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Central
Bedfordshire

Appendix 1

Outcomes of the scrutiny enquiry on areas of good practice to integrate health and social care in Central Bedfordshire (Autumn 2017)

Chairman's Introduction

The Council has an important role in promoting wellbeing and reducing health inequalities for its residents. This duty was set out clearly as part of the Health and Care Act that created health and wellbeing boards.

Local Government was charged in the 2012 Health and Social Care Act, with influencing the way in which health care is delivered to its residents. The path is clearly along the track of an integrated health and social care system. Local Government and Central Bedfordshire in particular, has taken on this role with enthusiasm to try to overcome barriers between health and social care, the different cultures between organisations and the different financial arrangements.

Central Bedfordshire Council has taken on a leading role in this work and earmarked capital to create two hubs within its boundaries. The success of this depends on all parties signing up to the changes that are necessary to create a superior environment in which health and social care are truly partnered.

This report follows on from 'Outcomes of the Scrutiny Enquiry on Integration of Health and Social Care (May 2017)'.

In endorsing the above report, the Executive (1st August 2017) requested that further work be done to investigate additional examples of good practice and agreed to add a further recommendation to the report. '*To note that the delivery of integrated health and social care in Central Bedfordshire is reliant on the cooperation and commitment from all the Council's partners'.*

That cooperation is a fundamental element of good practice and will be shown in the following pages.

A number of visits and attendance at conferences have been made to be able to identify good practice and to be a learning curve for integration in Central Bedfordshire: -

- Bromley by Bow (reported at Appendix B of the above report) May 2017
- Nottingham Vanguard visit and Conference September and November 2017
- LGA Conference October 2017
- North-East Hampshire and Farnham October 2017
- Biggleswade Hospital visit December 2017
- LGA Conference 6 March 2018 (verbal update)

The above are in addition to the literature found in 'New Care Models: Vanguards – developing a blueprint for the future of NHS and care services' (www.england.nhs.uk/vanguards/future NHS) which were circulated and studied by the enquiry team.

These visits and the literature have shown that the different structures and cultures of various partners in health and social care can be overcome to achieve meaningful co-operation to provide integrated health and social care services for the benefit of residents/patients.

The role of integrated Health and Care Hubs is reflected in the Central Bedfordshire Pre-submission Local Plan 2015-2035, page 50, stating that Integrated Health and Care Hubs will support the local ambition for access to modern, high quality and locality based health and care services. These Hubs will be aligned to key Spokes in our rural communities. More services will be accessible to people where they live, whilst also enhancing community based and out of hospital services. The Hubs will be the main centre for providing proactive and preventative care, out of hospital services and care packages for people who are vulnerable or have complex care needs.

Furthermore, a locality based integrated health and care hub approach improves cooperation and joined up working which improves the access and quality of care provision. The hubs are expected to serve as a base for multi-disciplinary teams, provide local access to a range of general medical and nursing, therapy, specialised and social care services with supporting information and advice systems. Enhanced services may include an extended GP service, minor injury and minor illness services, a community pharmacy, rehabilitation and re-enablement facilities, outreach services from local acute hospitals, public health and prevention services.

The body of this report brings forward evidence that integration is the way forward, that Health and Care Hubs are a suitable delivery mechanism to provide integrated health and social care services in the future.

I again thank the Members of the Enquiry team, Officers and others who have continued to contribute their time and effort to this important piece of work.

Cllr Peter Hollick
Enquiry Chairman

Table of contents

Page	Sections
	Chairman’s Introduction
4	Background and reason for the second phase of the Enquiry
5	Executive Summary
6	The Evidence
18	Conclusions and recommendations of the Enquiry
20	Approach to research
21	Appendix 1 and 2 - Background papers

Background and reason for the Enquiry and for the next stage

Central Bedfordshire Council is committed to ensuring that its residents have access to timely and best quality health and social care services. The Enquiry Team agreed to undertake an enquiry in September 2016 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 residents' existing experiences.
- What is feasible for Central Bedfordshire and how we deliver it.

