Social Care, Health and Housing Overview and Scrutiny Committee

Date of Meeting 19 March 2018

Update on the Sustainability and Transformation Partnership (STP) and Central Bedfordshire's Integration and Transformation Plans.

Report of:

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and

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Purpose of this report.

1. To provide an update on the progress of the Sustainability and Transformation Partnership (STP) across Bedfordshire, Luton and Milton Keynes (BLMK) and the emerging collaborative approach.

2. To inform the Scrutiny Committee of the publication of the NHS Planning Guidance announcing the shift from Accountable Care Systems to 'Integrated Care Systems' and the requirement to produce a 'System Plan'

3. To update the Scrutiny Committee on the Integration and Transformation projects incorporating the Better Care Fund Plan and progress on improving outcomes for frail older people.

RECOMMENDATIONS

The Committee is asked to:

1. Note the progress of the Sustainability and Transformation Partnership.

2. Note the publication of the NHS Planning Guidance 'Refreshing NHS Plans' 2018/19 and the use of the new term 'Integrated Care System' replacing Accountable Care Systems.

3. Note and consider progress on the five priorities of the STP and Transformation projects set out in the Better Care Fund Plan

4. Note and consider local initiatives supporting frail older people as part of the Integration and Transformation projects of the Better Care Fund Plan.

Background

1. The BLMK STP is one of eight first wave Accountable Care Systems in the Country. This enables the 16 STP partners to work closely to design a more integrated system. In addition, it enables BLMK to access transformational funding to enable change at a faster pace and deliver benefits to local people.

2. The recently published NHS England planning guidance 'Refreshing NHS Plans' 2018/19 makes clear that STPs are expected to take an increasingly prominent role in planning and managing system-wide efforts to improve services. STPs should:
    - ensure a system-wide approach to operating plans that aligns key assumptions between providers and commissioners which are credible in the round;
    - work with local clinical leaders to implement service improvements that require a system-wide effort; for example, implementing primary care networks or increasing system-wide resilience ahead of next winter;
    - identify system-wide efficiency opportunities such as reducing avoidable demand and unwarranted variation, or sharing clinical support and back office functions;
    - undertake a strategic, system-wide review of estates, developing a plan that supports investment in integrated care models, maximises the sharing of assets, and the disposal of unused or underutilised estate;
    - take further steps to enhance the capability of the system including stronger governance and aligned decision-making, and greater engagement with communities and other partners, including where appropriate, local authorities.

3. The Planning Guidance also announced that the term 'Integrated Care System' will now be used to describe both devolved health and care systems and those areas previously designated as 'shadow Accountable Care Systems' (ACS). An integrated Care System (ICS) is where health and care organisations voluntarily come together to provide integrated services for a defined population.

4. Integrated Care Systems are seen as key to sustainable improvements in health and care by:
    - creating more robust cross-organisational arrangements to tackle the systemic challenges facing the NHS;
    - supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
    - delivering more care through re-designed community-based and home-

based services, including in partnership with social care, the voluntary and community sector; and
- allowing systems to take collective responsibility for financial and operational performance and health outcomes.

5. Integrated Care Systems are required to prepare a Single System Operating Plan narrative that covers CCGs and NHS providers, rather than individual organisation plan narratives. The Single System Operating Plan should align key assumptions on income, expenditure, activity and workforce between commissioners and providers. System leaders should take an active role in this process, ensuring that organisational plans underpin and together express the system's priorities.

6. Future updates to the Scrutiny Committee will use the term 'Integrated Care System'.

7. The BLMK Partnership Plan, published in November 2016, sets out five priority areas:
- Priority 1 Prevention
- Priority 2 Primary, Community and Social Care
- Priority 3 Sustainable Secondary Care
- Priority 4 Digital Programme
- Priority 5 Systems Integration.

