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Central Bedfordshire

Appendix 1

Outcomes of the scrutiny enquiry on integration of health and social care (May 2017)

Grasp the nettle – but the dock leaf no longer eases the reaction

Chairman's Introduction

This enquiry has been undertaken in response to the considerable concern about the ability of health and care services to meet the future needs of our population. Central Bedfordshire is an area of growth and has an ageing population. Funding for health and care services is not keeping pace with demand. The Government states that health services funding has increased year on year, however, local funding challenges remain for our area. The Council's social care budget is also under great funding pressures. Although there is some additional funding for social care this year, it is unlikely to close the gap in the funding shortfall.

How money is used and how health and social care services are organised in the future is key to the provision of a viable service which must meet the needs of an increasing population, an ageing population and one where there are increasing complex health needs.

It has become clear that the public do not always use the health service in the most appropriate way with one clear example being the use of A&E when a visit to the GP Surgery would be more appropriate for e.g. a minor injury. The role of the local pharmacist needs also to be a part of an improved education programme about the use of the health service by the public.

There needs to be a determined effort to ensure people do not find themselves admitted to hospital when such could have been avoided. A programme of self health care, emphasising prevention, is axiomatic.

When a patient has rightly been admitted to hospital and is ready for discharge this has to be done more efficiently. There must be a seamless transition between what we currently see as the responsibility of the health service and that of the social services when the involvement of the latter is necessary to support the patient back in their own home or in a nursing or care home or at a 'step-up step-down' facility.

The way the services are funded is not always seen to be conducive to integrating health and social services. Discharge from hospital with the effective co-operation of social care saves the health service money. When people can be 'treated' elsewhere, than in hospital that also saves the health service money. It is said to be three times more expensive to treat a person in hospital than in the community or at Home. I have asked the question whether social care has come to be seen as the saviour of the health service. On discharge from hospital to convalescence where does the health responsibility end and social care begin or should there be no demarcation?

These boundaries mean nothing to people receiving health and care services; they expect the services to work together. As such should monies be seen as a pooled resource across health and social care? Investment to build capacity in social care to enable more people to be supported in the community should be a key consideration. The idea of a 'personal care

service' covering both health and social care from a single budget is no longer a distant one.

So, how might the future look?

The Enquiry has been informed through many interviews and papers including the NHS New Care Models: Vanguards – developing a blueprint for the future of NHS and care services. Many words of support have been given for a programme of integration to meet the needs of our local Central Bedfordshire population. One hopes that this is not simply 'lip service' to a transformation programme and that positive steps will be taken by all concerned to achieve a new model of care.

The integration of health and social care must be the way forward. A coordinated service at the primary stage is essential to help avoid where possible access to the secondary stage of care. The development of a 'hub and spoke' approach bringing together local GPs acting alongside community and social care professionals and the voluntary sector with appropriate services devolved from the local hospital would see an integrated approach at the primary stage. The spokes would bring aspects of integrated care into the rural areas.

The impetus to move forward has been embodied in the Care Act 2014 which inter alia lays a general duty on local authorities to promote an individual's well being. This includes an individual's physical and mental health and emotional well being. The Better Care Fund which seeks to join up health and care services so that people can manage their own health and well being and live independently for as long as possible and finally the Sustainability and Transformation Plan which will help to ensure health and social care services are built around the needs of the local population embed this further.

We have set out a number of recommendations in this report on which Members expect action to be taken. I hope that this work we have undertaken as an enquiry team would not have been a 'talking shop' with no practical impact. I have set out further conclusions at the end of this report.

I do thank my fellow Councillors who have given up much time to be a part of this Enquiry together with the Portfolio Holder, Officers, and the many interviewees who gave evidence.

Cllr Peter Hollick
Enquiry Chairman

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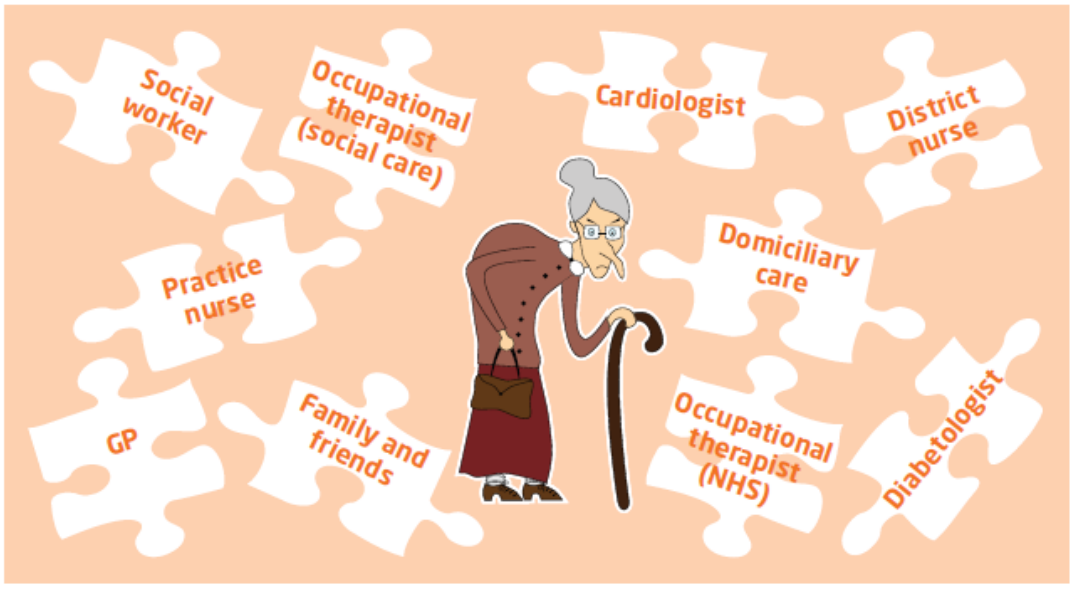
Background and reason for the enquiry

Central Bedfordshire Council is committed to ensuring that its residents have access to timely and best quality health and social care. The Overview and Scrutiny Enquiry Team recognise the need to work closely with other health and care partners so that local people are served by services that are integrated, seamless and where possible less fragmented. This requires a shared vision across the health and social care system. This view is consistent with legislation, the Care Act 2014 and more recently, the NHS Planning document Five Year Forward View which emphasises the need for integration and new ways of delivering health and care services that is fit for the future and sustainable.