It was felt that successful and effective integration of health and social care could deliver seamless and person-centred services for people, leading to improved outcomes and a better experience of health and care services. Importantly, it could also help to reduce duplication and maximise resources, therefore saving money. Consequently, the Enquiry Team 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 Executive considered the report of the Enquiry Team on the Integration of Health and Social Care at its meeting on 6 June 2017. The principles and recommendations were agreed along with an additional recommendation: -

"To note that the delivery of integrated health and social care in Central Bedfordshire is reliant on the cooperation and commitment from all the Council's health partners"

"The Executive welcomed the work of the task force and the second phase of work which was to investigate additional examples of good practice".

Our principles, recommendations and the good practice vanguards that support our thinking towards integration

Strategically the implementation of the principles relies on the commitment to a new 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: -

Our principles and areas of focus for successfully achieving integrated outcomes are: -

1. **Our residents will be at the centre of decision making.**
2. **Health and care will be assessed 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, particular 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.**

Our recommendations to Executive: Appendix 1

Executive Summary

In consideration of all the good practice and vanguard sites visited by the Enquiry Members and the additional research undertaken, it is evident that goals and outcomes are aligned to our principles and recommendations, however, each area has introduced specific and bespoke arrangements to suit the residents and health and care partners in their area.

To reiterate, the population of Central Bedfordshire is served by a number of hospitals, none of which are inside the Central Bedfordshire boundary. These include the Luton and Dunstable, Bedford, Lister, Milton Keynes, Buckinghamshire Hospital Trust (formerly Stoke Mandeville), Addenbrookes and Hitchingbrooke. This can present challenges in understanding, managing and ensuring smooth patient flows into and out of hospitals; as well as ease of access to the supporting community-based health and social care services.

Central Bedfordshire officers have successfully implemented enhanced support, training and upskilled workers in our Care Homes to reduce the transfer of residents to hospital as recommended by the Enquiry Team. This way of working is outlined in the Sutton Vanguard which has also led to the introduction of the Red Bag system to ensure residents that need treatment in hospital have their notes with them at all times.

Proposals to provide two integrated health and care hubs in Biggleswade and Dunstable to bring together GP's and multi disciplinary teams as well as voluntary and community workers providing social prescribing are in hand. Capital funds have been set aside in the Capital Budget to construct them.

Members of the enquiry team visited the Biggleswade hospital site and were met with enthusiasm by partner organisations to for the Hub. Business plans to roll out additional hubs in West Mid Beds, Leighton Buzzard and Houghton Regis are being produced. As can be seen from the evidence provided by North East Hampshire and Farnham, Plymouth and Nottinghamshire the benefits to GPs, Acute Hospitals and residents and the improved financial position of these health economies cannot be underestimated.

The hubs may also develop a range of additional or enhanced services in line with the needs of the local community. Enhanced services in Central Bedfordshire will include some of the following:

- Extended GP services on a seven day basis
- Enhanced services delivered by and across practices, e.g. minor injury and minor illness services, clinics to support patients with long-term conditions
- Face-to-face out of hours consultations
- Community pharmacy
- Rehabilitation and reablement facilities
- Outreach services from local acute hospitals and specialist services, e.g. outpatient appointments and other specialist consultations
- Less complex diagnostics
- Public Health and prevention services, e.g. smoking cessation, NHS Health Checks, lifestyle hubs
- Wellbeing services and community mental health services
- Voluntary and Carer support services.

The Director of Community Services advised that a Hub Development Steering Group, comprising directors from the CCG and Central Bedfordshire Council, has been established to oversee the Hub Development Programme. The Steering Group is supported by a Programme Board that comprises colleagues across the Council; in Adult Social Care, Assets, Major Projects, Children's Services and strategic leads from the CCG.

It is important not to underestimate the fantastic work already done in Central Bedfordshire that includes: -

- Enhanced support and training for care home workers
- Modernisation of IT systems in care homes
- Implementation of multidisciplinary approach across Central Bedfordshire with a move now for interim co-location of teams.
- Development of joined up community health services and social care services at operational and managerial level.

The Evidence

The NHS England new care models programme, saw the establishment of 50 vanguards who have taken the first steps towards delivering the Five Year Forward View (published October 2014) and to support improvement and integration of services.

