/11. This was identified as likely to be a combination of two factors: • Drop in performance for both these measures was shown across all local authorities for this one year, which seemed to show some problem in how the performance was captured by the National Office of the Information Centre for Social Care. • Data recording issues within SEPT which meant the information on these performance indicators were not recorded correctly.
2.3	From 2012/13 for both measures there has been an improvement in performance such that for 1F Central Bedfordshire is in line with the East of England average and for 1H above the East of England average. For both measures Central Bedfordshire is also above the overall England average.

	These performance measures are scrutinised at the quarterly performance management Group, (PMG) meeting with SEPT, chaired by the Assistant Director for Commissioning and this sustained improvement has been checked and verified. SEPT are now also providing case studies to give more qualitative information on the difference settled employment and housing is making to individuals. The full Performance Comparison Information for Central Bedfordshire and the England and East of England average are shown in Appendix 2.
3.	Other Key Performance Measures are also reported by South Essex Partnership Trust (SEPT). These measures are considered quarterly as part of the PMG meeting, and the measures reported on are shown in Appendix 3.
The Emerging Stepped Care Model	
4.	Following a number of workshops in Bedfordshire, a Stepped Care Model has been developed and proposed for Mental Health Services. The model is available at Appendix 4. The principle of this model is that whilst there will continue to be key services that meet the need of the wider Bedfordshire population, (including in patient beds and Crisis Team support) there will also be locality focused mental health teams who work in a more integrated across the range of adult mental health needs within their population. People who need support will be able to access it at the level of support that they need. This will reduce the need for a number of referrals across teams and enable people to get the right support at the right time, by the right service which should improve the experience for people receiving a service.

5.	**Recent Developments that have Potential Impact on Mental Health Outcomes**
5.1	**Mental Health and Learning Disability Procurement** The SEPT Mental Health and Learning Disability Contract is due to end in March 2014. Work has been on going in the development of the Stepped Care Model for Mental Health services. The model provides locality based teams, four of which will be for Central Bedfordshire, at Ivel Valley, Mid Beds, Leighton Buzzard and Chiltern Vale and the teams will provide a service to people across the York Clusters (which is a tool for identifying patients needs dependent on their diagnosis), as identified in the Payment by Results guidance for Mental Health.

	There have been two workshops to listen to service user and carers' to understand what is important to them when accessing Mental Health Services. This work continues and will help to develop Outcome Based Service Specifications for the local service. This will result in an improvement in the monitoring of the quality of service delivery with measures against the outcomes that service users and carers' have identified. The procurement of Mental Health Services beyond March 2014 has commenced, a steering group, including representation from Central Bedfordshire Council has been established and a project manager is in post. A sub group is working on the disaggregation of existing services, to make a Bedfordshire proposal that is coterminous with Central Bedfordshire and Bedford Borough Council populations. The recommendation for procurement of this contract will be made by the Governing Body of the CCG in February 2014, and is likely to be a joint procurement process with the two councils.
5.2	**Payment by Results**
	Following a series of workshops early this year, the clinical pathway for treatment, interventions and support has been completed for each cluster/identified diagnosis and development of tariffs has begun.
5.3	**Recent Partnership Concerns**
	Both the probation and the police services have raised some concerns regarding the mental health service support locally and will be providing a focused report on the issues being experienced. A group is being established to oversee this work, with CCGs, Police, Probation and three councils' representatives. The remit of this group will be to ensure immediate actions can be taken to address recent issues as well as provide oversight of services transition during the Mental Health Services procurement period.

6.0	**Detailed Recommendation**
6.1	That the Board note the progress made against the IAPT indicators.
6.2	That the Board note the progress made against the Accommodation and Employment indicators.
6.3	That the Board note the recent developments that have a potential to impact on mental health outcomes.

Issues	
Strategy Implications	
7.	This area aligns with Priority 9 of the HWBB Strategy: Improving Mental Health and Wellbeing of Adults.
8.	There is an alignment with the BCCG Strategic Commissioning Plan and the area of focus: 'care right now', and 'care when it's not that simple'.
Governance & Delivery	
9.	Delivery and Progress will also be reported to the: Mental Health Change Board, the Joint Commissioning Group, the Mental Health Delivery Partnership and HCOP. Progress for the ASCOF measures and wider KPI's will also be monitored through the CBC Section 75 Performance Management Group. Progress for the IAPT targets will be monitored through contract performance meetings with relevant contracts in BCCG.
Management Responsibility	
10.	Responsibility for the delivery rests with the Director for Social Care Health and Housing and the Chief Operating Officer for the Bedfordshire Clinical Commissioning Group. This responsibility may be delegated for day to day operational delivery.
Public Sector Equality Duty (PSED)	
11.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
	Are there any risks issues relating Public Sector Equality Duty No
	No Yes *Please describe in risk analysis*

Risk Analysis
Briefly analyse the major risks associated with the proposal and explain how these risks will be managed. This information may be presented in the following table.

Identified Risk	Likelihood	Impact	Actions to Manage Risk

Source Documents	Location (including url where possible)

Dr Judy Baxter (BCCG)
Elizabeth Saunders (CBC)

_____
Presented by (type name)

Appendix1	**Improving Access to Psychological Therapies (IAPT)- Q2**
Context / Additional Analysis	The National Target for IAPT is that 15% of the prevailing population of common mental health disorders will access therapy by March 2015. Bedfordshire CCG has agreed a local target of 10% by March 2014. The current performance data based at the end of Quarter 2 is • People with depression who receive psychological therapies Qtr. 2 (1.7%) • People with depression who completed treatment and moving to recovery Qtr. 2 (53.0%)
Recovery Actions	In April 2013, the BCCG Mental Health Change Management Board approved a two year recovery plan for IAPT, to meet a 10% prevalence of common mental health disorder in 2013/14 and 15% prevalence of common mental health disorder by March 2015. One of the key actions in achieving this target was to provide additional training to GP based counsellors to enable them to be IAPT compliant and therefore to enable their activity to be included in the performance target. Additional training was arranged and delivered in July, September and November and now 95% of the workforce in counselling is able to provide IAPT services. Another course is available in February 2014 and it is anticipated that the remaining counsellors will access this, resulting in 100% of current counsellors being compliant. The Moving to recovery indicator national target is 50% however locally a stretch target of 58% was agreed. Currently we are at 53% based on the activity by one of our providers. Following the completion of IAPT training for our counsellors, our second provider, Ready to Talk has begun to collect data on this target and the outcome will be reflected in Q3 submission. We continue to hold monthly contract monitoring meetings with our providers to review these targets and identify additional actions to improve outcomes. Additional resource has been identified to increase the workforce and this will be allocated in Q4.

	To enhance the referral route for IAPT in January to improve the number of people access IAPT through self-referral. In December, all counsellors have completed an IT course on IAPT system to record their activity data. The target is being closely monitored and the CCG remains confident that with the additional data/activity that will be captured from Q3, that the access target of 10% will be achieved.
Expected year end position	The local target of 10% access to IAPT services will be achieved.
Recovery Trajectory	Mental Health Programme Budget Business Case to deliver 10% prevalence of common mental health disorder for 2013/14 has been approved. It is expected that the impact of the additional funding will support a full year position of 10% for 2013/14 and 15% for 2015/16.
Lead Director	Judy Baxter

Appendix 2

Adults in contact with secondary mental health services in employment (ASCOF-1F)

Year	Central Bedfordshire	England Average	Eastern Region	Highest E Region	Lowest E Region
2010-11	17.5%	12.9%	9.2%	28.7%	3.5%
2011-12	5.4%	8.9%	10.1%	18%	2.8%
2012-13	**11.8%**	**7.7%**	**11.8%**	**15.9%**	**2.3%**

Adults in contact with secondary mental health services living independently with or without support (ASCOF 1H)

