Appendix 1

Central Bedfordshire Place Based Plan 2018/2019

Central Bedfordshire

NHS

Version Control			
Publication Date	July 2018		
Description	This document has been produced following the development of the Single Operating Plan (SOP) for BLMK in April 2018. The place based plan for Central Bedfordshire captures how the SOP will be implemented and outlines key assumptions on income, expenditure, activity and workforce align between commissioners and providers. It outlines the Central Bedfordshire system priorities and approach to transformation.		
Distribution Summary	Draft v1	24th May	CS, PC & MP– initial outline & content
	Draft V3	25 June	PC contributions
	Draft V4	26 June	CS, MP, (JO in PC's absence) contributions
	Draft V5	12 July	PC edits with EG comments
	Draft V5pc	18 July	PC Edits , CS
	Draft V5pc	20 July	PC; Rachel Porter, Nikki Barnes, Mike Thompson,
	Draft V5pc	20 July	Deliverables MP contribution
	Draft V5pc	23 July	Richard Fradgley contribution

1. Introduction

Welcome to the first Central Bedfordshire 'Place' based Implementation Plan. This Implementation Plan provides a 'Place' specific response to the Sustainability and Transformation Partnership's (STP) Single System Operating Plan (SSOP) which describe the transformation ambitions for the Bedfordshire, Luton & Milton Keynes (BLMK) Integrated Care System (ICS).

This Place Based Plan outlines how in Central Bedfordshire we will:

- deliver the national priorities and ambitions set out in our SSOP;
- continue to focus on improving the health and wellbeing of our population ;
- improve quality of care;
- improve efficiency and productivity.

Our Place based plan recognises the need for pace and scale in delivering transformation and builds on the work that is already ongoing. **This plan provides a summary of the implementation of the STP Single Operating Plan in Central Bedfordshire** to drive better care delivery, improve health outcomes and reduce inequalities for our local population, whilst at the same time making significant progress in ensuring a sustainable financial position going forward.

Although this is not a new strategy, it is a plan of the Health and Wellbeing Board and describes how STP priorities are delivered in Central Bedfordshire. It sets out what we will do, by when, by whom and with what impact.

2. Context & Purpose

In 2018/19 NHS England expects that STPs will take an increasingly prominent role in planning and managing system wide efforts to improve services and to ensure our residents -

- Experience **seamless access** to a timely, coordinated offer of health and care support
- Can access a wide range of support to **prevent ill-health** with increasing emphasis on early interventions through the support of voluntary, community and long term condition groups
- Are supported to **remain independent** through integrated GP and multi-disciplinary teams delivering the care within their own home, wherever possible
- Have access to a wider range of health and care **services in the community** that will help to avoid unnecessary hospital admission and, following any necessary admission, will enable discharge to home care as soon as it is safe to do so;
- Have access to **mental health services that are integrated with physical health and social care services**, through acute, primary, community and specialist teams and aligned to Integrated Health and Care Hubs.
- Have access to **integrated rehabilitation and reablement** services that will avoid or minimise the need to enter into residential or nursing home care;
- Experience **reduced variations** in care with improved outcomes;
- Have **support for carers** that is timely and person centred with an integrated response underpinned with joint planning and assessment, as appropriate;
- Experience services that are **person-centred,** highly responsive and flexible, designed to deliver the outcomes important to the individual; and
- Benefit from stream-lined and integrated working with **joint information systems**.

These ambitions are consistent with Central Bedfordshire's vision for better integrated care delivery, improved health outcomes and reduced inequalities for our local population.

