Appendix 1

Highlights and Successes:

MDT working:
Caring Together MDT meetings: Proactive care and risk stratification approach is continuing. The Luton and Dunstable Hospital Consultant Geriatrician is providing input into the meetings and supporting case management.

A 'place based' multidisciplinary approach in Ivel Valley with staff from community, mental health and social care is progressing. This multidisciplinary approach is being led by senior operational managers, who are now meeting on monthly basis. A staff directory has been produced. This test bed for a place based team is being supported by Health Education East who has provided important insights into the experiential learning from this way of working. Work is also on going to facilitate interim co-location of the team at the Biggleswade Hospital site. Plans are underway to roll out this approach across Central Bedfordshire from July 2017. This place based focus aligns with the STP vision and work packages for primary, community and social care priority.

End of Life: 2016/17 saw the review of EoL and palliative services across the health and social care pathway and a revised care model developed. There is greater integrated working, increased capacity and a more proactive approach to care management. An integrated care pathway is now being developed. Advanced Care Plans training has continued. Work with the Ambulance service has seen as reduction in the number of conveyances to hospitals with more calls to the PEPS Service. Up to 12 Care Homes in Central Bedfordshire have appointed an EoL Champion to work with professionals.

Delayed Transfers of Care: Additional investment and realignment of staff to support early and coordinated discharge from all hospitals used by Central Bedfordshire residents. Closer working with all acute trusts to improve understanding of patient flows is underway. Social care related reasons for delayed transfers of care reduced and is one of the best performers in the Eastern Region. Additional intermediate care beds have been made available.

Stroke Early Supported Discharge: ESD service went live in March and referrals have been received from the Luton & Dunstable, Bedford and Lister Hospitals. The stroke tracker developed by the team to be able to monitor impact of the service on length of stay and access to community stroke rehabilitation showed that in the first month of the service there were 19 referrals for Central Bedfordshire residents and all referrals were seen within 24 hours .

Supportive Technology: Disabled Facilities Grants - Developing a policy for more flexible use of resource to support early discharge from hospital and promote independence through wider use of assistive technology.

Falls: Business case approved for fracture liaison service to commence in April 2017 at Bedford Hospital. Individual care home providers are purchasing equipment to help get people up safely following the ISTUMBLE seminar.

The assessment against the enhanced care in care homes framework has been completed and priorities identified. Community nursing service specifications have been updated and include nursing homes having access to community nurses, contract variation is in discussion.

General Integration:

- The Social Care, Health and Housing Overview and Scrutiny Committee concluded its enquiry on the local approach to integration and integrated health and care hubs. A report is due to go to the Council's Executive in June 2017.

- The outcome of the LGA Peer Review into Reablement and Rehabilitation which took place in Q3 will be taken forward in an action plan which will form part of the 2017/19 BCF Plan.

- Successful funding bids: Following the success of the ETTF fund allocation for Integrated Health and Care Hubs in Dunstable and Biggleswade, we have also received funding from the One Public Estate to develop scoping documents and outline business cases for Hubs in Leighton Buzzard, West Mid Beds and requirements for Houghton Regis. On going discussions with NHS Property Services to secure the Biggleswade Hospital Site asset are critical to meet the ambition for the Ivel Valley Hub. Locality based integrated health and care hubs are a key part of the STP vision for out of hospital services and key also for the implementation of the GP Forward View.

Challenges and concerns:

- Challenge of working with several acute trusts, particularly in relation to DTOC and engagement in A&E delivery Boards where Central Bedfordshire residents are in minority.
- Recruiting and retaining sufficient care workers, particularly in the domiciliary care sector.
- Information and shared records to facilitate timely transfers of care and joint care planning.

Potential actions and support:

- Engagement with stakeholders for fracture liaison service
- Review into novel uses of DFG to facilitate early discharge and promote independence as well as expand use of assistive technology.
- Improvements in DTOC performance due to additional resources and capacity for early supported discharge.
- Development of integrated care pathways for Falls, stroke ESD and End of Life Care

- Developing multidisciplinary place based teams across Central Bedfordshire.
- Move to integrated health and social care offer to improve patient flow and reduce hand offs between professional groups.