Year	Central Bedfordshire	England Average	Eastern Region	Highest E Region	Lowest E Region
2010-11	92.8%	74.9%	66.7%	92.87%	45.5%
2011-12	53.1%	54.6%	55.5%	71.4%	19.5%
2012-13	**78.2%**	**59.3%**	**68.5%**	**79.9%**	**32.8%**

Appendix 3

Ref	Indicator Description	Target*	Current Position October 2013	2013-14 Outturn	RAG Rating	What's Excellent	Data Provider	Risk / Mitigating Action
NI132	Timeliness of Assessment (Year To Date (YTD))	99%	100%	100%	←	High %	LA	All 104 assessments were completed within 4 weeks of referral.
NI133	Timeliness of Packages following Assessment (YTD)	95%	91%	100%	↑	High %	LA	1 out of 11 care packages did not meet the 28 day target. This is currently being validated.
NI135	Carers receiving needs assessment or review and a specific carer's service, or advice and information (YTD)	100% (YTD 59%)	62 (46.6%)	152 (100%)	↑	Increasing Numbers and %	LA	The performance has increased with 4 additional carers added but this is still below the year to date trajectory
NI130	Number of Clients receiving Self Directed Support (YTD)	70% (YTD 59%)	186 (66.2%)	181 (61%)	↑	High % or Numbers	LA	There has been an increase of 3new Personal Budgets since September
D40	Service User Reviews (Rolling Year figure)	85% (YTD 50%)	172 (62.3%)	83%	↑	High %	LA	There has been a significant improvement made with reviews since last month

NI149	Adults with Mental Health Problems in Settled Accommodation	94%	93%	93%		Stable %	Trust	
NI150	Adults with Mental Health Problems in Employment	15%	9%	13%	←	Stable %	Trust	Performance has remained at 9%
Time taken to complete safeguarding investigations	5 days Strategy (YTD)	70%	31 (91%)	72 (98%)		High %	Trust	31 meetings out of 53 were held within 5 days. 17 cases were justified and 5 cases unjustified.
	35 days Investigation (YTD)	80%	25 (100%)	40 (100%)		High %	Trust	This indicator reports 25 completed investigations within 35 days. There were 3 cases completed over 35 days which were justified.
	Incomplete investigations over 35 days at month end	Snap shot	0	9		Low %	Trust	3cases are over 35 days(all justified) and10 under 35 days.

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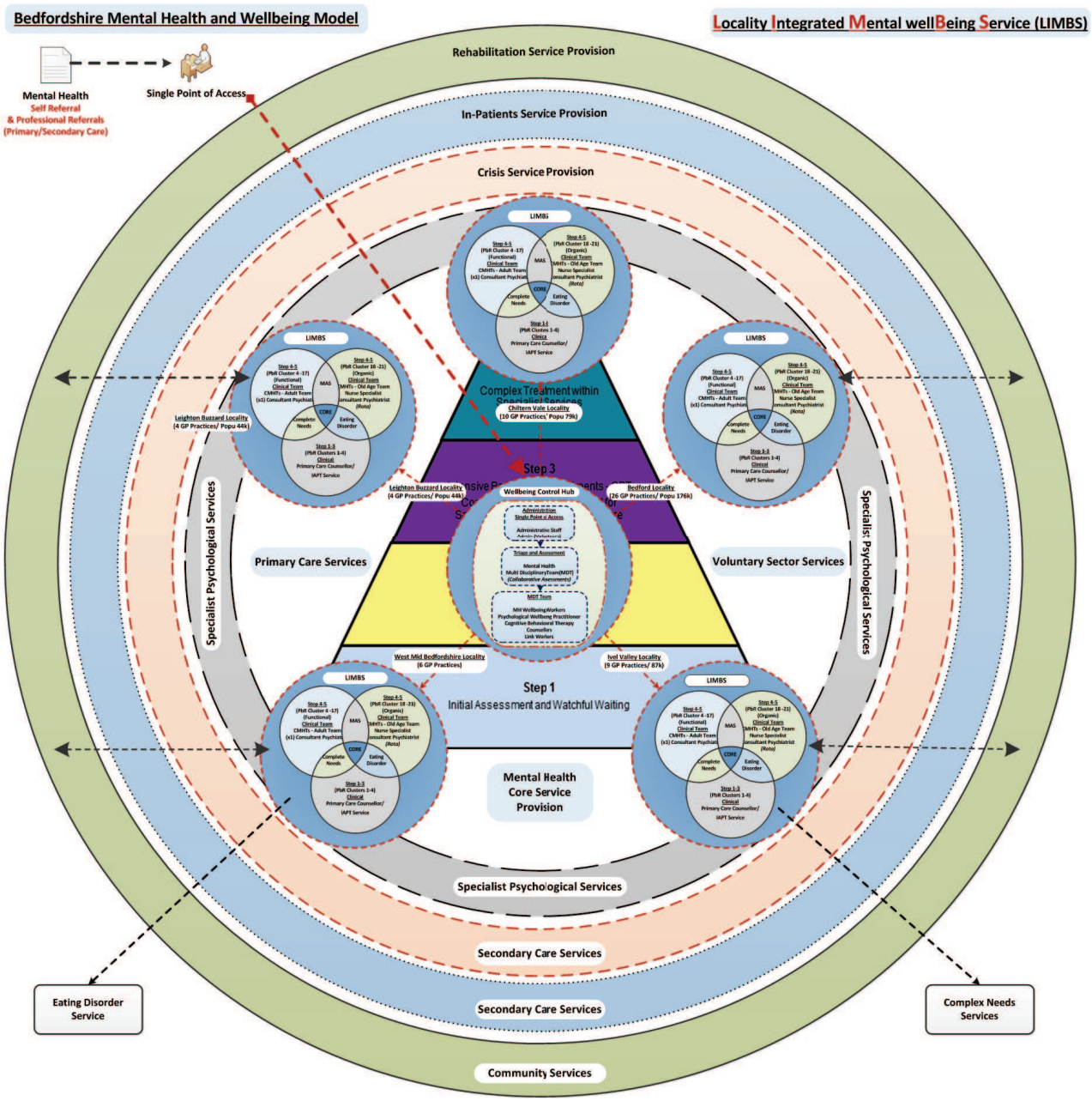
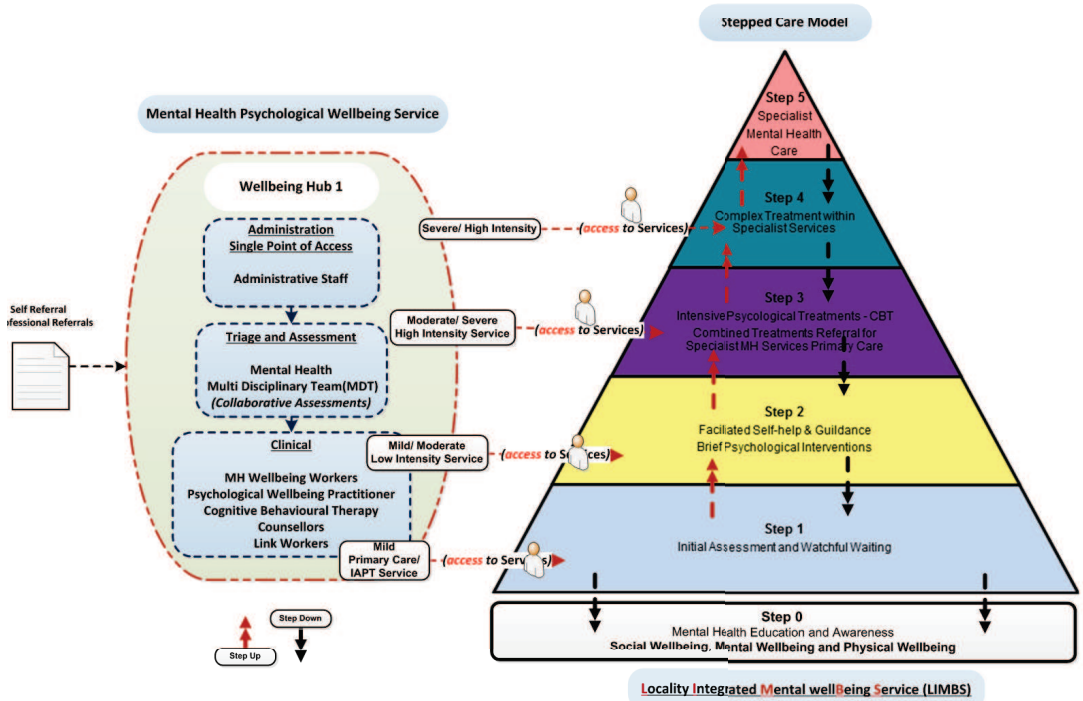