There are five vanguard types:

- integrated primary and acute care systems – joining up GP, hospital, community and mental health services
- **multispecialty community providers** – moving specialist care out of hospitals into the community
- enhanced health in care homes – offering older people better, joined up health, care and rehabilitation services
- urgent and emergency care – new approaches to improve the coordination of services and reduce pressure on A&E departments
- acute care collaborations – linking local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency.

Of particular interest to the Enquiry Team were multi-specialty community provider models, details of which can be found on the Good Practice NHS England Multispecialty community provider vanguards [1] of which there are 14 working to develop a population based health and social care model. The multispecialty community provider emerging care model and contract framework document [2] published in July 2016 illustrates the multispecialty community provider (MCP) care model.

Nottinghamshire Vanguards

The Mid Nottinghamshire Better Together vanguard is one of three Vanguards in Nottingham set up to connected services together. Their aim to ensure that people get better support themselves through self-care, get the right advice in the right place, first time when they need it. They also wish to ensure responsive urgent care services outside of hospital wherever possible are available and responsive treatment for people with serious or life threatening emergency care needs to maximise chances of survival and a good recovery. The health system has signed a memorandum of understanding with regulators in order to continue its work in this area.

With a new discharge process called 'transfer of care', patients are discharged from hospital as soon as they are medically fit, with wide-ranging health and social care support already put in place to help them.

The changes were made to reduce pressure on hospitals by helping patients leave hospital sooner and to ensure patients receive more and better care closer to home. By implementing these changes, it was possible to achieve the significant savings identified in their research that could be unlocked.

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[1] Good Practice NHS England Multispecialty community provider vanguards

[2] multispecialty community provider emerging care model and contract framework document

A decline in the length of hospital stays, long-term admissions to nursing and residential homes, secondary care elective referrals, non-elective acute admissions, A&E attendances and mortality rates have all been achieved.

An alliance contract between commissioners and providers was created that has allowed a more strategic approach to reduce deficits across the whole health system.

The second Nottingham vanguard is led by Principia, a multispecialty community provider (MCP) in Rushcliffe, Nottingham and they focused on:

- the diagnosis and management of Atrial Fibrillation (irregular, rapid heart rate) and introduced a new frail elderly care model.
- mental health initiatives, with a commitment to achieving parity of esteem between services for physical and mental health needs. This has included piloting a liaison psychiatry service in primary care for those with medically unexplained physical symptoms.

Improvements in each service area were reported by clinicians and patients alike. The provision of liaison psychiatry service in primary care has been introduced by the BCCG in Central Bedfordshire to improve the link with patients and services and reduce the number reaching crisis care.

The **Nottingham City CCG** care home vanguard focused on improving primary care support and data, IT and technology in care homes. Pharmacists were recruited to improve the dispensing of medicines in care homes and avoid hospital admissions. Care homes have also introduced telemedicine services, resulting in a reduction in 999 calls and admissions.

The purpose of these changes was to create a one umbrella organisation to provide integrated working between the services and to promote a culture of 'mutual accountability' to improve the patient experience and outcomes.

The Nottingham vanguards encompass the new models of care and the services support the reasoning behind the Enquiry Team's principles and recommendations. See appendix 1.

North East Hampshire and Farnham Vanguard

The vanguard aims to keep people happy, healthy and at home by motivating and supporting them to improve their own health and by providing a seamless health and care service when they are ill or need support.

Visited by Members of the Enquiry team in October 2017 the Happy Health at Home Vanguard proved to be the vision of integrated healthcare and hubs.

GPs' practices self selected into five newly created hubs in the area and made efficiencies delivered through new ways of working. The gap between the available resources and the costs of providing services to meet needs was

closed. Multi-disciplinary teams relocated in all localities so that patients' needs are better managed. GPs also provided training to upskill surgery staff and introduced a paramedic and matron home visiting service to reduce pressure on GPs' time.

A few of the initiatives implemented include: -

A system control total agreed for the health economy. Formal ACS board established.

- The introduction of an enhanced 'recovery at home team' helped to keep patients out of hospital.
- Community ambassadors appointed to listen to patients and feed back to commissioners to help them deliver the services that patients want. Patient and community ambassadors have been instrumental in shaping services, listening to residents and informing them of changes.
- The Provision of an Army medical centre presence in the Aldershot Hub.
- Shared care records achieved.
- Pharmacists and paramedics advise residents who call the out of hours service.