Progress in Key Priority Areas

8. **Priority 1 Prevention**

- **Seasonal flu**
  A whole-system approach to seasonal flu vaccinations led by the Health Protection Committee has resulted in year-on-year increases (to date) in 18 out of 20 eligible resident cohorts, equivalent to an additional 16,000 vaccinations across the Bedfordshire CCG area. Seasonal flu vaccination has been offered to Care Providers across Central Bedfordshire including Care Homes and Domiciliary Care staff. Targets for frontline staff have been met, for example 76% of frontline staff at the L&D are vaccinated to date. GP consultation rates for flu-like illness and the number of confirmed flu outbreaks are among the lowest in the East of England.

- **Social Prescribing**
  Sustainability and Transformation Funding awarded in Q3 2017/18 is enabling the development of social prescribing interventions across BLMK which will release capacity in primary care and support residents to find sustainable solutions to practical, social and emotional issues. Social Prescribing is a key area of focus in Central Bedfordshire's Integration and BCF Plan, and a local delivery model is being developed based on the expansion of the Village Care Scheme. Funding has been sought to continue the programme in 2018/19.

- **Detection of abnormal heart rhythm and high blood pressure in community pharmacies**
  Around 40% of high blood pressure (hypertension) and 30% of abnormal heart rhythm (atrial fibrillation, AF) is undiagnosed, leading to preventable heart attacks and strokes.
  Sustainability and Transformation Funding awarded in Q3 2017/18 is enabling 25 community pharmacies across BLMK, including 7 in Central Bedfordshire, to screen around 2,800 residents for hypertension and AF, identifying an estimated 500 people with hypertension and 20 with AF. Subsequent treatment will prevent an estimated 4 heart attacks and 7 strokes. Promotion of community pharmacy as a source of healthcare advice and support is part of a wider drive to ensure that prevention and care are delivered in the most appropriate settings.

  In collaboration with the Local Pharmaceutical Committee, pharmacies in three Central Bedfordshire wards with higher levels of deprivation and cardiovascular disease were identified for the programme: Houghton Hall, Parkside and Tithe Farm. The initial phase will run from mid-February to April 2018 and funding has been sought to extend the intervention in 2018/19.

- **2018/19 plans**
  Work on existing priorities will continue in 2018/19, along with a new focus on promoting self-care across BLMK and the development of a workplace wellbeing offer. Additional areas of focus under consideration for the Priority 1 work programme are preventing and managing obesity; tackling alcohol misuse and rising alcohol-related admissions; and improving mental wellbeing and resilience in children and young people.

9. **Priority 2 Primary, Community and Social Care**

Primary Care

- An STP wide Primary Care Programme has been agreed and funded by the STP and NHS England. This includes an Incentive Scheme for practices to demonstrate moving towards the new models of care and the National Association of Primary Care (NAPC) programme to implement Primary Care Home across the STP.

  The Primary Care Home model is centred on the delivery of health and care services by integrated multi-disciplinary teams. Developed around populations of 30,000 to 50,000, with networked GP services being at the centre of the patient's care, it involves building care management teams around GPs to provide effective management of patient lists. There is increased focus on preventing ill health and improving good health, through greater integration of range of services, including the voluntary sector.

- All clusters/localities will receive NAPC support over a 12-18mth period but a small group will receive intensive support to test the benefits over a shorter period and Leighton Buzzard has been proposed as one cluster for intensive support, with the potential for one of the Ivel Valley sub-clusters as well.
- Bedfordshire CCG is coordinating the recruitment of pharmacists (September wave now approved) and international recruitment of GPs (January).

- Currently two pharmacists have been working to review medication in care homes in Central Bedfordshire. BCCG is also coordinating an STP wide bid for care home pharmacists to be submitted in (March).