Bedfordshire Mental Health and Wellbeing Model
Locality Integrated Mental wellBeing Service (LIMBS)
Mental Health
Self Referral
& Professional Referrals
(Primary/Secondary Care)
Single Point of Access
Rehabilitation Service Provision
In-Patients Service Provision
Crisis Service Provision
LIMBS
Complex Treatment within Specialist Services
Chiltern Vale Locality
(10 GP Practices/ Popu 79k)
Step 3
Leighton Buzzard Locality
(4 GP Practices/ Popu 44k)
Bedford Locality
(26 GP Practices/ Popu 176k)
Wellbeing Control Hub
Administration
Single Point o Access
Administrative Staff
Triage and Assessment
Mental Health
Multi Disciplinary Team(MDT)
(Collaborative Assessments)
MDT Team
MH WellbeingWorkers
Psychological Wellbeing Practitioner
Cognitive Behavioural Therapy
Counsellors
Link Workers
Primary Care Services
Voluntary Sector Services
Specialist Psychological Services
West Mid Bedfordshire Locality
(6 GP Practices)
Ivel Valley Locality
(9 GP Practices/ 87k)
Step 1
Initial Assessment and Watchful Waiting
Mental Health
Core Service
Provision
Specialist Psychological Services
Secondary Care Services
Secondary Care Services
Community Services
Eating Disorder
Service
Complex Needs
Services


Stepped Care Model
Mental Health Psychological Wellbeing Service
Wellbeing Hub 1
Administration
Single Point of Access
Administrative Staff
Triage and Assessment
Mental Health
Multi Disciplinary Team(MDT)
(Collaborative Assessments)
Clinical
MH Wellbeing Workers
Psychological Wellbeing Practitioner
Cognitive Behavioural Therapy
Counsellors
Link Workers
Self Referral
Severe/ High Intensity
Moderate/ Severe
High Intensity Service
Mild/ Moderate
Low Intensity Service
Mild
Primary Care/
IAPT Service
Step Down
Step Up
Step 5
Specialist
Mental Health
Care
Step 4
Complex Treatment within
Specialist Services
Step 3
Intensive Psycological Treatments - CBT
Combined Treatments Referral for
Specialist MH Services Primary Care
Step 2
Facilated Self-help & Guidance
Brief Psychological Interventions
Step 1
Initial Assessment and Watchful Waiting
Step 0
Mental Health Education and Awareness
Social Wellbeing, Mental Wellbeing and Physical Wellbeing
Locality Integrated Mental wellBeing Service (LIMBS)

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	Better Care Fund (Integration Transformation Fund)
Meeting Date:	9 January 2014
Responsible Officer(s)	Julie Ogley, Director of Social Care, Health & Housing John Rooke, Chief Operating Officer, Bedfordshire Clinical Commissioning Group
Presented by:	Julie Ogley, Director of Social Care, Health & Housing John Rooke, Chief Operating Officer, Bedfordshire Clinical Commissioning Group

Action Required: The Board is asked to:

1. To note the requirements for the Better Care Fund.
2. Note the timescale and agree the proposed arrangements for the sign off of the Better Care Plan Template by the Health and Wellbeing Board.
3. Require a further report on the approach to integration in Central Bedfordshire.

Executive Summary	
1.	The £3.8 billion Better Care Fund (formerly Integration Transformation Fund) was announced by the Government in the June 2013 Spending Round, to ensure transformation in integrated health and social care. It is intended to provide a better experience of care to patients and service users and by so doing reduce the pressure on residential care and acute hospitals.
2.	Access to the Better Care Fund in 2015/16 will be dependent on agreement of a local 2-year plan for 2014/15 and 2015/16. Health and Wellbeing Boards are required to provide the first cut of their completed Better Care Plan template, as an integral part of the constituent Clinical Commissioning Groups'' Strategic and Operational Plans by 14 February 2014.

Background	
3.	The Government is encouraging all areas to develop their own reforms to public services. To this end, the Government, working in a collaborative of national partners, has set out an ambitious vision of making integrated person-centred care and support the norm across the health and social care system in England by 2018[i].
4.	The Better Care Fund (BCF - previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. However, £1bn of the £3.8bn is to be linked to achieving outcomes; the Planning Guidance summarises the basis on which the performance related elements will operate.
5.	The BCF provides an opportunity to transform local services so that people are provided with better integrated care and support and is seen as an important enabler to take the integration agenda forward at scale and pace. It supports the aim of providing people with the "right care, in the right place, at the right time", including through a significant expansion of care in Community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing to develop integrated care and on understanding the patient/service user experience.
6.	The funding must be used to support Adult Social Care Services in each local authority area and must be of health benefit. It also offers flexibility for local areas to determine how this investment in social care services in best used.
7.	A condition of the transfer is that local authorities agree with their health partners how the funding is best used within social care and the outcomes expected from this investment. Health and Wellbeing Boards will be the natural place for discussions between the Board, Clinical Commissioning Groups and local authorities on how the funding should be spent, as part of their wider determination of the use of their total health and care resources.
8.	The joint Better Care Plan should have regard to the Joint Strategic Needs Assessment for the local population and the existing commissioning plans for both health and social care.
9.	The tables below summarise the elements of the Spending Round announcement on the Fund:

The June 2013 Spending Round set out the following:	
2014/15	2015/16
A further £200m transfer from the NHS to adult social care, in addition to the £900m transfer already planned	£3.8bn to be deployed locally on health and social care through pooled budget arrangements
In 2015/16 the Fund will be created from:	
£1.9bn of NHS funding	
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise: • £130m Carers' Break funding • £300m CCG reablement funding • £354m capital funding (including £220m Disabled Facilities Grant) • £1.1bn existing transfer from health to adult social care.	

10.	Whilst the fund itself does not address the financial pressures faced by local authorities and CCGs, it can act as a catalyst for developing a new shared approach to delivering services and setting priorities.
11.	A template has been produced nationally for local areas to complete their submissions.(Appendix A) The template sets out the key information and metrics that Health and Wellbeing Boards will need to assure themselves that their plans address in order to meet the conditions of the BCF.
Central Bedfordshire Allocations	
12.	For 2014/15 the revenue allocation of the national pot of £1.1bn for Central Bedfordshire will be £3.821m, an increase of £0.722m over the NHS Transfer funding for 2013/14.
13.	The national allocation of £3.8bn for 2015/16 will lead to an apportionment of £15.290m to Central Bedfordshire taking account of the other funding streams set out above. The amount includes £1.19m for Disabled Facility Grants and Social Care capital grants with £14.1m transferring from the Bedfordshire Clinical Commissioning Group.
Statutory Framework for the Fund	
14.	In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75 joint governance arrangements between CCGs and councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these Plans must meet certain requirements.