Health and social care is often referred to in one breath. It is not always clear, for example where the responsibility of health organisations end and the social care organisations begins? We have put place a bewildering array of small disconnected services particularly for older people (as demonstrated below for Mrs Smith – Kings Fund). People receiving care do not necessarily distinguish between organisations. What is important to people is that they receive timely and appropriate care and support. Organisational boundaries should be less visible when person-centred health care is provided.

Mrs Smith's Story



This important need for care to be better coordinated around people's needs and delivered as locally as possible has been a key driver for the work of the Enquiry Team. Central Bedfordshire with its growing and ageing population faces a number of challenges, which are centered on the impact of demographic change, shrinking resources and workforce.

In September 2016 the Social Care Health and Housing Overview and Scrutiny Committee (SCHH OSC) agreed to undertake an enquiry to:-

- To understand the national strategic drivers, barriers and risks
- To receive evidence, advice and information from sector experts to agree an emerging approach to redesign how residents access health and care services.
- Gather evidence, appreciate and learn from existing best practice across the country including integrated health and care hubs.
- Understand resident's existing experiences
- What is feasible for Central Beds and how we deliver it

It was felt that successful and effective integration of health and social care could deliver seamless and person centered services for people, leading to improved outcomes and a better experience of health and care services. Importantly also, it could help to reduce duplication and maximise resources, therefore saving money. Consequently he Enquiry also agreed to:

- Examine the emerging approach for delivering integrated health and social care in Central Bedfordshire with a particular focus on integrated health and care hubs; and
- To agree an approach that sets out in an open and transparent manner how all partners will plan for integration and delivery of locality based health and social care hubs across the four localities in Central Bedfordshire.

The enquiry team sought within the time frame, to interview as many representatives from health and care organisations as possible and to learn from the many studies, papers, seminars, Vanguard sites and reports on health and social care integration to answer some of these questions. From these the enquiry team would focus primarily on developing a set of principles for the approach to delivery of the integration of health and social care in Central Bedfordshire.

Members received a wealth of information to consider and attended relevant workshops to study best practice in the country. A list of these background papers appear at Appendix A.

Approach to the Research

The Enquiry Team was made up of the following:-

Member	Committee	Ward
Cllr Peter Hollick (Enquiry Chairman)	Social Care Health and Housing OSC	Dunstable Watling
Cllr Susan Goodchild (Enquiry Vice-chairman)	Social Care Health and Housing OSC	Houghton Hall
Cllr Frank Firth (from second meeting)	Non-Executive Member	Northill
Cllr Paul Downing	Social Care Health and Housing OSC	Ampthill
Cllr Brian Saunders	Corporate Resources and Sustainability Communities OSC	Stotfold and Langford
Cllr Paul Duckett	Social Care Health and Housing OSC and Corporate Resources OSC	Ampthill
Cllr Eugene Ghent	Deputy Executive Member	Dunstable Manshead

Other attenders included:-

- Cllr Maurice Jones Executive Member for Health (until 10.03.2017)
- Cllr Carole Hegley Executive Member for Social Care and Housing and
- Julie Ogley Director of Social Care Health and Housing.
- Donna Derby, Director of Commissioning, Bedfordshire Clinical Commissioning Group.

The review was supported by Paula Everitt (Scrutiny Policy Adviser) and Patricia Coker (Head of Service Lead for Integration and BCF, Social Care Health and Housing)

The Enquiry Team met on 12 occasions with the following partners:-

Date	Consultee	Specific Interest
14 October 2016	None	
02 November 2016	None	
18 November 2016	• Richard Carr Chief Executive	Sustainability and Transformation Plans (STPs)
23 November 2016	• Ben Collins – Kings Fund	National Context

Date	Consultee	Specific Interest
09 December 2016	• Stephen Conroy Chief Executive Bedford Hospital • Mark England, Director of Re-Engineering - Luton and Dunstable Hospital • Sarah Brierley Director of Business Development & Partnerships East and North Herts Hospital	Health
19 January 2017	• Matthew Tait – Chief Accountable Officer, Bedfordshire Clinical Commissioning Group	BCCG
19 January 2017	• Dr Peter Graves Chief Executive - Local Medical Committee • Judith Chappell, Deputy Dean of Health and Social Sciences, University of Bedfordshire	Stakeholders
27 January 2017	• Michelle Bradley - Director of Mental Health and Wellbeing services in Bedfordshire ELFT • Richard Fradgley - Director of Integrated Care ELFT • Malcolm McCann, Executive Director of Community Services and Partnerships, SEPT • Stuart Mitchelmore Assistant Director, Adult Social Care	Stakeholders Officer
06 February 2017	• Julie Ogley – Director of Social Care, Health and Housing • Sue Harrison - Director Children's Services • Marcel Coiffait – Director Community Services • Celia Shohet – Assistant Director Public Health • Cllr Maurice Jones Deputy Leader and Executive Member for Health • Cllr Carole Hegley Executive Member for Social Care and Housing	CBC Officers and Executive Members

Date	Consultee	Specific Interest
09 February 2017	Locality Chairs including • Dr Alvin Low – Chairman BCCG • Emma Barter – West Mid Beds Locality Lead • Dr Chris Marshall – Leighton Buzzard Locality Lead	Partners
20 February 2017	• Caroline Holman Chief Operating Officer and Deputy to the Chief Executive - MIND, • Yvonne Clark Chief Executive Officers - Purple Trust • Jon Boswell Chief Executive BRCC	Partners
22 February 2017	• Diana Blackmun Chief Executive Healthwatch, • Dr William Hollington Friends of Biggleswade Hospital and GP Locality Lead for Ivel Valley • Ruth Featherstone Older People's Network • Linda Johnson Chief Executive - Homestart	Partners
27 February 2017	• Paul Tisi - Medical Director Bedford Hospital • Junaid Qazi - Consultant & Interface Geriatrician East and North Herts Hospital • Sarah Brierley - Director of Business Development & Partnerships East and North Herts Hospital • Sheran Oke - Director of Nursing Luton & Dunstable Hospital	Partners