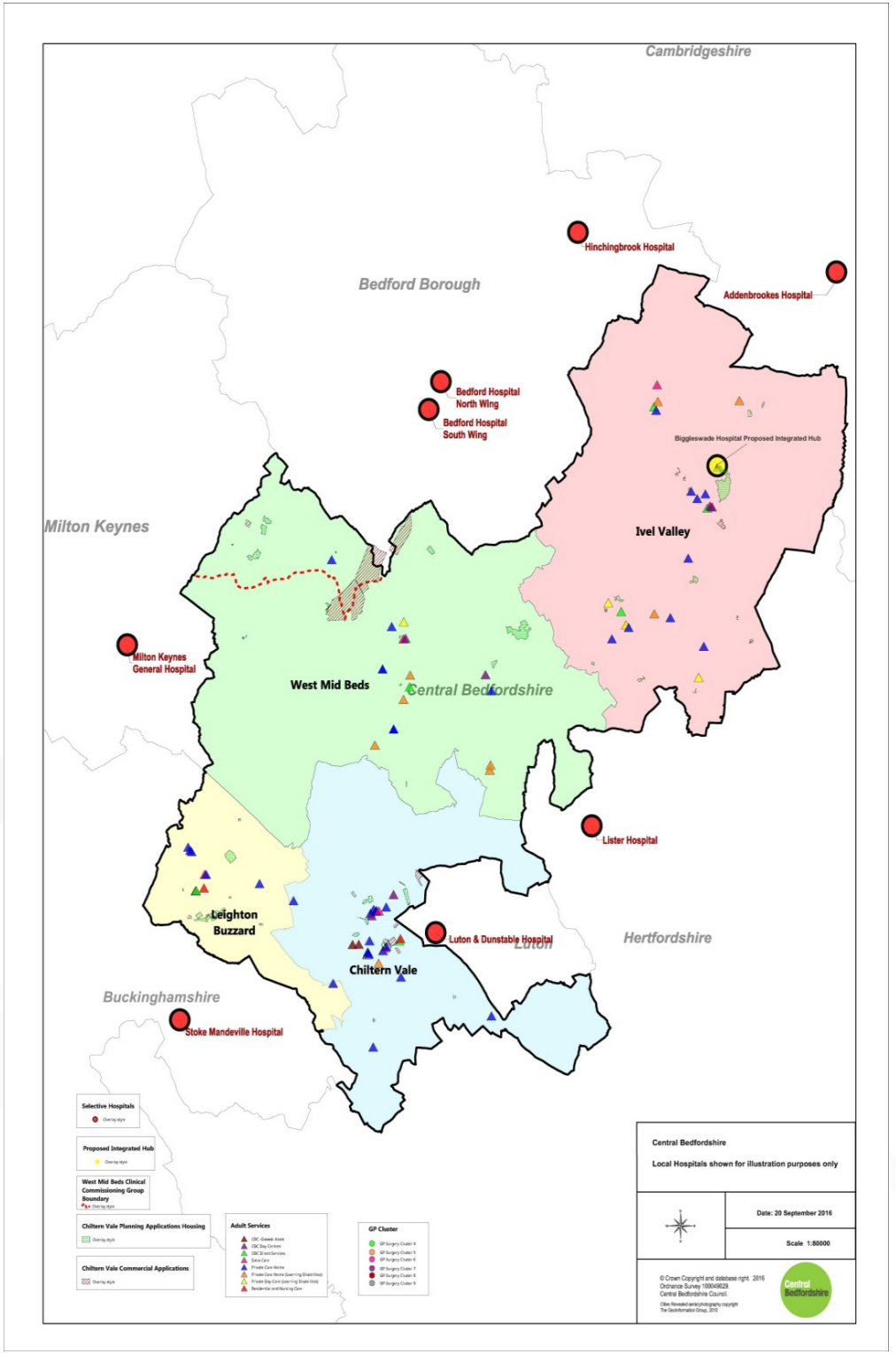
Central Bedfordshire is considered to be a highly desirable place to live and work. It is a area of significant growth with the current population estimated to be over 270,000 rising to 330,000 by 2031. This increase is driven in part by demographic change and also by considerable planned housing expansion. The population composition is also expected to change further in view of new housing developments bringing in younger families and children.

We have an increasing and ageing population. The number of people aged 85 and over is projected to double by 2035 and there will be a higher than average growth in number of adults aged 65 and over and the number of children and young people aged 0-14 years old.

Central Bedfordshire is predominantly rural and considered to be the most rural, least deprived and least diverse of the four areas in the STP footprint. There are however pockets of deprivation and around 30% of residents use other acute hospitals outside the STP footprint.

The largest towns in the area are Leighton Buzzard (41,000), Dunstable (38,200), Biggleswade (18,800) and Houghton Regis (18,500) (Source: ONS, 2015 mid year estimates).

There are also significant differences in demography and deprivation within Central Bedfordshire, with important variations in health and wellbeing outcomes and gaps in quality of care.