15.	Whilst the BCF mandates a minimum level of investment, CCGs and councils are free to extend the scope of their plans and pooled budget to support better integration in line with their Joint Health and Wellbeing Strategy.
16.	Each statutory Health and Wellbeing Board will sign off the plan for its constituent Councils and CCGs. The Fund plan must be developed as a fully integral part of a CCG's wider strategic and operational plan, but the Better Care Fund elements must be capable of being extracted to be seen as a stand-alone plan.
17.	The specific priorities and performance goals in the plan are clearly a matter for each locality but Central Government considers it will be valuable to be able to:
	• aggregate the ambitions set for the Fund across all Health and Wellbeing Boards; • assure that the national conditions have been achieved; and • understand the performance goals and payment regimes that have been agreed in each area.
Requirements of the Funding – National Conditions	
18.	Six national conditions for access to the Fund have been set:
	1. Plans to be jointly agreed 2. Protection for social care services (not spending) – explanation of how local services will be protected. 3. 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends 4. Better data sharing between health and social care, based on the NHS number 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 6. Agreement on the consequential impact of changes on the acute sector
19.	CCGs and Councils must engage from the outset with all providers, both NHS and social care (and also providers of housing and other related services), likely to be affected by the use of the fund in order to achieve best outcomes for local people. The Better Care Plan should set out how this engagement has taken place.
Reward for meeting goals	
20.	Key elements of the funding will be linked to performance measures. The national metrics underpinning the Fund will be:
	1. Delayed transfers of care; 2. Emergency admissions;

	3. Effectiveness of re-ablement; 4. Admissions to residential and nursing care; 5. Patient and service user experience (a new national measure is being developed);
21.	In addition to the five national metrics, local areas should choose one additional indicator that will contribute to the payment-for performance element of the fund. This could be from the Outcomes Framework for the NHS, Adult Social Care or Public Health.
22.	Local areas should set an appropriate level of ambition for improvement against each of the national indicators and the locally determined indicator. In signing off local plans, Health and Wellbeing Boards should be mindful of the link to the levels of ambition on outcomes that CCGs have been asked to set as part of their wider strategic and operational plans. Both the effectiveness of reablement and avoidable emergency admissions outcomes metrics are consistent with national Metrics for the Fund, and so Health and Wellbeing Boards will need to ensure consistency between the CCG levels of ambitions and the Fund plans.
Current Joint Working	
23.	The BCF should enhance the key work priorities of the Joint Health and Wellbeing Strategy. Principally, it has the potential to enhance delivery and improved outcomes through more integrated approaches to caring for frail older people. This remains one of the key priorities of the Health and Wellbeing Board, the Council and the CCG.
24.	The Pioneer Bid submitted in June 2013 provides a starting point and will be used to explore and determine the approach to taking forward the vision on wider integration.(Appendix B)
25.	The BCF will be a catalyst for on going work, initially through the Review of Community Beds and the wider strategic review of health and social care in Central Bedfordshire. A number of principles will underpin the development of services to deliver improved outcomes. These are:
	• Maximising opportunities to prevent ill health and increasing emphasis on early intervention; • People are supported to remain independent at home through joined up health and social care services delivered in a person's own home, wherever possible; • Services should support the objective of avoiding or reducing hospital admissions and facilitating timely discharges; • Services should support the objective of avoiding or reducing entry into long term residential care, residential nursing care and short term emergency respite care;

	• Services which are flexibly focused around customer outcomes and achieving independence, less prescriptive about eligibility criteria and lengths of provision that acts as a barrier to accessing care provision; • Simple and streamlined referral processes, joint health and care pathways and improved information sharing.
26.	Discussions are currently on-going to explore opportunities for the physical integration of health and social care in Biggleswade and Dunstable and the re-procurement of community services in the next 12-18 months.
27.	Agenda item 7 sets out a different approach to supporting frail patients in the South of Central Bedfordshire. The BCP will also determine how each locality in Central Bedfordshire is supported to deliver more focused improvements for older people.
Role of the Health and Wellbeing Board	
28.	A key element of assurance for the Better Care Plan is the sign off by the Health and Wellbeing Board which should consider whether the plans are sufficiently challenging; will deliver tangible benefits for the local population and is linked to the JSNA and the Joint Health and Wellbeing Strategy.
29.	The Health and Wellbeing Board is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process.
30.	The plans will also go through an assurance process involving NHS England and the Local Government Association. Ministers will give the final sign-off to plans and the release of performance related funds. Peer review arrangements may be activated if plans are not considered satisfactory.
31.	To assist Health and Wellbeing Boards, a draft template has been developed. This will be used in developing, agreeing and publishing the Better Care Plan. It sets out the key information and metrics that the Health and Wellbeing Board will need for assurance that the plan addresses the conditions of the BCF.
32.	As part of this template, local areas should provide an agreed shared risk register. This should include an agreed approach to risk sharing and mitigation covering, as a minimum, the impact on existing NHS and social care delivery and the steps that will be taken if activity volumes do not change as planned (for example, if emergency admissions or nursing home admissions increase).
33.	If the Health and Wellbeing Board is not satisfied and the plan is still lacking after a process of progressive iteration, an element of local government and NHS peer challenge will be facilitated by NHS England and the LGA.
34.	The Health and Well Being Board must return the completed planning template (uncompleted version attached) by 14 February 2014.

When should plans be submitted?	
35.	Health and Wellbeing Boards should provide the first cut of their completed Better Care Plan template, as an integral part of the constituent CCGs' Strategic and Operational Plans by 14 February 2014.
36.	A revised version of the Better Care Plan should be submitted to NHS England by 4 April 2014.

Conclusion and Next Steps	
37.	Work has started in gathering the information required to develop a deliverable Better Care Plan for Central Bedfordshire.
38.	Further work to develop a communication strategy and engagement plan with all key stakeholders is on-going. Key stakeholders will include General Practitioners, NHS and Care Providers, staff, patients, Healthwatch Central Bedfordshire as well as Voluntary and Community Groups.
39.	The CCG has engaged some external support for this work which should secure clinical engagement. This will also provide additional expertise, experience and capacity to ensure a draft submission can be delivered by mid February.
40.	It is imperative to secure a shared vision of what integrated care is and to agree where investment needs to be refocused to achieve it. This will require shifting the balance of care from the Acute sector and redistributed into primary, community and social care.
41.	The scale and impact of this will need to be modelled and set out in Commissioning Intentions and Market Position Statements.
40.	Further work to support engagement with all key stakeholders on the emerging Better Care Plan is also on-going.
42.	A more detailed Better Care Plan with implementation proposals will be brought to a future meeting of the Health and Wellbeing Board. This will also propose a Partnership Framework and governance arrangements that will be required to manage the pooled arrangements and delivery of the Better Care Plan.
Detailed Recommendation	
43.	The timescales for the production of the Joint 2 year local Better Care Plan which would need to be agreed by the Health and Wellbeing Board is short and not consistent with the Board's meeting schedules, consequently the recommendation is:

	1. That the Health and Wellbeing Board notes the requirements for the completion of the Template for the Better Care Fund and agrees arrangements to meet the deadline for signing off the Joint Plan by 14 February 2014.
.	2. That the Board delegates to the Chair and Vice Chair the authority to approve the template for submission.
	3. That a further report on the approach to integration in Central Bedfordshire be brought to a future meeting of the Board.

Issues	
Strategy Implications	
1.	Developing integration of health and social care will have a direct impact on improving health outcomes and experience of health and care services for people in Central Bedfordshire.
2.	Integration of Health and Social Care is a key ambition and priority for the Health and Wellbeing Board.
3.	The joint Health and Wellbeing Strategy and Bedfordshire Plan for Patients set out shared priorities based on the Joint Strategic Needs Assessment
Governance & Delivery	
4.	Progress on developing the Better Care Plan will be reported to the Health and Wellbeing Board and delivery will be through agreed joint commissioning mechanisms and governing boards for partners. The Health and Health Wellbeing board will provide overall assurance and sign off the BCP for Central Bedfordshire.
Management Responsibility	
5.	Management responsibility for the delivery of integrated health and social care services lies with the Director of Social Care, Health and Housing and the Chief Operating Officer for Bedfordshire Clinical Commissioning Group.

Public Sector Equality Duty (PSED)		
6.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The draft JHWS has had an equality impact assessment undertaken and this will inform the final strategy including the priority to improve outcomes for frail older people.	
	Are there any risks issues relating Public Sector Equality Duty	**No**
	No **Yes** *Please describe in risk analysis*	

Risk Analysis
There is a requirement to develop joint local plans for the pooled budget for health and social care. The development of the Better Care Plan will include considerations of associated risks. There may be risk issues if the national conditions described in this report are not met, especially as a significant amount of the funding is performance related. These risks are to be mitigated through the development of joint local plans and identification of the consequential impact of the proposed changes with all key providers.