Mental Health

- Delivering enhanced core 24/7 mental health support for patients with physical health needs being managed within hospital settings.
- Commitment from East London Foundation Trust (ELFT) and Central and North West London Foundation Trust (CNWL) to align some resource to support transformation work.
- Targeted work with ELFT and Kings Fund to take place March /April focussing on mental health in primary care

Workforce

- A Primary Care Workforce Development Plan submitted to NHS England at the end October 2017 received positive assurance though the target number of new GPs needed requires review.

10. **Priority 3 Sustainable Secondary Care**

- A proposal to merge Bedford Hospital and Luton & Dunstable Hospital to form a single organisation and management team has been developed. A full business case has been developed and was submitted to NHS Improvement (NHSI) on 22 December following approval by both Trust Boards.

- Plans for the proposed merger are ongoing with full engagement of clinicians, other staff and stakeholders. STP leads have undertaken a range of engagement activity, attended by over 500 people in total. Staff joined a briefing session led by the respective Chief Executive Officers at each Trust to hear about progress and have their questions answered.

- Two clinical events brought together consultants and leaders from both Trusts to consider the many benefits for their teams, patient pathways and how they might work together differently in the future. Patients, public and other stakeholders attended three events held in Luton, Bedford and Central Bedfordshire.

- As part of the merger, both hospital sites will retain their individual

names and identity; however, the integrated NHS Foundation Trust will have a new name. Both Trust Boards have discussed this and, given that this integrated Trust will enhance services for the whole Bedfordshire population, are considering Bedfordshire Hospitals NHS Foundation Trust as the new Trust name.

11. **Priority 4 Digitisation**

- Development of a Shared Health & Care Record with public facing architecture / patient portal is progressing. An Outline Business Case is currently being produced for completion by the end of March 2018. A programme is being established to take this forward into the next financial year with the key activity being identification of funding.

- An Information Sharing programme using Estate and Technology Transformation Fund (ETTF) has been established. Its main objective is to make BLMK SystmOne patient data (95% of all BLMK GP data) available in every care setting required.

- Funding has been provided for the three BLMK CCGs to implement Online Consultations in GP practices. GP Practices in West Mid Beds are part of the pilot cluster.

- Some ETTF funding has been allocated to pilot Telehealth remote monitoring in BLMK. An options appraisal was carried out to identify the best opportunities and an outline business case has been produced and agreed. A task and finish group, of the Enhanced Care in Care Homes Group, has been established and will take forward the planning and deployment of the remote monitoring solution to Care Homes in Central Bedfordshire.

- **Care Homes Digitisation -** A programme is underway to provide BLMK Care homes with a digital capability to the following standards:
    - Bronze standard – Secure Wi-Fi, NHS Mail addresses and IG training for the home
    - Silver standard – all of the above plus patient data access to SystmOne
    - Gold standard – all of the above plus access to a full Shared Health & Care record via the portal so that all permitted, relevant Health & Social Care data can be viewed.

- Phase 1 is implementing twelve Care Homes to the Bronze standard, three of which are in Central Bedfordshire. Funding for this has come from a successful Local Government Association (LGA) bid.
- Phase 2 is to take the rest of the 'in scope' care homes in BLMK to the Bronze standard using late arriving funds from ETTF.

12. **Priority 5 System Reengineering**

In September 2017, STP partners led by P5 began a work programme to determine what functions are best located at each of the three different levels of BLMK's triple-tier model. BLMK has segmented its ACS design and development work into three key components. These are:

- Strategic Commissioning
- Systems Integration
- Accountable Care Partnerships (ACPs)

The Strategic Commissioning component represents a major departure from current commissioning arrangements for both NHS and Council-commissioned services. Amongst other things, it will:

- Involve short, medium and long-term needs analysis, and associated near and long-term outcomes based commissioning.

- Rely on a new contractual relationship with service providers, who will be asked to accept responsibility for achieving outcomes set by a Strategic Commissioner whilst remaining within a capitated budget.

- Require new ways of:

    - **defining responsibilities**, both between service providers and with BLMK residents, particularly in respect of self-managed care.
    - **developing services**, especially those that cut across traditional boundaries.
    - **transacting, and sharing risk and reward**, underpinned by new ways of contracting.