Central Bedfordshire Health and Wellbeing

Life expectancy and health inequalities

- Life expectancy across Central Bedfordshire has been risen over the past 10 years by 3.6 years for men and 2.1 years for women, although is now plateauing.
- Male life expectancy at birth is now 81.5 years and for females 84.0 years. However healthy life expectancy is much lower, at 67.5 years for men and 64.4 years for women, with **men spending an average of 14 years in poor health and women almost 20 years** – this is the period when health and care requirements are likely to be greatest.
- There are significant gradients of life expectancy within each local authority area. For men the life expectancy gap between the least and most deprived areas is 6.4 years and for women it is 5.4 years

Wider determinants of health

- Wider determinants of health including social, economic and environmental factors contribute to an estimated 50% of health outcomes.
- Central Bedfordshire is ranked 88/151 Authorities for GCSE achievement, with disadvantaged pupils underperforming by 1.5 grades relative to other pupils in every subject they take at GCSE
- Although 71% of children achieve a good level of development by the end of their reception year, this is significantly below statistical neighbours
- Less than half of adult social care users in CB report that they have as much social contact as they would like.

Health behaviour and risk factors

- 20% of children aged 5 to 6 are overweight or obese, rising to 30% by age 10 to 11.
- In line with the national trend, hospital admissions for self-harm are rising
- Four unhealthy behaviours are responsible for the majority of preventable ill health and mortality: smoking, poor diet, lack of physical activity and excessive alcohol consumption.
- Compared to statistical neighbours, death rates under 75 are worse than average for cancer (particularly breast cancer) heart disease and stroke, lung disease (predominantly chronic obstructive pulmonary disease) and liver disease.
- Alcohol related admissions continue to rise.
- 64% of adults in Central Bedfordshire who are overweight or obese

What does our System Look Like Now

The focus on population based integrated health and care systems aims to overcome the substantial organisational, professional and regulatory boundaries within the health and care sector to ensure that people receive the most cost-effective care when and where they need it. Key issues for us are as follows:

- Central Bedfordshire is not coterminous with an acute hospital and our residents use up to seven hospitals in surrounding areas, four of which are outside the STP footprint
- We have an ageing population and increasing demand and expectation for health and social care
- Insufficient and fragmented capacity within the community to respond appropriately to local needs
- Data sharing and timely access to information for health and care service delivery across a wide range of provider organisations and different systems remains a challenge
- The adult social care market is under pressure, fragmented and complex. Sustainability, particularly in the Home Care market remains a concern
- Both the local authority and Bedfordshire Clinical Commissioning Group have important financial challenges. The council has to make significant efficiency savings and has sought to protect the Adult Social Care market. Bedfordshire CCG is in financial recovery with important challenges ahead. As part of an integrated care service we see important opportunities to help address some of these challenges
- Central Bedfordshire is an area of projected housing growth, some of the towns will double in size. This will have significant impact on the shape of the population and the supporting health and care infrastructure
- Current primary care estates are not fit for future needs and new ways of working

Our Local Vision

Our local vision is for the people of Central Bedfordshire to have access to good quality, safe, local health and social care across its towns and rural areas.

This will be centred on the integration of health and social care through a whole system and seamless approach to improving physical and mental health, so that people can experience care 'better care, locally without organisational boundaries'. Integrated Health and Care Hubs will act as focal points for joining up health and social care and provide facilitate the Primary Care Home model and the ambitions of the GP Five Year Forward View.

We want care to be coordinated around an individual's needs with prevention and support for maintaining and maximising independence at its core and underpinned by the following principles:

- Care coordinated around the individual
- Decisions made with, and as close to, the individual as possible
- Care should be provided in the most appropriate setting; and
- Funding flowing to where it is needed.