Evidence produced by the Vanguard shows a reduction in unplanned admissions to hospital and a reduction in the need for re-admittance. Residents and staff had indicated they have noticed a difference in the care they receive and the way it is delivered. Probably one of the most challenging and complex aspect of the changes was the establishment of partnership working, however, with a strong alliance the new model of care has kept patients out of hospital and reduced the need for re-admittance.

- Feedback from patients and staff indicated they had noticed a difference in the care they received and the way it was delivered.
- System impact - Month 5 showed a 0.2% decrease in emergency attendances, 4% ahead of target. GP referrals 9% down.
- GPs have seen a real improvement to their work life balance. It is also worth noting in the first 18 months of implementation, there was no impact on A&E admissions.

It was of particular note to the Team that establishing a GP presence in A&E confused residents who were being signposted away from A&E except in cases of a genuine emergency and this initiative was stopped.

The North East Hampshire and Farnham vanguard has delivered the enquiry team recommendations set out in Appendix 1 and identifies the benefits that the new model of care can bring to Central Bedfordshire.

Multispecialty Community Providers Vanguards – moving specialist care out of hospitals into the community

In addition to the visits outlined above, the Enquiry Team investigated a number of schemes in the country from website sources. What was evident from this investigation was that each vanguard is unique and individual to the area it serves, and it would not be appropriate to select one and recommend the implementation as such. There is, however, similarities that are featured in each one. There is opportunity to consider each vanguard on its own merits and select concepts that could work for Central Bedfordshire. There are a number of schemes that impressed the Enquiry Team, and some initiatives are being introduced or being considered in Central Bedfordshire.

Those schemes considered included: -

1. **Hertfordshire - Enhanced care in care homes** - trusted assessor model

The 'better care for care home residents' vanguard supports health and social care providers to work together to provide enhanced levels of care for vulnerable patients in care homes and avoid unnecessary trips to hospital.

The vanguard's main focus was to improve services through workforce development, with new integrated teams and enhanced training. The new teams created include GPs, district and practice nurses, mental health nurses, older people's specialists and pharmacists who work closely with care home staff. The vanguard also offers an extra 'complex care premium' which allows care home staff to undertake a new package of training and education, equipping them with enhanced skills to look after patients who have complex needs with increased confidence.

For enhanced urgent care the vanguard has brought together additional 'rapid response' teams of community nurses, matrons, therapists and home carers who can arrive at care homes to provide support within 60 minutes. Where appropriate, the teams are able to put care in place within the home as an alternative to sending elderly patients to A&E.

There will also be an investment in technology to give all GPs access to comprehensive information about each care home resident during visits.

- Improving staff skills and confidence to support care home residents.
- Reducing unnecessary and distressing visits to A&E through an improved urgent care service within care homes.

The enhanced care in care homes model is a key recommendation and an initiative is being introduced in care homes in Central Bedfordshire supported by multi disciplinary teams and GPs.

Sutton Homes of Care - the vanguard

The Sutton Homes of Care vanguard has brought together partners from across health and care working together to enhance the health and wellbeing of care home residents with their partners. The vanguard focused on three key components of integrated care, education and training and quality assurance and safety. In a similar way to the Hertfordshire model, the focus on care home residents has seen the number of unnecessary hospital admissions drop. The joined up teams of medical, nursing, social care and voluntary sector professionals work together to improve care for each individual, particularly for residents with complex long-term conditions or mental illness, including dementia.

The vanguard has delivered **c**onsistently safe and high quality nursing and social care in care homes and enhanced competence and confidence of care home staff.

Sutton Homes of Care also launched a Red Bag model which is a simple initiative to help people living in Sutton care homes receive quick and effective treatment should they need to go into hospital in an emergency.

The "Red Bag" keeps important information about a care home resident's health in one place, easily accessible to ambulance and hospital staff.

Key benefits include communication between care home staff and trust staff that has improved greatly because of the Red Bag and provided a better understanding of the roles of each partner in the care of vulnerable patients.

As well as being a key recommendation from the enquiry team, this initiative forms part of the Improved Better Care Fund actions and will be rolled out in Central Bedfordshire Care Homes.

