

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.”

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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 2011/13
- 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.