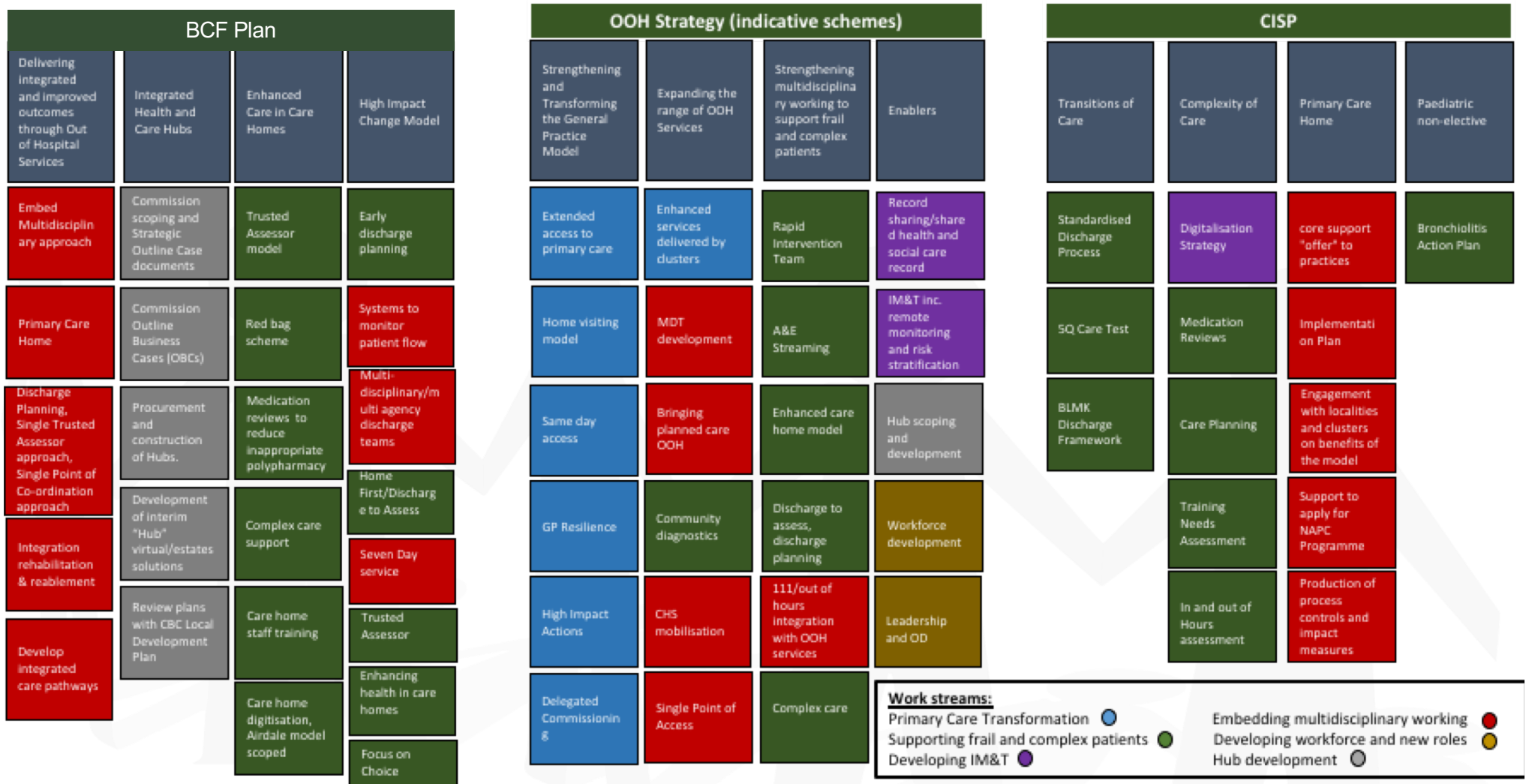
This will ensure our populations are provided with the opportunities to realise their full potential and have the support they require to lead healthy and independent lives; that they receive timely access to high quality services such as health and care when they need it.

Our Place based focus

In order to secure the key priorities for 2018/19, and ensuring we address the current and challenges facing our health and care system, we will focus on:

- **Streamlining our Health & Social Care system** to reduce fragmentation and variations to access and quality of care
- Developing five **Integrated Health and Care Hubs** which enable the primary care home model and access to a wider range of out of hospital services
- **Prevention and early intervention** and empowering children, their families and adults to develop well, remain independent and self care
- Delivering better care locally by ensuring a **person centred approach** across organisational boundaries through multidisciplinary working
- Delivering **integrated solutions** which extend beyond health, social care and housing, that takes account of the wider determinants of health in partnership with community and voluntary sector organisations
- Meeting the **challenges of an ageing population** with increasing level of disability and frailty. This includes depression, social isolation, dementia, bereavement, and long term conditions
- **Reducing reliance on institutional forms of care** and pressure on hospitals such as reducing non-elective admissions and ensuring admission avoidance plans are in place where necessary
- **Shaping the care market** with partners to design and create diversity in the care market through new and innovative care models, particularly for the rural communities. As well as mitigating key areas of risk in care market, this includes capacity and workforce challenges.
- Establishing **integrated joint commissioning** approaches to ensure cohesion in contractual and management arrangements as well as maximising our resources.
- Planning for **significant housing delivery** across Central Bedfordshire which will increase the population, twofold in some cases ensuring that primary and social care estate and infrastructure needs are addressed.