A Functional Review of Commissioning, which attracted over 100 participants over three workshops across BLMK was undertaken between September and December 2017. The Review concluded that Strategic Commissioning (for health and wellbeing outcomes) should be organised, delivered and held primarily accountable at "Place" in BLMK's ACS model. This will support delivery of integrated health and wellbeing commissioning and will build on existing Health and Wellbeing Board strategies and accountability arrangements. There may be opportunities to "pool" some strategic commissioning on a "multi-place" basis. This will be a decision for the four place-based strategic commissioners to make.

There was strong support for the development of the whole population health analytic and management capability as a priority for BLMK's ICS (ACS). There was also consensus that this should be provided "at scale" whilst being established and operated in a way that is responsive to the needs of each of the four "places" in BLMK.

To enable the next stage of ICS (ACS) development to proceed at pace, STP

CEOs agreed to take steps to establish ICS - level capacity and capability to support the development and early operationalisation of BLMK's ICS and to drive the transformation programme forwards at pace. Several approaches could be adopted including:

- Closer joint working between the three CCGs in BLMK which could provide a strong platform for piloting and developing Strategic Commissioning and Systems Integration across BLMK. The three BLMK CCGs are considering options to achieve closer working.

- Building the BLMK's ACS transformation capability by establishing interim roles that are working solely on the development of the BLMK ACS. These roles would not be aligned to any STP partners. Roles might include increasing the core STP PMO resources and creating interim ACS-focussed roles, such as an ACS Finance Lead;

- Maximising the contribution of the development work being undertaken via place-based initiatives such as the Luton concordat and the development of ACPs in each of the four "places".

The February edition of BLMK STP Newsletter is attached for further information on the STP Plan. Appendix Two

Integration and Better Care Fund Plan

13. There is a close strategic fit between the aims of the Integration and Better Care Fund Plan (BCF), and the aims of the STP which are both centred on shifting the balance of care to focus on out of hospital services, promoting independence and wellbeing and reducing reliance on institutional forms of care. Appendix One shows the cross section of Integration and Transformation Projects for Central Bedfordshire.

BCF Update and Quarter 3 Submission

14. The Q3 performance return for the BCF was submitted to NHS England on 19 January. It reported that Central Bedfordshire was on track to meet the targets for two of the national metrics- admissions to residential care and reablement and not on target to meet the target for non-elective admissions and delayed transfers of care.

Non elective admissions remain challenging particularly in the context of winter pressures and higher incidence of Flu. We are working with A&E Delivery Boards to understand as a whole system how we can develop further the admission avoidance strategy and are implementing new approaches. In addition, the introduction of GP Led Care Plans in Qtr4 should provide a remedial action to reduce admissions.

Delayed Transfer of Care (DTOCs): December and January proved to be very challenging due to winter pressures. Additional investment in discharge

teams at the Hospital and a patient tracker will provide whole system oversight and ensure resources are appropriately targeted to deliver the required reduction in DTOC. A patient tracker has been developed which is helping to expedite discharges and provide whole system oversight of patient flow. IBCF investment in non-weight bearing beds and hospital discharge coordinators are helping to reduce DTOCs.

Enhanced Care in Care Homes

15. The targeted work with the care homes in Central Bedfordshire to support complex care management of frail older people and to reduce pressure on the acute system is ongoing. Key areas of focus are as follows:

- The Red Bag Scheme, which will enable timely and safe transfer of patients between care homes and hospital, is being implemented and there is good engagement with Care Providers.
- There are plans to introduce other initiatives, such as, Hydration training and remote baseline monitoring into the Care Homes.
- The Trusted Assessor role will begin in February 2018, with a Trusted Assessor for Bedford Hospital covering both Bedford and Central Bedfordshire residents. Another Trusted Assessor has been appointed for the Luton & Dunstable Hospital to start from March 2018 to cover Central Bedfordshire residents.
- There are plans to engage with Hertfordshire Care Association to provide Trusted Assessor support to Central Bedfordshire residents at the Lister Hospital.
- Three Central Bedfordshire care homes (Tudor House, Swiss Cottage and Park House) are participating in digitisation pilot and have received information governance training. Work has begun to deliver the IT capabilities for NHSmail, which will allow secure sharing of emails between hospitals, clinicians and the Care Homes. This is part of the wider STP digitisation programme, described in earlier sections.
- Activity data for hospital admissions from Care Homes has been produced and will be disaggregated for each local authority area to provide local intelligence and ensure targeted support to care homes.

Improving Outcomes for Frail Older People

16. Improving Outcomes for Frail Older People is one of the existing priorities of the Health and Wellbeing Board and the vision for care and support for frail older people is one that is person centred, safe, cost and clinically effective. The Joint Health and Wellbeing Strategy set out the following two key outcomes for this priority:

- Enabling older people to stay well at home for longer
- Helping people with dementia and their carers to feel supported to manage their dementia.

17. Both the Better Care Fund Plan and the STP Projects are focused on supporting frail older people through proactive care for people with long term conditions and complex care management support ensuring people are

supported in their usual place of residence and remain independent in their communities.

18. Through the Improved Better Care Fund, there has been additional investment:

- Increasing voluntary sector and community capacity. A Voluntary and Community sector Grant Scheme has been launched to deliver the following outcomes:
  - People are able to live independently at home
  - People are able to participate in their local community
  - People are not socially isolated or lonely
  - People feel safe, secure, valued and respected

- Additional resources to support timely discharge from hospital are now in place, with the Hospital Discharge Service now operating across all acute trusts used by Central Bedfordshire residents.

- In homecare – so that the new Homecare contract now includes incentive payments to support timely discharge from hospital.

19. The Good Neighbour and Village Care Scheme coordinated by the Bedfordshire Rural Communities Charity continues to provide comprehensive volunteering support across Central Bedfordshire. The schemes are focused on supporting older people, who may be socially isolated and many of the volunteers are older people.

20. During 2016/17, the good neighbour scheme supported around 867 people and completed over 13,900 tasks. Over the same period, they harnessed the support of about 962 volunteers.

21. Helping people with health related travel is the most requested support task accounting for 37% of all tasks. Other travel support accounted for a further 23% of all tasks. Befriending related tasks accounted for almost a quarter of all requested support tasks. The good neighbour scheme is now operating in 39 locations across Central Bedfordshire.

22. In late 2016, a number of voluntary sector support services were commissioned to provide support to carers, people with dementia, autism, sensory impairment, stroke and learning disabilities. Across this range of services there are over 280 volunteers engaged in providing support to over 1,500 people.

23. These services were commissioned to deliver one or more of the outcomes listed above. Furthermore, for those that relate to a long term health conditions, an additional outcome to help people understand, manage and live well with their condition was required.

24. Early feedback suggests that 80% of people feel these services help them feel less isolated and lonely; two thirds feel able to participate in their community and feel safe, secure, respected and valued. For those services supporting people with long term conditions, three quarters felt it helped them

understand and live well with their condition.

25. In 2016/17, there were 780 Dementia Champions and the number of Dementia Friends increased to over 8000.

26. A good measure for determining effectiveness of the services and experience of service users is through the Adult Social Care Survey. This anonymised, perception survey seeks to learn about how effectively services are helping people to live safely and independently in their usual place of residence and the impact that services are having on their quality of life. The results of the summary measures mentioned above as a result of the 2016/17 survey based on 441responses for Central Bedfordshire are:

- Information and advice, some 76.0% said that they found it easy to find information about services (nationally 73.5%).
- Adult Social Care users reporting that they have as much social contact as they would like had decreased to 43.6% compared to 44.9% when last measured, but 4.2% (nationally 5.7%) reported that they felt socially isolated.
- 26.4% said they did not leave home, (27.1% nationally), and an additional 20.5% said they were not able to get to all of the places they wanted to.
- Depression and anxiety, 47.2% (45.8% nationally), said they were not anxious or depressed, 46.4% (45.8% nationally) were moderately anxious/depressed and 6.4% (8.4% nationally) were extremely anxious/depressed.
- 86.3% of people receiving services said they helped them to feel safe, in line with the national average of 86.4%.