National Message

With an ageing population and people suffering with multiple complex needs, the strain on the NHS system has been covered daily by the media. In preparing for this enquiry, the Team considered the national messages and challenges around health and social care, and reviewed a number of national strategic documents from the NHS, The Kings Fund and the Nuffield Institute. These strategic documents all set out common national messages which should shape the future commissioning and provision of health and social care. These messages suggest the need for the following in order to secure a fit for purpose and sustainable health and care system:

- Need for collective leadership for health and care services
- Need for closer alignment of primary (GPs), community and social care services.
- Role of the voluntary sector and multi disciplinary working
- Pooled budgets to deliver cost efficiency and better care
- Changing payment systems

The current fragmented response to the challenges of demography, finance, workforce and complex health and care needs of the population means that across the country, health and care systems are facing very similar issues.

People often receive their health and social care through a complex range of organisations, professionals and services. Both nationally and locally this can mean uncoordinated and fragmented care particularly for people who have multiple needs.

Such fragmentation has the potential to lead to:

- multiple and uncoordinated assessments from health and social care, resulting in delay to provision of services;
- multiple and uncoordinated visits from health and social care professionals;
- multiple trips to hospitals for tests, diagnostics and treatment;
- unreliable transitions through care pathways, including from childhood to adult care;
- emergency admissions to hospital, for example after avoidable worsening of a condition or an avoidable fall; and
- delayed discharges from hospitals.

A recent national audit report into integration noted that performance and outcomes in the health and social care sectors are worsening. Much has been said in the national press about the delays in discharging people from hospital, particularly affecting frail older people.

The Audit report noted that across the country, community health and care services face very similar challenges….

- Ad hoc development of community health and care services typically adding new services for particular groups without thought for how they relate to the wider system.
- As a result, a pattern of small, narrowly defined and poorly coordinated services based around historic but unhelpful dividing lines of primary, community and social care.
- People with multiple chronic conditions and a mix of physical health, mental health and social care problems interact with multiple specialist teams – with multiple care plans and an absence of holistic whole person care.
- Patients receive multiple visits from different professionals with duplication and poor communication and coordination. Both patients and professionals find the system hard to understand and are unsure who to contact or who is in charge.
- Initial solutions such as care navigators, care coordinators, single point of access and other interventions address symptoms of a poorly designed system but do not address the root cause.

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The Care Act April 2014 was introduced to make care and support clearer and fairer for everybody. It aimed to help prevent people's care needs getting more serious by providing more services and more information to help people stay healthy and independent for longer. It also set the legislative framework for integrating health and social care service, through the Better Care Fund Plan.

Since then, NHS England published its Five Year Forward View in October 2014 and set out a shared vision for the future of the NHS based around new models of care.

The structure of the NHS is challenging. It is clear that supporting the complex needs of the local population requires concerted efforts. Nationally the integration of health and social care has been introduced at a strategic level firstly with the implementation of the Better Care Fund plan and more recently Sustainability and Transformation Plan (STPs) to try and respond to growing trends. The STP sets out a number of priorities which must address current and future challenges within the health and care system by delivering NHS England's triple aim:

I. Sound health and wellbeing of the local population
II. High quality health and social care supplied to local people, with service users, their family carers and others in receipt of care, acknowledging a positive experience
III. Living within the resources available.

Central Bedfordshire is part of the Bedfordshire Luton and Milton Keynes STP which is one of 44 health and care 'footprints' in England. The plans will show how local services will evolve, develop and become clinically and financially sustainable over the next five years

Local Strategic Context

CBC is an area with a growing and ageing population, a rural environment without a hospital within its boundary. These and other issues pose challenges for the system. The Joint Strategic Needs Assessment (JSNA) provides a comprehensive picture of what we know about the health and wellbeing of the people living in Central Bedfordshire. The intelligence has helped us shape our whole systems approach to date.

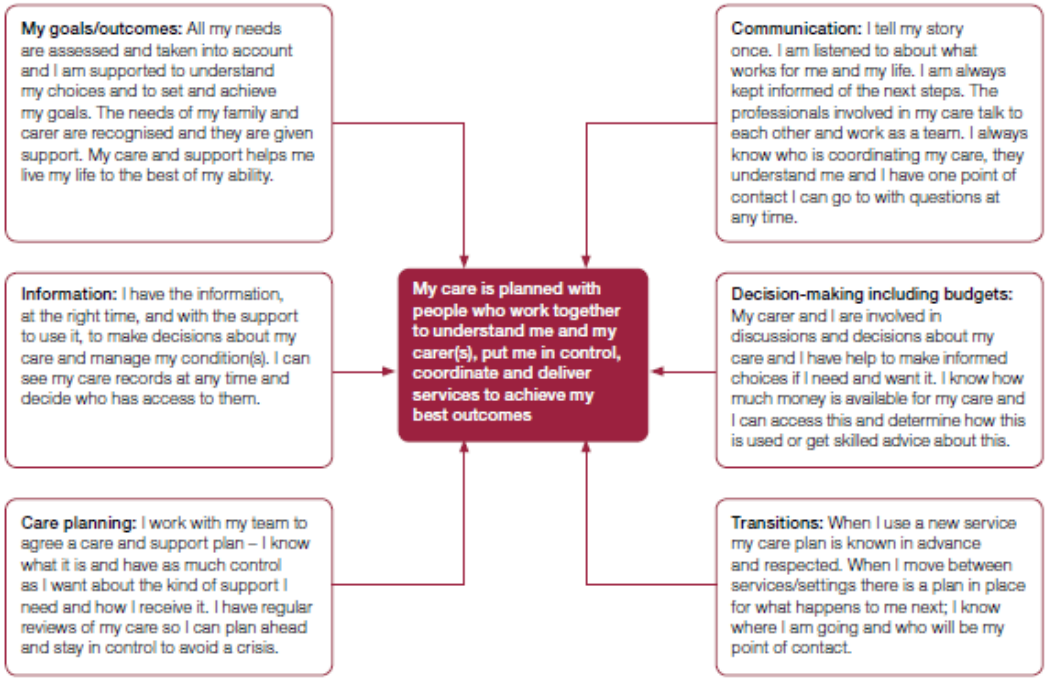
Our Better Care Fund plans set out a shared vision for health and social care in Central Bedfordshire, set in a locality-based delivery model. It describes the agreed strategic approach based on four key priorities for delivering integrated care. The Better Care Fund plan is central to the ambition for the integration of health and care services in Central Bedfordshire. The overarching ambition is to secure a fundamental shift in the ways in which care and support is provided to residents of Central Bedfordshire, in their localities, so that people can experience equitable and timely local services tailored to their needs.