Central Bedfordshire Place Based Transformation Programme



What do we want the future to look like?

We want to shift the balance of care for Central Bedfordshire residents so that they only need to go into hospital when they require highly specialist acute care. That the services people experience are person-centred, highly responsive, flexible, reduces variations and designed to deliver the outcomes important them. Through the strong partnership between the council, health providers and the wider voluntary and community sector, our residents, will receive health and care services in integrated health and care hubs in their communities, where they:

- Experience timely and seamless coordinated offer of health and care support with an increased emphasis on early interventions through the support of voluntary, community and long term condition groups
- Are supported to self-care, with appropriate technology as well as access to a wide range of support to prevent ill-health.
- Will be supported to remain independent through integrated GP and multi-disciplinary teams delivering the care within their own home wherever possible
- Have access to a wider range of health and care services in the community that will help to avoid unnecessary hospital admission and, following any necessary admission, will enable discharge to home care as soon as it is safe to do so;
- Access to mental health services that are integrated with physical health and social care services, through acute, primary, community and specialist teams in local communities.
- Receive integrated rehabilitation and reablement services that avoids or minimises the need to go into residential or nursing home care;
- Benefit from stream-lined and integrated working with joint information systems to facilitate joint care planning and assessments.

What will be different?

Improved

- Resident patient and carer experience of our services
- Outcomes for our people, focusing in 18/19 on high priority areas of variation to national outcomes, Cancer, Mental Health, Respiratory, Cardio Vascular Disease (Including Diabetes)
- Focus on early intervention, prevention and promotion of independence
- Self management and prevention of health and social care service need
- Access to primary care services
- Staff satisfaction, retention of workforce.
- Service collaboration, resilience and service sustainability with capacity and capability to provide high quality services for our growing and increasing complex and rising comorbidities of our residents
- Robust Care Market and a multidisciplinary workforce

Reduced

- Ambulance conveyancing where historic crisis support has necessitated this
- High end service utilisation by mental health needs
- Demand on urgent services and acute inpatient services
- Non-medical demand on Primary Care
- Non-medical use of acute provider beds resulting from delayed transfers of care to appropriate alternative environments

Changes

Create financial sustainability of our system, creating circa an additional £15 – 30m savings through collaboration and partnership resolving complex service issues at the point where our organisational boundaries have historically inhibited shared innovation.

Priority 1 – Prevention

CB's approach (what)
To reduce the likelihood of developing preventable long term conditions we will:

- Support schools to deliver high quality personal, health and social education (PHSE);
- Ensure that residents have access to the information and advice they need to optimise their own health and wellbeing e.g. easily available trusted sources of advice and information;
- Develop a detailed understanding of what would help local residents to adopt healthier lifestyles, including the impact of growth;

To ensure that those with long term conditions or with poor health have appropriate support we need to:

- Encourage front-line staff to take a more pro-active preventative approach, prompt decisions, deliver brief interventions and signpost people to sources of additional support and advice;
- Provide lifestyle services for those people who require additional support, particularly in the more vulnerable groups;
- Deliver social prescribing and self management initiatives to support and enable people to take control of their health and wellbeing
- Increase uptake of seasonal flu vaccination;

Lead: CBC Public Health

High level actions (how and when)

- Reducing non-medical demand on Primary Care – through implementation of Social Prescribing, social support, health coaching and navigation.
- Deployment of social prescribing using Health and Wellbeing Champions aligned to Primary Care and Village Care/Good Neighbour Schemes.
- Support residents to optimise their own health & wellbeing including effective use of information & guidance and digitised solutions.
- Interventions and brief advice for smokers and harmful drinkers through community services provider and primary care commencing in April 2018
- Flu campaign and priorities to be agreed and delivered in Q2 2018 with the ambition that seasonal flu vaccination will be delivered before end Q3
- Participation in BLMK wide cardiovascular prevention communities of practice, including working with private business to secure greater awareness of early identification of cardiovascular disease
- Commission customer insight for delivery in Q3 2018

Additional resources requirement
CB share of £65k across BLMK (remainder of 17/18 allocation) to continue the pilot of the detection of atrial fibrillation and hypertension
CB share of £496k across BLMK (remainder of 17/18 allocation) to deliver full roll-out of social prescribing

Impact
Improved population level outcome measures for smoking prevalence, excess weight, physical activity and alcohol related admissions. Residents and pupil surveys will show improved measures of health and wellbeing. Main outcomes of social prescribing are improvements in individual wellbeing and reduced primary and / or social care use.
Longer term outcome is increasing Healthy Life Expectancy.