27. The Better Care Fund Plan and the wider Transformation projects are ensuring a continuing focus on improving outcomes for frail older people, wherever their usual place of residence.

Next Steps

28. Work will continue to progress the priority areas of the STP to benefit the population of Central Bedfordshire.

29. STP Leads will continue to develop a Single System Operating Plan narrative and support the emerging Integrated Care Systems.

30. Bedfordshire CCG and Central Bedfordshire Council leads will progress work on establishing a programme to design and develop a ‘Place based’ strategic outcome based commissioning framework.

31. The Transformation Board will continue to monitor progress on the key projects for the BCF and STP as well as ensuring that a single delivery framework for the key Integration and Transformation strategies is in place.

Implications for Work Programme

32. Further update reports on the STP priorities, emerging Integrated Care System and the Single System Operating Plan narrative will be presented to the Scrutiny Committee at future meetings.

Council Priorities	
33.	Health and Wellbeing Boards have a key role in shaping the future of health and social care in their areas and need to ensure that they have meaningful input to the STPs. The emerging vision and priorities of the STP are consistent with the priorities of Joint Health and Wellbeing Strategy for Central Bedfordshire for improving health, wellbeing and reducing health inequalities and also aligns with the Council's priority on Protecting the vulnerable; improving wellbeing.
34.	Health and care systems have been asked to come together to create their own ambitious local blueprint for implementing the Five Year Forward View, covering Oct 2016 to March 2021. NHS England will assess each STP. Plans of the highest standard will gain access to transformation funding from April 2017.
35.	NHS England planning guidance 'Refreshing NHS Plans' 2018/19 makes clear that STPs are expected to take an increasingly prominent role in planning and managing system-wide efforts to improve services.
36.	The STP has implications for Central Bedfordshire's vision for integration and Out of Hospital services.

Corporate Implications	
Governance & Delivery	
37.	The BLMK STP programme has been overseen and driven by an STP Steering Group. This includes 16 key STP partners, all of whom act as equal partners in the STP programme. Representation on the STP Steering Group is at the CEOs and/or Director level. The Chief Executive of Central Bedfordshire Council is deputy to the nominated STP lead. The overarching design principle used to formulate the STP work programme has been that, as far as practical, the STP working groups draw on resources provided and/or insourced from STP partners. This helps to ensure that: • Ownership is achieved • Barriers in accessing data, intelligence, people and advice are reduced • Local expertise is harnessed • Third party costs are minimised
Financial	
38.	One of the triple aims of the STPs is to secure financial balance across the local health system and improve the efficiency of NHS services. However, the financial position of Bedfordshire Clinical Commissioning Group remains of concern in the wider ACS position.

39.	As an ACS in 2018/19 the system will need to be managed with a single system based budget, balancing pressures between partners.
40.	In 2017/18 the continued rapid growth in emergency admissions, and A&E attendances, compared to last year, reflects sub-optimal experience for our residents and is creating financial pressure within the system.
Public Sector Equality Duty (PSED)	
41.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between and in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
42.	Are there any risks issues relating Public Sector Equality Duty Yes/**No**
43.	If yes – outline the risks and how these would be mitigated

Source Documents	**Location (including url where possible)**

Appendices

The following Appendix is attached:
Appendix 1 - Central Beds Place Based Transformation Programme
Appendix 2 - February 2018 Monthly BLMK briefing.

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