The Better Care Fund Plans describe an agreed approach to develop integrated health and care hubs which will see the co-location of primary, community health, mental health and social care colleagues and provide access for a range of diagnostic services and assessments.

Central Bedfordshire's approach to integration, as set out in the BCF Plans, is focused on the 'person' and delivering what good quality integrated care looks like, from the point of view of anyone who needs access to multiple services over time, as set out below.

Figure 5
Definition of integrated care

The Department of Health and national partners have defined what integrated care and support looks like from a user's perspective



Source: National Collaboration for Integrated Care and Support

Local progress on integration to date

Although some joint working and planning for integration is already taking place, it is however clear from the evidence given to the Enquiry Team that integration in Central Bedfordshire is limited and at best patchy. The Enquiry panel received evidence on key areas and activities taking place to achieve integrated outcomes; these included some of the locality arrangements and multidisciplinary working taking place in some parts of Central Bedfordshire.

Members were informed of the ambition for four separate locality hubs in Central Bedfordshire. Significant progress had been made to establish the case for integrated health and care hubs in the Chiltern Vale and Ivel Valley areas. Proposals for hubs in West Mid Beds, Leighton Buzzard and discussions for a fifth hub in Houghton Regis are also planned. Without exception the concept of these hubs in Central Bedfordshire was supported by partners and stakeholders.

Members heard about the successful applications for funding to the One Public Estate and the NHS Estates, Technology and Transformation Funds to support the development of the Integrated Health and Care Hubs. Locality Hubs are currently planned for Chiltern Vale (Dunstable), Ivel Valley (Biggleswade), West Mid Beds, Leighton Buzzard with a further hub being considered for Houghton Regis.

In carrying out their review Members heard about some of the joint working initiatives already underway. A group of GPs in the Ivel Valley area have moved to a new Medical Centre in Biggleswade and have social care teams co-located in the premises.

Findings of Enquiry

The Enquiry team asked each representative from organisations, partners or stakeholders for their view on the integration of health and social care, what barriers existed and how the Council might help to overcome these barriers. There was unanimous support for the integration of health and social care services in order the save the National Health Service for future generations and agreement that a clearly defined set of principles for all partners to work to would promote a consistent approach.

In order to fully understand the implications of the national strategic drivers, such as the STP, which will have significant influence on the transformation of health and care services over the next five years, the enquiry team met with Richard Carr, Chief Executive and Deputy STP lead.

In order to address health inequalities along with financial and clinical challenges, NHS England established a Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP). Members learnt that engagement between partners was strong.

In the BLMK STP submission to NHS England, five priorities for the transformation of health and social were established. Three 'front line priorities focus on:-

STP Principles	
P1	Prevention, encouraging healthy living and self care, supporting people to stay well and take more control of their own health and well being.
P2	Primary, community and social care services building high quality, resilient, integrated primary, community and social care services across BLMK. This includes strengthening GP services, delivering more care closer to home, having a single point of access for urgent care, supporting transformed services for people with learning disabilities and integrated physical and mental health services.
P3	Sustainable secondary care, making our hospital services clinically and financially sustainable by working collaboratively across the three hospital sites, building on the best from each and removing unnecessary duplication

A further two ‘behind the scenes’ priorities focus on:-

STP Principles	
P4	Technology transforming our ability to communicate with each other, for example by having shared digital records easily accessible by patients and clinicians alike, using mobile technology (e.g. apps), for better coordinated care.
P5	System redesign improving the way we plan, buy and manage health and social care services across BLMK to achieve a joined up approach that places people’s health and wellbeing at the heart of services.

There is a drive to shift the balance of care from hospitals to community based solutions; improving access to out of hospital services to reduce pressure on acute care. The ambition for integrated locality health and care hubs aligns particularly with P2 and P5 of the STP principles.

Given the importance of the STP process as the national initiative designed to give local NHS organisations and councils the opportunity to work together to improve the way health and social care is planned and delivered, there was a call for all partners to engage with the STP process and align working practices with it.

Members noted that the three hospitals in the BLMK footprint do not represent the full experience of Central Bedfordshire residents, who access other hospitals outside the footprint. Members supported the process of delivering improved quality of care through joint working, sharing resources and more sustainable financing. Joint working with partners and the building of relationships is fundamental and throughout the Enquiry evidence there was a commitment to work towards a seamless health and care service that is equitable in Central Bedfordshire.

Throughout the enquiry, Members gathered information and developed five key principles. Each principle represented an area of focus for successfully achieving integrated outcomes:

1. **Our residents will be at the centre of decision making**
2. **Health and care will be accessed as close to home as possible**
3. **Residents will be able to self serve and manage their health and care**
4. **Funding and resources should be available at the right time and right place, particularly in relation to locality working.**
5. **Health, care, and housing colleagues will work together to deliver one plan to meet the needs of our residents**

Strategically the implementations of these principles rely on the commitment to this way of working and a change in culture within the workforce. Members

reflected on the critical importance of looking at services from a person's point of view and are clear that this is the responsibility of all partners.

The remainder of the report is organised around these principles and provides the rationale and evidence received for each of them. It highlights some of the good practice examples shared with the enquiry. Further specific recommendations are outlined as necessary below:-

Recommendation

That all partners of the health and social care sector adopt and demonstrate a commitment to delivering the five principles outlined above.

Principle One:
Our residents will be at the centre of decision making

Members felt that this principle is about seeing the whole person and not just their condition. Ensuring people are at the centre of the decisions made about their care, would ensure that the system is focusing on 'what matters to people', as opposed to 'what is the matter with them' Members agreed that this is a key principle for ensuring people have access to the right services. The focus should be on supporting people to take greater responsibility and manage their own health and wellbeing better.