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
			.
Source Documents		**Location (including url where possible)**	

Appendix A – Better Care Fund Planning Template

Appendix B – Pioneer Bid – Expression of Interest

[i] **Integrated Care and Support: our shared** commitment – a framework document on integration, co-produced by all the national partners, signals how the national partnership will work together to enable and encourage local innovation, address barriers, disseminate and promote learning in support of better integration for the benefit of patients, people who use services and local communities. It requires all localities to develop plans for integration and sets out how local areas can use existing structures such as Health and Wellbeing Boards to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration.

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Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**<Name of Local Authority>**
Clinical Commissioning Groups	**<CCG Name/s>**
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
Boundary Differences	**<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	<Name of ccg>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	<Name of council>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Please explain how local social care services will be protected within your plans.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
<Risk 1>		
<Risk 2>		
<Risk 3>		
<Risk 4>		

NHS Bedfordshire Clinical Commissioning Group

Central Bedfordshire

EXPRESSIONS OF INTEREST FOR HEALTH AND SOCIAL CARE INTEGRATION 'PIONEERS'

1. Central Bedfordshire's Vision for Integrated Health and Social Care

1.1 The Why?

Central Bedfordshire is a place of both great opportunity and challenge. As a relatively new group of Health and Council leaders we are both very ambitious for our residents. We are driven by the belief that to deliver significantly improved and sustainable outcomes for our people we need to

- embrace timely decisions being made at a local level, by staff who are close to their patients and clients;
- consider Council and Health funding streams together to deliver improved local access to good quality care, pooling budgets where it is possible;
- address any imbalance in provision of good quality care across Central Bedfordshire.
- redesign services to deliver public health priorities particularly as it relates to prevention and maintaining independence
- work with providers to break down barriers between Physical Health and Mental Health services
- promote personalisation of support across health and social care

Our principal challenges are

- our significantly ageing population and above average rate of growth for England, and the demands on services that are unfolding;
- the impact of higher levels of dementia in our population
- Delivering effective services across a rural area
- significant housing and general population growth in a largely rural environment;
- ensuring the quality and accessibility of services locally - patients are currently discharged from 6 District General Hospitals outside of Central Bedfordshire and there are issues about the viability of these;
- the need to support family carers to keep caring and maintain their cared for independence
- our current comparatively low level of integrated community health/mental health responses;
- ensuring real focus on the needs of our residents following changes to Health Commissioning and other governance arrangements and increasing our efforts to deliver joined up approaches.

However, we believe that our track record in shifting investment to a prevention/intervention approach demonstrates our commitment to the transformational system type change that is required to improve outcomes for our growing population. We are using the levers available to the Council and its Health partners to shape our future, for instance, our Local Development Strategy clearly identifying our expectations around the accommodation types required for meeting the needs of our ageing population. We are using Health transfer funds to provide real alternatives to hospital care and creating

preventative options to future proof the system. This includes our risk stratification and case management approach with GPs and community health services colleagues, and, our sub-acute short stay medical unit and step up/down residential beds which has had a very significant impact on Urgent hospital activity in a relatively short space of time.

1.2 The What?

To deliver the on-going transformational changes required we believe that there needs to be a greater degree of very local decision making. We will bring together the decision making about levels of investment at a strategic level between the Council and CCG and at a local level between medical, health and social care practitioners.

We want to see a changed relationship between Council and Health Commissioners and Health Provider organisations to enable a focus and ownership of their local population and meeting their needs. This will require a programme running over the next 3 – 5 years to deliver an integrated approach to commissioning and service delivery. Over this period we want to explore the following freedoms:

- Simpler means of creating pooled budgets between Councils, Health Commissioners and Providers.
- Collaborative commissioning with NHS England including earlier transfer of the 0 – 5 years children's budget and devolved responsibilities for elements of GP Primary Health Care contracts.
- Development of integrated non-urgent Patient Transport Services with Council and other public sector transport services to create a single service, allowing Ambulance services to concentrate on Urgent Care
- Support from Government and Monitor to enable flexibilities in the financial mechanisms of Hospital and Community Foundation Trusts to enable surpluses and reserves to be targeted on supporting local transformation Programmes.
- Integrating Hospital Services with GP, Community Health and Social Care services which may include establishing new types of mutual or social enterprise type organisations.
- Building social capacity in communities so communities can be self-sustaining and more resilient
- Building effective support to family carers to keep caring for longer
- Further development of innovative care models i.e. CBC village care agents, Telehealth, parish council level volunteers, good neighbours etc

1.3 The How?

Central Bedfordshire and the CCG will achieve this change by

Empowering the Central Bedfordshire Health and Well Being Board to lead and hold to account the partners for driving through this change.

Moving towards local whole system approaches and governance rather than the current focus on individual organisations such as Foundation Trusts where the emphasis of accountability is to Monitor rather than local people.

Utilising our well established 4 Primary Care Localities in Central Bedfordshire to provide the building blocks to deliver transformational change. This will include the creation of Primary

and Community Service Hubs for Health and Social Care staff to deliver integrated services to their local population.

Utilising the housing growth and town centre developments to deliver new accommodation for hub services to facilitate local access to a wider range of good quality health and social care interventions.

Establishing a Provider Board for Central Bedfordshire consisting of NHS, Council, independent sector, and voluntary and community sector providers.
Utilising the area's housing growth to meet the needs of older people through extra care sheltered housing developments in close proximity to new build care homes and providing a different approach to community bed provision.

2. Plan for Whole System Integration

2.1. A Whole System Approach

The Council and CCG recognise that person centred, co-ordinated care and support is key to improving outcomes for those individuals who use health and social care services. However, the National Voices programme has identified that across the UK it is the experience of Users and Carers that local organisations do not always communicate effectively with each other, do not always work together and do not always treat people as whole individuals. This can result in care being fragmented, delayed or duplicated and can also result in missed opportunities to prevent needs from escalating, and missed opportunities for early interventions. This leads to poorer outcomes and experience.

Achieving truly integrated care is a major challenge. Although most local systems can offer examples of good practice it is generally acknowledged that the overall development of Integrated Care has not reached its full potential.

Agencies within the Council and CCG system recognise this challenge and also the importance of delivering Integrated Care at scale and pace. The local system is taking forward a robust programme to develop a common view of what whole system Integration really means, why it matters and what it can achieve. It is acknowledged that Integrated Care means overcoming barriers between

- Primary and Secondary Care
- Physical and Mental Health
- Health and Social Care and third/independent sector
- Different organisations, their competing priorities and fiscal constraints

There are a number of approaches to integrating care including

- Merging Organisations
- Enabling organisations to work more closely together through 'virtual integration' in the form of networks, partnerships and alliances.
- Covering whole populations or focusing on particular care groups with stratified need.

The current focus in the CBC/BCCG system will be very much upon clinical and service integration through partnerships. Organisational change will be considered as the programme progresses. There is also a strong desire to involve citizens and communities in co-producing the model of integration to meet their needs and make best use of their social capital. For this to be effective this must be embedded in the community but with leadership and organisation through the CBC and BCCG system.

2.2 Aims

The principal aims of the CBC and BCCG integrated care programme are to

- Provide more proactive rather than reactive care
- Develop 'people' rather than 'organisation' focused care pathways
- Apply the local intelligence gathered from listening to the voice of the communities
- To co-produce support for individuals, their families and communities to remain independent
- Work with communities and individuals to use public services effectively and thus manage their own independence and maintain their own health better
- Improve outcomes focused on maximising independence and improved experience of health and care services for the population.
- Reduce the numbers of individuals admitted to hospital with urgent but sub-acute care needs with a consequent reduction in capacity in acute services
- Reduce the number of people in long term residential care.
- Improve the support to family carers

The Central Bedfordshire system will integrate and deliver these aims and achieve the vision by

- Committing to an open book approach to make the most effective use of resources.
- Taking forward a 'cradle to grave' approach to integrated care using General Practice and aligned community health and social care teams as the focus for support to families.
- Developing new Integrated Health and Care Partnerships at a locality level involving GPs, Community Health Services, Mental Health Community Services, Social Care, Housing and Community and Public Health.
- Developing new Integrated Health and Care Partnerships at Hospital Catchment/Council area level to support a major re-structuring of Older People's services.