Tower Hamlets Together - Multi speciality community care provider

Tower Hamlets Together is a multispecialty community provider vanguard provided by the East London Foundation Trust (ELFT) that works with partners to deliver innovative, integrated and seamless care to patients, carers and families. Care is user focused and better coordinated to reduce duplication and improve the patients' experience.

The transformation changes included a model of care for adults with complex needs, a model of care for children and young people and the development of a population-wide health programme that focused on prevention. Residents of Tower Hamlets are encouraged to find and develop resources and skills within themselves and their communities and to have the confidence to work in partnership with services to improve their own and their family's health and wellbeing. Care is coordinated around residents needs and more vulnerable

patients receive care in their own homes, reducing the time they have to spend in hospital away from their family and friends.

The outcome of this vanguard has seen services working together to offer joined-up, patient focused care. Emphasis to help people look after themselves better has reduced pressure on the health and care system.

ELFT have been awarded the community services contract in Bedfordshire that begins in April 2018. It is proposed Central Bedfordshire community services will mirror this model of working and again this underpins the Council's and the STP focus on prevention.

Northumberland Integrated Care Vanguard - Building a Caring Service

Integrated care in Northumberland is well established with all hospital, community health **and** adult social care services delivered through a single provider – Northumbria Healthcare NHS Foundation Trust. Over 9,500 staff work together to deliver care in people's own homes, from various community settings and from hospitals across the county.

Northumberland has a well 'integrated' health and social care system. As a trust, they provide adult social care, as well as hospital and community services, and this gives them a very strong foundation on which to build and will include.

- easy-to-access, joined-up system that supports self-management and ensures the right level of care and the right professionals to meet individual patient needs.
- a single health record, that patients have access to and is shared across organisations in a timely way amongst all health professionals
- access to information and resources that will allow them to take responsibility for maintaining and improving their own health and wellbeing
- access to 24/7 advice (as part of planned or ongoing care and in urgent situations) via electronic, telephone, or face-to-face consultation with the right professional
- better support for patients with long-term conditions using bespoke care plans and responsive services which meet individual needs
- better support for carers in local communities

Integrated Hubs have been established through Northumberland, examples include the Blyth Community Hospital which provides care in the heart of the town, helping many people to have their treatment locally.

The effect of the system change has shown: -

- Improved outcomes for seriously ill patients requiring emergency hospital care
- Increased same day access to GP advice and reduced out-of-hours activity

- Reduced reliance on emergency care and hospital admissions
- Created more time for GPs to plan and care for those with long term or complex needs
- Supports the future efficiency and financial stability of the health and social care system as a whole.

Northumberland Healthcare Trust is unique in its set up as a single provider, however, the foundations of their healthcare system are echoed in the recommendations.

West Cheshire Way Vanguard

A further example outlining the transformation of care from cradle to grave, is shown in the West Cheshire vanguard where local people are encouraged again to take more control of their own health and wellbeing with a promise that children and young people are equipped with the tools they need to live happy and healthy lives.

Following feedback from GPs, a new liaison role for an Age UK wellbeing coordinator was introduced. Coordinators were often asked by patients about issues where there was no appropriate medical solution but where social issues were impacting on their patient's health.

By supporting people to manage the wider issues that affect their health in more appropriate ways, this new service helps to reduce the pressure on GP practices.

- A self-care management programme that empowers patients to manage their own health conditions is being funded for two years as part of the new care models programme.
- During 2015/16, 145 patients completed a six-week course run by volunteers who have a long-term condition themselves and have received training to become self-management coaches.
- Empowering patients to better manage their health conditions will reduce unnecessary hospital admissions and the demand for GP appointments.

As shown in the visit to Bromley-by-Bow in London by the Enquiry Team the benefits of social prescribing can have a dramatic and positive effect on residents that would otherwise visit their GP and look for medical intervention. In Central Bedfordshire, Primary Care and GPs continue to link up with the Village Care Scheme coordinators. The BRCC has enhanced the scheme and Village Care workers are the linchpin in social prescribing in Central Bedfordshire.