Julie Ogley Director of SCHH explained to Members that as part of the reforms we should encourage people to ask for the support they need. Involving people would ensure that resources are allocated appropriately, giving people the care and support they want, not the care and support we think they should have.

Members received evidence from service user representatives and organisations on the current complexity of access to services, especially for those patients with multiple conditions. Ruth Featherstone representing the Older Peoples' Network advised some patients received diagnosis and treatment from as many as four hospital consultants.

Judith Chappell Deputy Dean of Health and Social Sciences, University of Bedfordshire, explained the joint working taking place to provide the right training and qualifications for health and social care workers together for a flexible workforce for the future. With a multi-skilled workforce, information flow would improve and patient time would be saved. A super carer qualification was in development and gave carers the ability and skills to support patients in their homes and care homes.

Dr Peter Graves, Chief Executive, Local Medical Council highlighted the importance of 'saving patient time', a principle that had been adopted in Canterbury, New Zealand.

The Enquiry panel observed that the emerging consensus was that there needed to be a shift in the relationship between health and care services

providers and those who are using the services. It is important to recognise the outcomes the individual wishes to achieve.

Recommendation(s)

- Services should be developed to support people to stay well and take increased responsibility for their own health and wellbeing.
- All partners and stakeholders should adopt the principle that, where appropriate care is planned with a mix of care professionals working together. People should feel they are in control and able to coordinate delivery of services to achieve the best outcome for them. (National Voices 2013).
- As one of the front line priorities in the STP is prevention – there be a greater focus on early intervention and promotion of self management.

Principle Two:
Health and care being accessed as close to home as possible

Members learnt that the current provision of health and social care across Central Bedfordshire is fragmented and often leads to uneven access to good care. The population uses several hospitals, none of which is in our area. The lack of a hospital within our boundaries, the geography and rural nature of Central Bedfordshire presents challenges in understanding and managing patient flows into and out of hospitals. This makes it difficult to access a cohesive supporting range of services.

The demographic pressures and economic challenges facing the health and care economy means a radical rethink of how services are provided. It is important to reduce demand on hospital services. Achieving this requires health and social care services to be better coordinated to ensure that the right care is offered at the right time, in the right place and by the most appropriate person. Witnesses agreed that the aim should be for high quality accessible services made available locally with community based integrated multi-disciplinary teams.

There are examples of health, social care, community and voluntary groups working together to enable residents to improve their wellbeing, using their own informal support network and increase self-care eg Village Care Scheme

Members discussed the importance of shifting the cultural focus from one where treatment is provided in hospitals to one where health and care is available in local communities as close to the patient as possible. People should be enabled to stay well in their own homes and communities. The need to deliver more services out of the hospital was noted.

Members learnt of plans to build on existing locality structures to address care pathways, from prevention and early intervention right through to integrated pathways and support for people at home. Support for carers, intervening at the right point to maintain independence, physical health and mental wellbeing, and using housing options and equipment effectively to deal with

increasing volumes and complexity of older people's conditions, is fundamental.

ELFT has taken the lead in developing an integrated team of physical and mental health workers to support the needs in localities. The focus for these teams included:

- Continued care assessment of patients
- Greater early intervention
- Self care
- Patient responsibility to seek help for themselves at the earliest opportunity
- Joint working with village agents and community workers
- Possibility of one organisation delivering these services.

The teams have supported the delivery of outcomes that include a reduced flow of patients to hospital and care homes.

Malcolm McCann (Executive Director of Community Services and Partnerships at EPUT) also advised that integrated teams were currently working in Essex and informed Members that a dedicated senior operations person to lead operations was essential to help guide and develop an approach and gave each partner a sense of ownership. Services working together included community services and dementia nursing services working with GP's, social workers and CPN's and the voluntary sector.

ELFT explained they had instigated cultural change by adding a social care aspect to the training of mental health nurses. Cases involving children and young people were studied by practitioners to pick up early signs of problems, for example self harming or drug and alcohol problems. Members supported the work of public health colleagues and ELFT to support patients that would require a commissioned pathway to support patients.

The concept of locality working and services wrapped around social care was supported by Malcolm McCann, EPUT (formally known as SEPT) Members were informed that if GP practices were given the ability to probe the age of the local population it would enable them to get a sense of the needs of the locality. Accompanied by the intelligence available in the Joint Strategic Needs Assessment this would enable more effective planning for services for localities.

In an attempt to ensure health and care services can be delivered closer to home, the initial requirement is that patients and their carers are able to state what services are need to be provided to keep them in their home. It has been common practice for GPs to refer a patient with complex multiple needs for consultant advice on an individual basis. With an integrated approach, professionals and the patient would identify and plan a care package together.

This information would be provided to a mix of care professionals working together to understand the needs of the patient and carers and puts them in control to ensure care is coordinated and to achieve the best outcomes.

The issue of transport, particularly access to services in rural areas was highlighted. Concerns were raised about transport from some rural villages to the main population centres, which are likely to be the focal point for the integrated health and care hubs. This was also a concern for the Older People's Network. The work of the Village Care Schemes, which provides support in the rural villages, was noted.

Dr Hollington emphasised the important need to understand transport requirements and to grasp the opportunity to keep people well and out of hospital. Cllr Maurice Jones advised the Enquiry Team that a review of Community Transport had been undertaken; however, a further look at the use of the Council's Community Buses to shuttle residents to hubs and spokes in each locality with BCCG colleagues is pertinent at this time.

All agreed that services should be more accessible to people in their localities and especially those in predominantly rural areas. Having a focal point, such as an integrated health and care hub with associated spokes across Central Bedfordshire will provide residents with access locally to health and care such as diagnostics and out-patient appointments in a manner, which can be flexed to meet the needs of the local population. The successful delivery of this approach requires effective partnership working to drive this proposal forward.