Priority 2 – Delivering high quality and resilient primary, community and social care services

CB's approach (what)

1. Implementation of the **Primary Care Home model** is a key priority for the STP. The approach is to support and accelerate the development of primary care networks / primary care home for our local communities with a focus on population health management. Six clusters of GP Practices are signed up to NAPC Programme to support delivery of primary Care Home model and the Clusters are required to demonstrate Level 2 of NHS E ICS Primary Care maturity matrix by end of 18/19.

2. Five **Integrated Health and Care Hubs** as focal points for Primary Care Home model for delivery of primary care led, integrated multidisciplinary out of hospital teams and services.

3. Complex **Proactive Care**: Residents with complex needs and those at high risk of deterioration are identified and supported within a multidisciplinary framework. Ambition is to proactively support complex care patients; prevent rising health care risks, improve primary care access for patients, and reduce inappropriate preventable crisis demand on the acute sector.

4. Delivering **enhanced health in care homes** and implementation of a frailty index to improve outcomes for frail older people and better complex care management in the community.

5. **Transitions of care** – (See Collaborative Investment Savings Plan) At "Home First" and "Discharge 2 Assess" focused on reducing DTOCs and Length of stay alongside improving access to urgent care and primary care services to avoid unnecessary A&E and inpatient admissions.

6. **Children and Young people** – 2018/19 initiatives to focus on reducing NEL activity and providing care closer to home and transformation of CAMHS

7. Delivering in line with the Five Year Forward View to secure rapid and tangible progress in improving mental health outcomes. **Parity of esteem for Mental Health** With a focus on implementing early intervention programmes to prevent development of mental health problems and improved support at times of crisis.

8. Condition Specific Focus on: **Diabetes** - improve health outcomes and reduce unplanned episodes of care and **Respiratory Conditions**

Lead and partners(who). GP Clusters; ELFT /CBC , BCCG and Community and Voluntary sector

Priority 2 – cntd

High level actions (how and when)

Primary Care Home

- GP Clusters collaborate to make best use of shared assets and workforce; uniformly deliver care through integrated teams to high risk groups; make use of data to understand their populations, identifying variation in resource use and outcomes, and guiding clinical decision making.
- Clusters have developed transformation project and development plan to work collaboratively to deliver services out of hospital and extended access to primary care. (by Oct 18)
- PMS scheme for 18/19 to support cluster practices to work together with other health and social care teams to expand the multidisciplinary working approach currently in place across all Central Bedfordshire localities
- Continued delivery of GPFV commitments and alignment of projects and activities with primary care home model.
- Target use of additional NHSE primary care resource to align with local investment opportunities, STP, Locality and overarching programme.
- Development of Business Cases for Integrated Health and Care Hubs. OBC/FBC for Dunstable and Biggleswade Hubs.

Complex Proactive Care

- Community provider incentive scheme to develop names cohort of patients within agreed criteria to be proactively managed by community provider supported by GPs, social care, and voluntary sector.
- Multi-disciplinary approaches are being implemented as set out in the BCF. High level actions are as described in the Integration and Better Care Fund Plan (BCF).
- Implementation of CHS transformation and agreed outcomes
- Ensuring appropriate access to urgent and emergency treatment centres for the whole of the population
- Ensuring that people with mental health problems (including dementia), drug and alcohol problems and learning disability are explicitly included in the developing model for complex care
- Key outcome areas include Discharge to Assess; End of Life and ACP for dementia patients
- Delivery of Enhanced Health in Care Homes and High Impact Change Model (see BCF Plan)

Transitions

- Reviewing points of access, clear discharge to assess model
- Implementation of telemonitoring support to Care Homes (Airedale).
- Development of integrated complex discharge teams for Central Bedfordshire residents providing system-wide response to reducing DTOC
- Development of Single Point of Access / Assessment solutions and ensure continuity of services