2.3 Principal Integrated care programmes

2.3.1 Locality Partnerships

Central Bedfordshire Council has a population of 260,000 (2011) within an area of 716 square kilometres. It is the 11th largest Unitary Council by area in England. The council area is described as predominantly rural with four main population centres. Considerable Housing and Economic growth is planned.

Central Bedfordshire will experience a significant growth in population in future years with the population projected to rise to 280,000 by 2021 and 303,000 by 2031. Within that general expansion the population over the age of 65 is projected to increase from 40,000 in 2011 to 56,000 by 2021. In addition to the challenge of an expanding and ageing population, there are also significant pockets of urban and rural deprivation.

Bedfordshire Clinical Commissioning Group was a first wave applicant authorised without conditions. Co-terminus with two unitary authorities, it has thirty GP practice members within the CBC area. It has been jointly developing the CBC Health and Wellbeing Board from shadow form and holds the vice chair.

A combined locality structure is in place centred on four main population centres. These localities and their populations are described

- Leighton Buzzard and Linslade 40,000
- Dunstable and Houghton Regis 80,000
- Biggleswade and Sandy 80,000
- Ampthill and Flitwick 60,000

GP primary care services, CHS and Adult Social Care services tend to be concentrated in these population centres with many practices in close proximity to one another. There are a number of other practices in the larger more rural towns and villages.

There is a robust history of GP Consortium working focused on these localities. Community Health and Social Care Services are aligned with the GP Consortia clusters. Work has been done to develop Locality Health and Care Partnerships around these natural communities which will be formalised to enable budgets and decision making to be devolved. The partnerships will include Patient representatives and the Voluntary Sector.

There has been a progressive programme of prevention and localisation of health and care services developed by localities in recent years and the integrated care plans will take forward the following programmes

- Locality Integrated Care Hubs for Primary Care and Community Services
- Continuing progress on Older people's and Children's programmes to include
    - Multi-agency Prevention programmes which are appropriately co-ordinated and focused
    - Joint Risk Stratification and Case Management of vulnerable Children, Adults with Complex needs and the Frail elderly.
    - Development of a virtual single Health and Social Care Service with Integrated operational management in the provision of intermediate care and treatment.
    - Implementation of the Council and CCG Community Bed Review including new investment in Sub-acute care, Health beds in Residential care homes also ensuring that a range of supported housing in particular Extra care Housing is available to enable individuals to remain at home for as long as possible.
    - Development of locality hubs to support Children with high level, complex needs and their families

2.3.2 Locality Integrated Primary and Community Care Hubs

Central Bedfordshire is unusual in that there is not a District General Hospital within the boundaries of the Council area. This can create difficulties in terms of access particularly for the Elderly Frail. In response to this there is a strong commitment to localise services through the development of Integrated Primary and Community Care Hubs in each of the four localities. These hubs will provide a focus for many of the priority programmes. Primary Care Hubs feature as a high priority within the CCG Estate Strategy.

It is anticipated that the Primary Care hubs will provide

- A wider range of Primary Health care services providing accommodation for groups of practices to co-locate 'under one roof'
- Improved access to GP services through extended hours.
- GP out of hours and walk-in services.
- A focus for LTC management for the whole locality including Dementia Care and the use of new technologies.
- Access to Mental health care services as part of mainstream primary and community care co-location of less complex hospital specialist outreach services.
- Access to all out of hospital care services through the Integrated care hubs
- Alternative management to patients with urgent but sub-acute care needs avoiding hospital admission.

The Primary Care Hubs will be strategically located to support Town Centre Master Plans and Growth areas. In some localities these will be new joint capital developments utilising land and property development opportunities available from both Health and the Council. The development and running costs of these new buildings will be resourced through economies and efficiencies associated with practice co-location and more effective working with the Hospital Sector.

2.3.3. Older People's Programmes

Integrated working on a locality basis provides a platform for a wider re-structuring of care for older people. Older people with frailty and their family carers are those who would benefit the most from person centred and co-ordinated care and support. They are disproportionately vulnerable and regularly cross organisational boundaries. There has previously been an over reliance on the Hospital sector in meeting their urgent care needs.

The scale of change is very significant. A joint clinical audit at the Luton and Dunstable Hospital established that substantial numbers of sub-acute patients are occupying acute hospital beds linked to restricted capacity within alternative community based services. The CBC and CCG Urgent Care programme has begun the process of re-structuring the care pathways so that only patients who are acutely ill are treated in acute settings. By re-structuring the care pathways in this way

- Resources will be shifted to community to provide increased capacity for prevention, earlier intervention and care.
- Experience of users and carers will be improved.
- Hospitals are able to focus on a wider range of complex care including localising very specialist services currently only available at distant tertiary providers.

2.3.4 Children's Services

There is also a very important agenda for Children with Disabilities. Integrated Care Hub arrangements will be developed in the Dunstable and Biggleswade Localities to underpin the new 'Support and Aspiration' agenda. These hubs will provide support to children with Complex Health needs, Special Educational needs and children with Mental Health problems. There will also be a focus on transition from Children's to Adult Services.

Work to identify the health needs of families included in the Troubled Families cohort is developing, along with work to identify and jointly commission projects going forward. These will particularly support the further establishment of the Early Help offer, providing preventative and early intervention services.

2.4 National Strategic Review and New Integrated Care Organisations

The NHS CEO has announced a major review of Health and Care Strategy. In this context the DH is seeking to liberate services to enable flexible solutions to the challenges ahead. This progressive programme is likely to enable new types of provider organisations to emerge which may also have responsibility for service re-design and other elements of commissioning. The Integrated care ambitions of CBC and BCCG are very much in line with this national programme of change.

With reference to services for Older People in particular there is much to do to ensure that the health and care system is delivering the right care, at the right time in the right place. If this is to be achieved it is important for the Health and Care system to achieve a higher level of collaboration through new formal partnerships. New partnerships between Primary Care, Social Care, Hospital Services and Community Health Services are now being put into place to manage the change in care pathways.

It is anticipated that programme budgets will be identified for Older People's Services and that the system will move towards Integrated Outcome based contracts. Such contracts will set clear targets for the re-structuring of these services.

In the context of the National review, these partnerships will also need to consider whether new types of health and care organisations are needed to provide the new care arrangements.

2.5 Financial Constraints and Reinvestment

The CBC /BCCG system recognise the seriousness of this care challenge at a time of increasing financial constraint. It is accepted that by working together the health and care system is better placed to meet the challenges and able to provide sustainable services which offer the right care at the right time in the right place.

We are developing an approach which will overcome fragmentation through integrated models of care and deliver best value. This can be demonstrated by a recent project focused on Sub-Acute care of older people which has indicated that it is possible to both re-structure and provide better quality care within current levels of funding.

Investment in Primary Integrated Care Hubs will be met from a combination of re-cycled GP rent and rates payments, streamlined GP administrative functions and efficiencies within the use of the Hospital sector.

2.6 Integrated Outcome Frameworks

We recognise that new types of integrated outcome frameworks will be needed. Between CCGs, Community Health Services and Social Services there are relatively few shared indicators. The programme in Central Beds will develop jointly integrated outcome indicators initially focusing on prevention and urgent care needs of the frail older people. We expect to work closely with Public Health England and NHS England in this development.

2.7 External Support – Pioneer Programme

Being part of the National Pioneer programme will enable organisations in the Central Bedfordshire system to benefit from being linked to other progressive care systems who are finding new ways to deal with some of the challenges of integrated services.