In most cases the establishment of hubs requires a physical building, although Dr Chris Marshall raised the possibility of creating a virtual hub supported by the different professions such, GP's, Hospital Clinicians as well as service providers ie Essex Partnership University Trust (EPUT), ELFT and all voluntary organisations, potentially on a 24/7 basis. The important benefits of co-locating teams to foster a culture of joint working were continuously emphasised.

Representatives from the Acute Hospitals agreed that integrated health and care hubs could facilitate closer working, and networking between consultants and GPs, as well as upskilling GPs as a softer benefit of co-location.

Recommendation(s)

- Primary, community, mental health and social care should be developed to support people in community based setting and ensure continuity of care in their localities remains a primary focus.
- Complexity of access to hospital services should be addressed through development of more local and appropriate health and social care services that are less dependent on acute hospital provision.
- Integrated health and care hubs should be developed to provide a focal point for the provision of out of hospital care services in each of the localities.

- The Council and the CCG should explore the opportunity to use local assets to support the development of Integrated Health and Care Hubs.
- Integrated Health and Care Hubs should provide services across the age spectrum and other community related services for children and older people.
- Discussions with partners including the BCCG on how the Council's community transport facilities can be used to supplement the needs of localities should be reopened.
- There should be closer alignment of mental health with physical health care and the relationship between health providers and social care/mental health teams must be enhanced through improved communication and joint care delivery.

Principle Three:
Residents will be able to self serve/manage their health and care

The limitation of current technology in the NHS is well documented. Attempts to share medical records electronically amongst partners have not materialised and patients and carers are continually required to provide personal and medical history.

Through multi-agency working, people ought to be encouraged and supported to stay well and healthy. This should start in the early stages of life, educating our children and young people and their families to take more control of their own health and well-being. This education could include delivery from local community groups and outreach workers as well as, for example, schools, children's centres and GPs.

It is also important for people to have access to information that will enable them to manage their conditions and be involved in their care. There should be greater links with other factors which impact and influence people health and life experience. This includes things like housing, community and leisure services. The STP proposes the growth of 'social prescribing' by GPs and clinicians through referrals to appropriate support groups, community groups, counselling and voluntary organisations for help and support in making informed choices, improving confidence and self-esteem etc.

Models of community and social care are already established in some areas across the STP footprint, and by sharing best practice, these models can be adapted and delivered in other areas to meet the specific needs of local communities.

Priority four of the STP aims to transform our ability to communicate with each other and would give the patient access to their own records too. A system that allowed professionals to access records and add information was required and Junaid Qazi Emergency Director at the East and North Herts Hospital Trust raised the importance of communication and that Hospitals were embracing new technology. Julie Ogley advised new software system

for social workers would be procured that would replace the current Swift system by 2020. One of the main criteria of the new system would include an interface with NHS systems and to liberate staff and allow them to work in a modern less bureaucratic way.

To be able to deliver self management, Stephen Conroy, Chief Executive, Bedford Hospital described the Airedale telemedicine model, based on the use of wide ranging digital healthcare solutions to support the delivery of out of hospital services. Carers and patients would be able to seek advice using this service. Bedford Hospital Trust is looking at integration with GPs, to provide outreach for patients with specific need from hospital. A roll out of out of hospital services, consultant led, with a specialist nurse service following patients home from hospital and providing specialist rehabilitation at home or in the community was being established.

Mark England from the Luton and Dunstable Hospital noted that there is increasing urgency to address the pressures on Acute Hospitals. More episodes of care should be managed outside the hospital. A single location for care locally at scale is very important. An out of hospital care service lead by hospital clinicians had been rolled out successfully to patients in some areas. There was an opportunity for enhanced care in the community or in care homes, however, this would need to be a pooled budget and all providers to sign up to delivery care in this way.

There has been considerable effort to encourage residents to live a healthy life style. Public health colleagues have gathered evidence that a healthy life style and some physical activity lead to good mental health and avoided in many cases a cocktail of medical conditions like diabetes, stroke and heart attacks from occurring. Much has been done to educate the public

There was a clear message from Paul Tisi, Medical Director at Bedford Hospital that residents should advise quickly if they feel unwell. By early intervention, symptoms can be treated and the risk of complications and urgent or emergency care avoided. NHS 111 and pharmacists are available and GP's advice sought in more serious cases. Innovative ways to educate the public on keeping themselves well have been introduced by NHS England and Public Health colleagues, and Cllr Carole Hegley, Executive Member for Social Care and Housing, suggested the idea of a television channel dedicated to health and care or at GP's waiting rooms. Marcel Coiffait, Director of Community Services mentioned that consideration was being given to the use of libraries as community learning centres.

Julie Ogley, Director of SCHH advised that data sharing agreements had been created to overcome this issue, however, evidence obtained during the Enquiry indicated that not all partners were aware of these agreements.

Recommendation(s)

- Continue to involve the public in managing their own care through public health information on lifestyle, health and wellbeing.
- A single point of contact for residents to ensure that care needs can be assessed once and save patient time should be established.
- Ensure that where appropriate telemedicine, telehealth and support for Carers is aligned with self management. Consider ways in which people can be empowered to better manage their own care needs.
- Explore the potential added value of universal services, both council led and voluntary sector, to support social prescribing.
- Address the issue of data sharing to enable integrated working.

Principle Four:
Making sure that funding and resources are available at the right time and right place. This is particularly important around locality working.

This principle is key to ensuring people receive timely and appropriate complex care, when needed.

Matthew Tait, Accountable Officer at Bedfordshire Clinical Commissioning Group advised Members that to overcome the issue of a pooled funding an integrated care system, the development of an accountable care organisation, based on local authority boundaries, has been a focus for the STP. The STP gives the strategic overview to deliver out of hospital care models. Once such an organisation has been established, a new tariff system would need to be created to ensure services are sustainable for the future. BCCG is committed to negotiating a joint commissioning model with Social Care, hospitals and primary care services and is working with GP's to help alleviate pressures on them. Evidence was provided where GP surgeries worked together in localities, shared clinics or by providing different specialist appointments for patients not on their register. Back office support was also shared in some cases to cut costs and provide efficiencies.

The Luton and Dunstable Hospital had successfully introduced a GP presence within A&E and patients that required urgent care were signposted to this service.