Plymouth – Pooling Pioneers in health and care integration

Plymouth City Council and the Northern, Eastern and Western Devon Clinical Commissioning Groups' Vanguard have an integrated budget and finance system even though they cover different areas and have different accounting

systems. Integration focused on improved health and wellbeing; reduced health inequalities; to improve the experience of care and better sustain the health and wellbeing system. The whole set-up is supported by a risk-sharing agreement and extends to all those with a role in wellbeing, including public health, leisure, housing and children's services.

There were elements of the finance integration that could not be overcome that included some statutory duties which had to remain within the confines of the Council or the CCG. Other challenges included the need to split the budget into geographic areas.

The complexities of integration have seen the majority of the budget, reportedly £475m successfully transitioned, the remaining £20m is tied up legally and is not easily transferred. However, despite these challenges integration has been highly beneficial, allowing the Council and the CCG to spend their budgets more efficiently.

The outcome of this Vanguard's work has seen budgets that are better managed across the health system.

Control of budgets is a huge challenge for all health and social care providers, however, sharing budgets and financial risk with our partners would see a stabilising of budgets and ensure benefits to residents in Central Bedfordshire.

The framework for joint commissioning arrangements for Central Bedfordshire is being taken forward as part of the Sustainability and Transformation Partnership, which has adopted a 'place-based' approach for Integration. This emerging arrangement could mirror the 'Plymouth approach' which includes Adults, Children and Public Health joint commissioning through a single budget.

LGA Conference September 2017

A Member of the Enquiry Team attended a LGA Housing, Health and Ageing Population event that show-cased innovations in designing and delivering homes suitable for older people. Topics included: shaping the market to deliver; integrating housing and health; engagement with older people; commissioning adaptation and support and developing a long-term strategy.

Central Bedfordshire Council's MANOP Team presented at this LGA event on the theme of developing and promoting investment in housing solutions for older people. The link between health, wellbeing and housing is well-documented and Central Bedfordshire had commissioned extensive quantitative and qualitative research in order to better understand older people's housing needs and preferences.

Members also heard about a scheme in Birmingham where houses had been designed for older people in the first instance and would cater for a disabled older person(s) with accommodation for carer(s) or visiting family members. The homes were versatile and would accommodate a family too.

The Enquiry Team recognised and supported the call for development sites to be identified which are suitable for the delivery of housing for older people across tenure types and with different levels of care and support available. It welcomed and supported the use of Council land for such schemes, especially in areas where the market had not delivered. It noted the importance of having a clear definition of the different types of housing for older people, including mainstream homes suitable for older people to downsize into.

The Enquiry Team is supportive of exploring the use of 'Smarter Construction' methods for the delivery of suitable accommodation as it may allow for faster delivery and at a lower cost. Such methods can include modular designs, use of novel building materials and varying degrees of offsite construction.

Members supported the idea of a right-sizing housing project to further explore what would increase the incentive of residents to move and the effect that moves would have on the overall housing needs as moving to smaller properties would release larger ones for occupation by families.

The Enquiry Team considered that current national planning policy did not go far enough and could be improved but noted the work of officers to ensure that the housing needs of older people are reflected in the emerging Local Plan 2015-2035. The proposed Enquiry into Housing and Homelessness Team would be asked to investigate this idea further.

The Council continues with its programme to develop further affordable housing-with-care Independent Living schemes like Priory View and Greenfields – aiming for a total of six by the end of 2020, including schemes at Houghton Regis, Biggleswade and Flitwick/Ampthill.

As the Council's service at Priory View develops there is growing evidence that such schemes can support people with significant care needs, helping them to live independently and enjoy a good quality of life. In addition, working alongside health professionals, the care team can help people avoid hospital admissions and consequently reduce demands on the NHS. There are opportunities to develop the services within Independent Living further in the future by offering short term accommodation to support people on discharge from hospital alongside additional day care services.

Sustainability and Transformation Plan

In an interview with Central Bedfordshire Council's Chief Executive and STP Lead for the Bedfordshire, Luton and Milton Keynes (BLMK) footprint (see appendix 2), Members were reminded of the complexity and fragmented

nature of the NHS and the drive to deliver a model focussed on better outcomes for residents. There is an optimism throughout the BLMK STP footprint to achieve this, but the challenges are there for all organisations involved. The new process centres round the residents and their journey and it is important in moving forward to overcome and remove system barriers.