BCCG is already developing a pioneering specification to procure musculoskeletal services on an integrated MSK system with a capitated (programme budget) contract based on incentivising outcomes and innovation, one of the first in the country to do this at scale. By being part of a small club of CCGs commissioning in this way, we have access to learning from other areas - such as Oxfordshire and Northumberland - that are already developing outcomes-based contracts for frail older people.

The Council and CCG would wish to make best use of the programme of support available through the Pioneer Programme in particular,

- Organisational development so that providers are appropriately configured to support new pathways.
- Local financial mechanisms to ensure funding follows the patient as care pathways change, including pooled budgets, greater use of Section 75 and section 256 arrangements, also imaginative use of Foundation Trust surpluses to support change.
- Ensuring that the programme of change is taken forward appropriately regarding choice, competition and procurement.
- Development of a flexible workforce in conjunction with the Bedfordshire and Hertfordshire Workforce Partnership Group with close links to local colleges of Higher Education and Universities.
- Ensuring that there is patient engagement and professional support for the programme of change
- New arrangements are based upon emerging best practice from other ‘Pioneer’ sites.
- Opportunities to look at international models of care delivery in rural communities

3. Whole System Involvement and Strategy.

CBC and CCG have made a good deal of progress in developing joint working since the creation of the Council. The CBC Health and Well-being Board has been firmly established with a key responsibility for taking forward Integrated Care.

We have developed a range of joint commissioning strategies and implementation programmes for the principal care groups including Children's Services, Older People, Learning Disability and Mental Health. A 'Joint Non-Acute Health and Social Care Services Review' has been completed which included a needs assessment for Community Beds i.e. supported housing, nursing home care and intermediate step up/step down care. When considered with other existing strategic commissioning plans the review document provides the basis of an initial Integrated Care Strategy for the CBC and CCG system.

New Partnerships will be established at Locality and across Hospital catchment areas. By introducing these new partnerships alongside existing Care Group based Joint Commissioning and Delivery groups the whole system will be fully co-ordinated and engaged.

4. Track Record of Developing Transformation at Scale and Pace

4.1 Recent progress in Transformational Change – Sub Acute Care of Elderly Frail Patients

In the Dunstable and Houghton Regis Locality, CBC and CCG system has made very significant progress in the development of Sub-Acute care pathways for the Frail Elderly in full collaboration between Hospital, Community, Social Care and GP services.

A joint integrated care project was commenced in March 2012 in the Dunstable and Houghton Regis Locality within the catchment area of the Luton and Dunstable Hospital to restructure sub-acute pathways for Elderly Frail patients. This has become a principal transformation programme for the CBC/BCCG system.

The project was taken forward in partnership between BCCG, CBC Adult Social Care, The Luton and Dunstable Hospital FT and South Essex Partnership Trust. The project has required the development of a flexible range of out of hospital care services offering alternative health and care management. Services have been developed in line with Royal College of Physicians guidelines. This programme commenced in April? We said March in the previous para ?2012 and very good progress has been achieved at both at scale and pace.

The project was resourced both through Health Transformation funds and the focused deployment of the DH Special Allocation to Local Authorities for Rehabilitation services. Overall pump-priming investment in out of hospital infrastructure was approximately £2.6m.

The infrastructure put in place to provide alternative management includes.

- Community Consultant Geriatrician Led Out of Hospital Care services
- Nursing and Social Care navigation within A&E, Assessment Units and Base Wards
- Step up and Step down Short Stay Medical Unit Beds in the Community (ALOS 7 days)
- Health Funded slower stream rehabilitation beds within Council owned Residential Care units
- Multidisciplinary desk co-ordinating out of hospital care for a locality
- Additional Capacity in Rapid Intervention Nursing, Rehabilitation and Enablement, and Social care re-ablement.
- Personalisation and support to carers

In support of this programme the CBC/BCCG system has also established

- Practice Matrons and Primary Care Social Workers with responsibilities for case management of Patients at higher risk of admission.
- All Nursing and Residential care homes are aligned to a responsible practice with urgent care needs co-ordinated through a Practice Matron.
- Fallers fast response Programme reducing the numbers of patients attending A&E
- Restructured Residential care unit to become Rehabilitation unit (Greenacres)
- Re-structured Rehabilitation Services.
- Extra care housing programme with consequent reduction in Residential care home placements.
- Restructured Dementia care programme.
- Mental Health primary care link workers and dementia outreach nurse

4.2 Programme Outcomes

Patient Vignette……..

Mrs Roberts, 88yrs old, lives alone. Her daughter, who visits weekly, finds that mum has gone "off her feet" and calls the GP. The doctor diagnosed an infection that may need intravenous antibiotics. Mrs Roberts refuses admission to the hospital however accepts admission to the local Short Stay Medical Unit (SSMU)

Here she is assessed by the community geriatric team and treatment started. Over the next few days Mrs Roberts receives intensive rehabilitation and after six days is discharged home with a short term support package while longer term needs are assessed.

Other patients in the unit have spent 48 hours being stabilised in the acute hospital and then transferred for intensive rehabilitation

The experience of this admission was described by her daughter as "very much better than Mum's previous admission to an acute hospital where the focus was, naturally, on patients who were very unwell and there was not the emphasis on getting mum back to her usual functioning and home as quickly as possible."

…….

Within 9 months of commencement of the programme hospital admissions of patients over 75 have experienced

- An increase in <48 hour stays moving from 19% in 2011/12 to 32% in Q3 20112/13
- Reduction in Average length of stay of 30%.
- Reduction in hospital tariffs of 12%
- Reduction in Excess bed days of 50%
- Reduced re-admissions to hospital within 30 days for those cared for at the SSMU.
- Reduced placements in Long term residential care
- Increased quality and increased satisfaction with new services
- Reported improved service accessibility and responsiveness
- Reduced reported social isolation

The system is very proud of the scale and pace of change which was achieved in just 9 months. The overall savings resulting from reduced tariffs and shorter hospital stays is

broadly sufficient to fund the out of hospital sub-acute investment. This successful project will now be consolidated into ongoing care pathways and the learning from the project will be rolled out across the wider system.

5. Commitment to sharing learning

The CBC system will be keen to commit to sharing learning and has already commenced dissemination of the Sub-Acute Care project by making submissions to Nursing Times and HSJ awards. The project was endorsed by Professor Keith Willett last summer.

The system is also working closely with Professor David Oliver formerly National Clinical Director for Older People and now President of the British Geriatric Society. Professor Oliver is linked to the Emergency Care Intensive Support Team and King's Fund Integrated Care Team.

Through the involvement of National experts such as Professor Oliver it is expected that the learning from the local programme will be shared across ECIST and King's Fund networks

6. Using Best Evidence

The CBC /BCCG system will wish to demonstrate that its vision and approach are, and will continue to be, based on a robust understanding of the evidence, to include

- Plans that take into account the latest available evidence
- Understanding of the impact on the relevant local providers and intended outcomes.
- A commitment to work with national partners in co-producing, testing and refining new measurements of people's experience of integrated care and support across sectors
- A commitment to participate actively in a systematic evaluation of progress and impact over time.

We commit to applying best practice evidence base in all future developments.

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Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	**Bedfordshire Plan for Patients 2014/15 to 2018/19**
Meeting Date:	9 January 2014
Responsible Officer(s)	John Rooke, Chief Operating Officer, Bedfordshire Clinical Commissioning Group
Presented by:	John Rooke, Chief Operating Officer, Bedfordshire Clinical Commissioning Group

Action Required:

1. **to note the requirements for Everyone Counts: Planning for Patients 2014/15 to 2018/19 (NHS England 20 December 2013); and**
2. **to agree the timescale and proposed arrangements for the sign off of Bedfordshire Plan for Patients 2014/15 to 2018/19.**

Executive Summary	
1.	The following report outlines the requirements of national planning guidance "Everyone Counts: Planning for Patients 2014/15 to 2018/19 (NHS England 20 December 2013)" and the implications for plans for local health care services.