Members identified funding issues that could be resolved with the implementation of pooled budgets. Stephen Conroy, Chief Executive, Bedford Hospital explained all partners would need a pooled budget similar to that for the Better Care Fund along with appropriate governance arrangements for joint commissioning to be established. The importance of robust governance arrangements was raised at the interview with Sarah Brierley (North and East Herts NHS Trust).

Sarah Brierley North and East Herts Hospital Trust advised Members of the importance of designing new pathways of care around the patient.

Paul Tisi, Medical Director Bedford Hospital advised that plans to provide GP presence at Bedford Hospital were advanced and would see those patients in need of urgent care directed to the Cauldwell Surgery adjacent to the hospital.

Workforce challenges were also highlighted. Shortages and vacancies in primary, community and social care services were also brought to the attention of the Enquiry. In order to deliver care in the communities, staffing resources are needed. Judith Chappell, Deputy Dean at Bedfordshire University advised the Enquiry Team about funding changes to health care education. With the removal of a bursary, students are treated in the same way as other students and require a loan for fees and maintenance. On a more positive note, new ideas to educate doctors and nurses have been identified including a joint Mental Health and Social Worker degree and apprenticeship schemes. A super carers qualification (SEN equivalent) is now available to help with integrated health and social care skilled workforce.

The shortage of GPs had inspired some innovative thinking to attract young GPs not wishing to take on a traditional practice. Emma Barter Locality Chair for West Mid Beds advised that new GPs wishing to work in the locality could study for an MBA at Cranfield University, practice at local GP surgeries as well as work with Clinical Commissioning Group colleagues.

GPs support patients during a period of social wellbeing break down. With the proposal that GPs are situated as part of a multi-disciplinary team in a locality hub, support from partners or the third sector would be on hand to help.

The importance of working together with other service providers including voluntary organisations both national and locally to deliver services should not be under estimated. Members learnt of examples in Alaska and Canterbury, New Zealand where this model had been successfully achieved, albeit that achievement took several years.

Recommendation(s)

- Through the STP, continue to focus on increasing investment in community based interventions and the development of integrated health and care hubs.
- The Council and CCG should explore the opportunity of joint commissioning to deliver improved and integrated outcome for people.
- Using the STP priorities to transform services and free up hospital based specialist resources to provide complex care and support in the localities.
- Provide community geriatrician in put into the multidisciplinary place based or neighbourhood teams.

Principle Five:
Health, care and housing services working together to deliver one plan to meet the needs of our residents

The fragmented approach to providing services was evident in the conversations with witnesses. The Council, as a unitary authority is uniquely placed to align universal services with health and care provision to improve wellbeing and promote independence.

Julie Ogley advised the Enquiry Team that social stability and good housing enabled families to live a healthy life style and was vital to prevent poor health. Housing had not previously been a consideration in this context but was raised as an important element.

Health and social care services have over the years provided services in isolation to patients. A huge barrier has been the inability of services to share data and the data protection act has been used as a deliberate block in some cases. In order to overcome this obstacle, hospital services and GP's in line with the STP p4 supports the aim for a 'one stop approach' and a locality co location hub with a single point of access for patients. It has been evident during the process of this enquiry that quietly and under the radar in a lot of cases joint working is taking place. Member recalled the slide below which showed the number of organisations providing health and care services to people in Central Bedfordshire.

In an interview with Matthew Tait, Chief Accountable Officer, Bedfordshire Clinical Commissioning Group, he highlighted the need to build relationships and work towards an understanding of what integrated services means in practical terms. Multi disciplinary teams working in hubs across Central

Bedfordshire is the vision and there is a need to clearly define what the next steps are and what commissioning model is needed to support this.

Jon Boswell, Chief Executive at Bedfordshire Rural Communities Charities talked about the Village Care Scheme and their role in supporting people, particularly older people in the rural communities. Village care and community agents work hard to identify residents who need help at an early stage and refer them to the services that can help them. On many occasions, isolation is the biggest issue to cause a decline in health and well being. Initiatives including walks for health network and a local initiative provided at the Warden Abbey Vineyard.

Jon Boswell observed that, in the past the voluntary sector had not been good at talking to each other, however, this situation was improving and events like the Older People's Festival was a useful networking opportunity. Examples of joint working were given and MIND and Carers in Bedfordshire colleagues shared facilities in Leighton Buzzard referred patients to each other where appropriate.

Funding remained a big concern for voluntary organisations along with an overlap in some of the services they provide. In Milton Keynes the voluntary organisations work well together and provided a better coverage of services to residents. Some self help groups had been formed in rural areas for families as well as older people.

It is fundamental that Voluntary groups are kept informed with regards to integration, cultural change and new ways of working. Voluntary groups welcomed the opportunity to work at a hub environment or in a 'day centre' environment to help support the very young to the elderly resident. An opportunity was identified for the Purple Trust group to provide services within the day care homes and this would be followed up by officers.

Enabling staff to work together across: primary care, community health, social care, mental health based around population clusters in the localities of Central Bedfordshire delivering a prevention agenda, promoting independence and ensuring that people are signposted to the most appropriate support at the appropriate time.

It was also felt that an Integrated Health and Care Hub should provide care for the whole population including children and the services they require. These Hubs should become community assets and focal points for lifestyle education, support to families

Recommendation(s)

- The Council and the CCG should continue to bring together voluntary groups with community and social care providers at events like the Older People's festival.
- Continue to educate staff, professionals and residents in the change of culture and new approach to health and social care services.

- Ensure that appropriate Governance arrangements and negotiations with partners are developed
- Use funding across the health and care and system to drive a greater investment in prevention
- Explore the opportunity to widen the role of the Village Care Scheme to work closely with primary care services and the multidisciplinary teams in the locality hubs.

Chairman's conclusion

The above recommendations are seen to be essential to move health and social care forward to meet the needs of our residents – greater accessibility to more local health services; the integration of health and social care to more efficient and effectively develop personal pathways; local health and social care hubs to bring together GP's, social and mental health care workers; sexual advice clinics; obesity advice; and aspects of the voluntary sector.

A summary of observations to be considered are:-

That an integrated health and social care hub, built to ensure flexibility of accommodation and room for expansion to meet any changing needs, could also include rentable accommodation above to make better use of the land and provide an income for the Council.