Accepting the ambition of the STP and its aims, which includes the reduction in the number of unplanned admissions to hospital and relieve pressure on the GP community by the continued roll out of multi-disciplinary teams in localities and health and care hubs. Support in care homes is one example where residents now receive additional care to help avoid the trauma of unnecessary visits to hospital.

Central Bedfordshire has shown leadership and commitment by budgeting for integrated health and care hubs in Biggleswade and Dunstable. The Hub Development programme for Central Bedfordshire is also part of the STP's wider Hub Programme.

This commitment will lead to a continued momentum and support from professionals to ensure the new models of care succeed. Additional funding was also secured from the One Public Estate Programme to help develop the scoping and strategic case for the remaining three Hubs; West Mid Beds, Leighton Buzzard and Houghton Regis.

New ways of working in Social Care and Children's Services

The Director of Social Care Health and Housing described the how BCF monies had enabled services and working arrangements of Adult Social Care and Communities Services teams to come together. Work was underway to create an integrated management structure to mirror the changes. Primary Care was also moving in the direction of a modern way of working and targeting same day access arrangement and to reduce attendance at A&E.

The Council's attempts to bring together commissioning plans have been unsuccessful to date, mainly due to the continued financial difficulties faced by the BCCG. The Director acknowledged there was a fragmented approach to residents' care in the community and her vision is to see a 'one front door' arrangement in the community. A tracker had been designed to log activity of residents in and out of hospital and reasons for this. The information would inform transformation teams and partners working on the integration of Health and Social Care. Delayed transfer of care was also a key focus for the transformation team.

Good practice and new ways of working from far and wide have been researched and some aspects introduced in Central Bedfordshire.

- These include MDT working as seen in Tower Hamlets and Airedale.

- An enhanced role of the voluntary sector, i.e. village care schemes, to support communities and avoid the need for primary and secondary care.

Head of Child Poverty, Early Intervention & Prevention, Children's Services advised the transformation programme based around locality working had been successfully introduced and aimed to provide one worker to one family with one plan. The proposed hubs are very much welcomed by Children's Services. Currently multi-disciplinary teams are delivering services from their base at Watling House.

At the same meeting, Cllr Richard Wenham, Deputy Leader and Executive Member for Corporate Resources advised £30m had been earmarked in the Capital Budget for Integrated health and care hubs in Biggleswade and Dunstable. The Deputy Leader was clear that a detailed business plan was required from officers to support this huge commitment. Concerns remained over the timeframe to deliver change.

The role of the Assets Service at Central Bedfordshire

The Director of Community Services reiterated the proposals for integrated health and care hubs in Central Bedfordshire and his aim to deliver the Council's vision. Each Hub proposal would require a full and concise business plan and take advantage of funding and partnership working available to make the projects viable and, in some cases, provide the Council with an income to reinvest. The hubs will feature in the Local Plan. And it was proposed a planning document be produced that set out a 'clarity of purpose' or 'joint vision' that can be owned by CBC and by partners and gives clear guidance of how services will be delivered and how it links to the STP, BCF and the integrated place-based vision. The document should also contain a list of those services that can be devolved by hospitals into the community. It is important that hospitals continue their role to provide treatment and the community provide care.

Of equal importance is to bring the residents of Central Bedfordshire along the journey and educate them to look after themselves by visiting the many community support groups providing support to help them.

Work of the Buurtzorg Nursing Team

Members of the Enquiry Team looked into the Buurtzorg model of district nursing. The scheme was introduced in the Netherlands in 2006/07, and is a district nursing scheme, completely nurse-led and cost effective, meeting the needs of an ageing population. The Royal College of Nursing have also

taken a keen interest in this way of nursing and pilots are being set up including one in the East of England region.

The district nursing team have greater control over patient care and there has been a significant saving to the resident who can choose their own provider in Holland. Currently the Buurtzorg's workforce cares for over 70,000 patients of which 50 per cent of these have some form of dementia. With holistic assessment of the client's needs which includes medical, long-term conditions and personal/social care needs, care plans are drafted from this assessment. The aim of this approach is to engage three key national health priorities:

- health promotion
- management of conditions
- disease prevention

Buurtzorg has achieved some notable breakthroughs, particularly in the following three areas

- Higher levels of patient satisfaction
- Significant reductions in the cost of care provision
- The development of a self-directed structure for nurses.