Background	
2.	The national planning guidance "Everyone Counts: Planning for Patients 2014/15 to 2018/19 (NHS England 20 December 2013)", sets out how NHS England proposes that the NHS budget is invested so as to drive continuous improvement and to make high quality care for all a reality.
3.	The NHS is facing an unprecedented challenge to transform outcomes for patients and to minimise inequalities within and between communities. A *Call to Action* forecasts a financial gap of around £30 billion by 2020/21, and the affordability challenges in 2014/15 and 2015/16 are real and urgent.

4.	The planning guidance acknowledges that a longer term view of the planning of services to reflect the step changes required to tackle these unprecedented challenges is required. Commissioners are required to plan for the transformation of services on a 5 year basis. This 5 year plan should include the first two years of operational delivery in detail, which must be explicit in dealing with the financial gap and contain appropriate risk and mitigation strategies.
Bedfordshire Clinical Commissioning Group Financial Challenge	
5.	The financial challenge for BCCG in 2014/15 is £15,530 million, current early assumptions is that this gap will be £2,534 million in 2015/16 and £2,906 million in 2016/17.
Better Care Fund (Integration Transformation Fund)	
6.	The Better Care Fund local 2-year plan for 2014/15 and 2015/16 will be incorporated within and form a significant sub-set of Bedfordshire Plan for Patients 2014/15 to 2018/19. The proposed joint working with Central Bedfordshire Council to develop the Better Care Fund Plan, will therefore, also become an critical part of the partnership approach to developing Bedfordshire Plan for Patients 2014/15 to 2018/19. The funding and implementation of the Better Care Fund has the potential to improve sustainability and raise quality across health and care systems, including by reducing emergency admissions. Planning guidance flags that hospital emergency activity will need to reduce by around 15 per cent. Bedfordshire Plan for Patients 2014/15 to 2018/19 will need to demonstrate how significant progress will be made towards this reduction during 2014/15.
Working in Partnership	
7.	Health and Wellbeing Boards will be a key forum for agreeing plans with all stakeholders and accounting to the local community that these plans meet their needs and are delivered. A Central Bedfordshire facing plan developed. BCCG will ensure that public, patient and carer voices are at the centre of healthcare services from planning to delivery. We will build upon our platform of engagement with patients and public and health and social care provider representatives within the local community. Early plans were deliberated at two well attended local events in June 2013 (a full report can be found on the BCCG website at https://www.bedfordshireccg.nhs.uk/page/?id=3713). We will continue to ensure that citizens participate in the shaping and development of healthcare services and we are working with public members, locality patient reference groups and patient representative organisations such as Healthwatch, to develop our plans.

	For each individual service/care pathway change our processes embed a robust approach to stakeholder engagement and communication. Assessments to determine significant variation in service changes are routinely made and we work closely with Local Authority Overview and Scrutiny processes to ensure a robust and best practice approach to public consultation.
Strategic Review of Health Care Services in Bedfordshire	
7.	All five partners – BCCG, MKCCG, the TDA, Monitor and NHS England have agreed terms of reference for the review of healthcare across Beds and Milton Keynes. The national partners will work with a consultancy firm to help deliver the review from January to July 2014. The outcomes of this review will inform and mould Bedfordshire Plan for Patient's 2014/15 to 2018/19. Planning to meet the financial gap of £15,530m in 2014/15 must continue alongside this review, as a critical factor to ensuring the local health economy remains sustainable until review recommendations can deliver the longer term transformation of community and hospital services.
Planning Timetable	
8.	Plans need to be approved by Boards by 31 March 2014. Submission to NHS England of final 2 year operational plans and draft 5 year strategic plan by 4 April 2014. Submission to NHS England of the final 5 year strategic plans 20 June 2014.
Planning Fundamentals	
9.	**Outcomes**: Plans must describe how the government's mandate, set out in the NHS Outcomes Framework, will be delivered, in part by translating these outcomes into additional specific, measurable ambitions, within the following areas: • Securing additional years of life for people with treatable mental and physical health conditions. • Improving health related quality of life for people with one or more long term health condition, including mental health conditions. • Reducing the amount of time people spend avoidably in hospital through better and more integrated care in community, outside of hospital. • Increasing the proportion of older people living independently at home following discharge from hospital. • Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community. • Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care. • Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

	Additionally there are three more key measures for *improving health, reducing health inequalities and in ensuring parity of esteem*; making sure we are just as focussed on improving mental as physical health.
10.	**Patient Services:** Fulfilling longer term ambitions will require a change in the way health services are delivered. Plans for high quality, sustainable health care services will include the following characteristics: • A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care. • Wider primary care, provided at scale. • A modern model of integrated care. • Access to the highest quality urgent and emergency care. • A step change in the productivity of elective care. • Specialised Services concentrated in centres of excellence.

11.	**A focus on maintaining the essentials:** these essential elements are expected to be characteristics of all service plans;
	• Access
	  ○ Convenient access for everyone
	  ○ Meeting the NHS Constitution Standards
	• Quality
	  ○ Response to Francis, Berwick and Winterbourne View
	  ○ Patient Safety
	  ○ Patient Experience
	  ○ Compassion in practice
	  ○ Staff Satisfaction
	  ○ Seven day services
	  ○ Safeguarding
	• Innovation
	  ○ Research and innovation; plans support statutory responsibilities and adopt innovative approaches.
	• Value for Money
	  ○ Financial resilience; delivering value for money for taxpayers and patients and procurement.

Conclusions and Next Steps	
12.	Planning assumptions are being built upon the existing platform of priorities; the mental health service procurement process, the development of joint plans such as those for Children and Young People, the end of our community contracts, the development of the Better Care Fund plan and the Strategic Review of health care services. Existing partnership forums and the joint strategic commission group will also continue to ensure partnered approach to planning development.
13.	The documents to be approved by Boards will include a technical plan for NHS England assurance and two Local Authority facing plans.

Detailed Recommendation	
14.	Central Bedfordshire Health and Wellbeing Board have a development meeting on 13 February 2014, where the more detailed Better Care Fund proposal will be discussed. Given the interdependency of these two plans it is proposed that the board review both the Better Care Fund Proposal and Bedfordshire Plan for Patients for approval at this meeting.
15.	The Health and Wellbeing Board note the planning requirements and the deadline of Board approval by 31 March 2014.

Issues	
Strategy Implications	
16.	As described within the planning guidance BCCG will increasingly adopt an outcomes based approach, which means focussing less on *what* is done for our patients and more on the *results* of what is done. Bedfordshire Plan for Patients 2014/15 to 2018/19 will align to the NHS Outcomes Framework.
17.	The Bedfordshire Plan for Patients 2014/15 to 2018/19 will reflect the Central Bedfordshire Health and Wellbeing strategy and Joint Strategic Needs Assessment.
Governance & Delivery	
18.	The Bedfordshire Plan for Patients 2014/15 to 2018/19 needs to be aligned across health economies and BCCG will work closely with Central Bedfordshire Council, health care providers and NHS England to enable wider and more strategic health economy planning.
Management Responsibility	
19.	Operating Officer for Bedfordshire Clinical Commissioning Group
Public Sector Equality Duty (PSED)	
20.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Bedfordshire Plan for Patients will fully acknowledge PSED and equality objectives will be described within the Plan. Each individual service change will undertake an Equality Impact Assessment.

	Are there any risks issues relating Public Sector Equality Duty		No
	No	Yes	*Please describe in risk analysis*

Risk Analysis
Bedfordshire Plan for Patients 2014/15 to 2018/19 will annex a full risk assessment. A System Quality Impact Assessment process is undertaken to determine the safety, quality, patient experience, workforce, activity and finance implications of collective local health economy plans.

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

Source Documents	**Location (including url where possible)**
Deliberative Events Report 2013	https://www.bedfordshireccg.nhs.uk/page/?id=3713

Presented by John Rooke