That hub spokes need to be considered in village locations to help bring aspects of health and social care into the heart of our rural communities.

One raises the profile of education programs run by Public Health that encourages residents to take care for ones' own health with an emphasis on stopping smoking, drinking excess alcohol, taking illegal drugs, obesity and to encourage healthy eating and an active lifestyle, needs to be actively considered.

That there has to be a review of how funding for health and social care is organised – it can be done as it has in Plymouth where Plymouth Council and the CCG have set up an integrated system for wellbeing, covering a large range of services.

That the role of pharmacies being so important, they need to be able to add value to local health care. That pharmacies could close as a result of a new funding regime is a matter for great concern. They must be seen as an important part of primary care.

There has been no specific recommendation as to what services could/should or might be devolved from the local hospital to a hub and indeed whether there could be some virtual services accommodated within a hub. That will be a matter for the consultants and other clinicians. However, given the need to develop an improved and better accessible local health service running alongside social care, there needs to be a serious review of how many services current accessed through the General Hospitals which Central Bedfordshire residents use, can be devolved to a hub or accommodated in a spoke location.

This report is now set before the Social Care Health and Housing Overview and Scrutiny Committee on Monday 15 May 2017 for its consideration and then on to Executive for its deliberation on Tuesday 6 June 2017.

Appendix 1

SCHH OSC Enquiry Background Reading List:

1. NHS England - Sustainability and Transformation Plans CEOs Briefing
2. CBC Better Care Fund Plan – 2016-17 http://www.centralbedfordshire.gov.uk/health-social-care/better-care-fund/plan-2016-17.aspx
3. NHS England General Practice Forward Viewhttps://www.england.nhs.uk/ourwork/gpfv/
4. Kings Fund – New Care Models: http://www.kingsfund.org.uk/publications/new-care-models
5. One Public Estate – LGA/Cabinet Office: http://www.local.gov.uk/onepublicestate/-/journal_content/56/10180/6678286/ARTICLE **LINK ONLY**
6. Nuffield Trust – The Evidence Base for Integrated Care: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjL__TDrOnPAhWsLMAKHWv7AG4QFggvMAA&url=http%3A%2F%2Fwww.nuffieldtrust.org.uk%2Fsites%2Ffiles%2Fnuffield%2Fevidence-base-for-integrated-care-251011.pdf&usg=AFQjCNGOLlv7C1J9P9_jE6mrydo28ptj8Q&bvm=bv.136499718,d.bGg
7. Delivery the Forward View : NHS Planning Guidance 2016-17 to 2020/21 https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjyg5SIrenPAhUhBMAKHaZ1C8gQFggqMAA&url=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2015%2F12%2Fplanning-guid-16-17-20-21.pdf&usg=AFQjCNEL3Y7tUP78PQhPUOqiFc6IPGAsyA
8. NHS Operational Planning Contracting Guidance 2017-2019 https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjN3bmOrunPAhXMD8AKHdlzAYoQFggjMAA&url=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2016%2F09%2FNHS-operational-planning-guidance-201617-201819.pdf&usg=AFQjCNG3YsxGbnc73_jU6lsGe5D4JQ5weA&bvm=bv.136499718,d.bGg
9. New Care Models – Vanguards https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/
10. Vanguards – recommended reading: **LINKS ONLY**
    - Integrated primary and acute care systems – joining up GP, hospital, community and mental health services:- My Life a Full Life (Isle of Wight)
    - Multispecialty community providers – moving specialist care out of hospitals into the community:- Tower Hamlets Integrated Provider Partnership, Lakeside Healthcare (Northamptonshire)
    - Enhanced health in care homes – offering older people better, joined up health, care and rehabilitation services:- East and North Hertfordshire Clinical Commissioning Group
11. Think Tank – Unblocking: Securing a health and social care system that protects older people. http://www.localis.org.uk/research/unblocking-securing-a-health-and-social-care-system-that-protects-older-people/

12. Public Finance – Pooling Pioneers, Health and Care Integration, Plymouth http://www.publicfinance.co.uk/case-study/2016/06/pooling-pioneers-health-and-care-integration-plymouth
13. Kings Fund commissioned report commissioned through the BCF Plan regional support for HWB**. To follow.**
14. Centre for Public Scrutiny - Piecing it together - Effective scrutiny of health and social care integration
15. LGA briefing – debate on STPs in the NHS
16. Kings Fund – Policy changes to implement the NHS five year forward view: progress report https://www.kingsfund.org.uk/projects/five-year-forward-view-progress-report?utm_source=The%20King%27s%20Fund%20newsletters&utm_medium=email&utm_campaign=7677109_NEWSL_The%20Weekly%20Update%202016-10-27&utm_content=fyfvbutton&dm_i=21A8,4KJP1,FLXG36,GYK4Y,1
17. Social Care Health and Housing OSC report 20 September 2016, the Integration of Health and Social Care in Central Bedfordshire
18. Executive Report 2 August 2016 the Integration of Health and Social Care in Central Bedfordshire

Appendix 2 – Sustainability and Transformation Plan Partners

There are 16 organisations within the footprint of the BLMK STP area including Central Bedfordshire Council as follows:-

- Central Bedfordshire Council
- Bedfordshire Clinical Commissioning Group
- Luton Clinical Commissioning Group
- Milton Keynes Clinical Commissioning Group
- Bedford Borough Council
- Luton Borough Council
- Milton Keynes Council
- Bedford Hospital
- Luton and Dunstable University Hospital
- Milton Keynes Hospital
- Cambridgeshire Community Services NHS Trust
- Central and North West London NHS Foundation Trust
- East of England Ambulance Service Trust
- South Central Ambulance Service NHS Foundation Trust
- South Essex Partnership University Trust (now known as Essex Partnership University NHS Foundation Trust EPUT.

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Contact us…

by telephone: 0300 300 8028
by email: customer.services@centralbedfordshire.gov.uk
on the web: www.centralbedfordshire.gov.uk
Write to Central Bedfordshire Council, Priory House,
Monks Walk, Chicksands, Shefford, Bedfordshire SG17 5TQ