The East of England LGA are looking to roll out a Buurtzog pilot in the Suffolk area. It is believed that significant cost savings could be realised across the health and care system. Although this model of district nursing is not under consideration by Central Bedfordshire at the moment, the scheme pilot results would be of interest.

In Conclusion

In order to share the knowledge acquired by the Enquiry, it was proposed an Integration Conference be arranged. The date of Thursday 5 April 2018 has been proposed to which inter alia, Central Bedfordshire Members, and GPs in particular, be invited to explore good practice.

At the request of the Executive and the detailed evidence of the good practice now provided, The Enquiry Team feels it has done everything required of it in the pursuit of Integrated Health and Social Care in Central Bedfordshire.

RECOMMENDED

Phase II Recommendations: -

- **That in light of the further detailed evidence and best practice outlined in the report the Council seek to urgently implement the principles and recommendations outlined in the original report in order to achieve the most positive outcomes for residents of Central Bedfordshire.**
- **That an integration conference be organised during 2018 for Members in order to enhance awareness and highlight the importance of integrating health and social care.**

- **That the MANOP Team liaise with the Local Plan service and the planning team in order to promote the Birmingham model of social housing detailed in this report.**
- **That a 'clarity of purpose' or 'joint vision' document that sets out the range of services that can be delivered in a community setting be produced that steers Central Bedfordshire residents away from hospitals and towards on the integrated health and care hubs provided. Place as part of the STP officer to work with health partners to establish a clear vision for integrated services and joint commissioning for CBC in light of the STP within the framework of the new accountable care system.**

Approach to the Research

Enquiry Team membership: -

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
Patricia Coker	Head of Service Lead for Integration and the Better Care Fund Plan	Social Care Health and Housing Directorate.

Other attendees include: -

- Cllr Carole Hegley, Executive Member for Social Care and Housing and Cllr Brian Spurr, Executive Member for Health and
- Julie Ogley, Director of Social Care Health and Housing.

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 further occasions with the following partners: -

Date	Consultee	Specific Interest
09 October 2017	Tim Hoyle	Health and Housing
04 December 2017	• Richard Carr, Chief Executive and Lead Officer STP	STP
12 December 2017	• Julie Ogley, Director of Social Care Health and Housing • Sue Tyler – Head of Child Poverty, Early Int & Prev Children's Serv - Safeguarding • Cllr Richard Wenham, Deputy Leader and Executive Member for Corporate Resources	Capital Budget Hub proposals
14 December 2017	• Visit to Biggleswade Hospital	Hub proposal
15 January 2018	• Interview with Marcel Coiffiat Director of Community Services	Assets/hubs
2018	• Integration Conference	Education

APPENDIX 1

Enquiry Recommendations

	Recommendations
1.	Services should be developed to support people to stay well and take increased responsibility for their own health and wellbeing.
2.	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).
3.	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.
4.	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.
5.	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.
6.	The Council and the CCG should explore the opportunity to use local assets to support the development of Integrated Health and Care Hubs.
7.	Integrated Health and Care Hubs should provide services across the age spectrum and other community related services for children and older people.
8.	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.
9.	Continue to involve the public in managing their own care through public health information on lifestyle, health and wellbeing.

10.	A single point of contact for residents to ensure that care needs can be assessed once and save patient time should be established.
11.	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.
12.	Explore the potential added value of universal services, both council led and voluntary sector, to support social prescribing.
13.	Address the issue of data sharing to enable integrated working.
14.	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.
15.	Continue to educate staff, professionals and residents in the change of culture and new approach to health and social care services.
16.	Ensure that appropriate Governance arrangements and negotiations with partners are developed
17.	Use funding across the health and care and system to drive a greater investment in prevention
18.	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.
19.	A single point of contact for residents to ensure that care needs can be assessed once and save patient time should be established.

Appendix 2

STP Principles	
P1	Prevention, encouraging healthy living and self care, supporting people to stay well and take more control of their own health and wellbeing.
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.

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