Children

- Roll out of additional 6 high volume pathways across primary care; Formalisation of urgent A&G; Front door triage; Community Nursing for children with acute short term illness.
- Implementation of Local Transformation Plan including further development of Specialist Eating disorders community service (across STP); 7 day crisis service; Early intervention and schools support; Roll out of CYP IAPT; Development of seamless pathways for inpatient admission with specialist commissioning

Priority 2 – cntd

High level actions (how and when)

- Improved service provision and management of bronchitis pathway
- Saturation monitors to be distributed during May / June 2018.
- CAKES training for assessing children with acute short term illness and train the trainer sessions to be provided Practice Nurses.
- Joint initiative with NSHI delivering paediatric asthma management guidelines targeting high referring GP practices rolling into Yr2 delivery.

Mental Health

- Delivering Five Year Forward View for Mental Health priorities, including:
- Achieving 67% of people with dementia having a diagnosis
- Meeting the national access requirements for CAMHS, IAPT, developing the mental health offer to schools and Early Intervention Services
- Improving the physical health checks for people with serious mental illness (physical health checks)
- Working with the STP to develop a multi-year mental health investment plan
- Continue to develop dementia services with support to care homes
- Work with ELFT to embed mental health in multidisciplinary working across clusters.
- Housing Officers support to mental health patients
- Scope the potential for achieving economies of scale and improving specialist mental health pathways through provision across the STP footprint

Diabetes

- Two-year NHS Diabetes Prevention Programme providing education and support for people at risk of diabetes to help prevent or delay onset
- Patient participation in care planning as part of annual review including jointly agreed care plan
- Improved access to services including health and well-being services and structured education, provided by Integrated Diabetes Service
- Early identification of foot problems and referral to specialist MDFT services, Investment within the Integrated Community Diabetes Service to support patients who are struggling to optimise control of their diabetes and tailored support to practices where indicated by current outcomes and performance

Respiratory conditions

Children:

- Ensuring all Practices have access to paediatric oxygen saturation monitor with the necessary equipment and training
- Mobilisation of the local bronchiolitis management pathway
- Provision of Paediatric Community Nursing support, in line with what is already available in Luton and MK

Adults:

- Structured preventative care in primary care to
- Proactive recall of patients at risk of COPD for spirometry
- Enhance delivery of community based services.
- Providing access to timely treatment and support significantly impact on patients quality of life, psychological issues associated with chronic conditions and co-morbidities such as obesity, social isolation and mortality, which create pressures on other areas of the system

Priority 2 – cntd

Additional resources requirement

- Capital Funding applied for development of Integrated Health and Care Hubs in localities to provide a range of primary care and out of hospital services – closer to home.
- CB share of NAPC development programme (circa £90k)
- CB share of £1.4m business case for STP transformation funds
- Funding required for 2019/20 to develop Outline Business Cases for Hubs in Leighton Buzzard, West Mid Bedfordshire and Houghton Regis. – may be able to use ETTF funding from NHS England.
- Investment to support additional workforce to strengthen multidisciplinary place based teams in localities
- An ICS mental health investment plan identifying costs of full FYFV delivery through to 2021 and including investment requirement, return on investment through integrated care, & innovation is being developed
- Awaiting outcome of bid submitted as part of national Wave 2 perinatal process to secure NICE guidance compliant perinatal mental service across ICS.
- An STP wide workforce plan is being developed

Impact

- 100% coverage of self-identified primary care networks, mitigating primary care workforce recruitment and retention issues
- Access to care from fully integrated teams in primary care home model
- Improved and extended access to integrated services in the community including delivery of primary care at scale
- Reduced A&E attendances and hospital outpatient appointments
- Avoid unplanned hospital admissions across all ages
- Reduce length of stay in hospital
- People are supported to better understand their condition and improve self-management
- People with long term conditions, including dementia have person-centred care plans in place
- Improved outcomes for adults and children with mental health issues.
- Complex care support to Care homes residents and equitable access to health and care services
- Increased access to mental health support for children and young people,
- improved access to psychological therapies for people with common mental health problems
- Increased the number of people being diagnosed with dementia and receiving post diagnostic care
- Improved physical health care for people with severe mental illness (SMI)
- Increased access to perinatal mental health support.
- To reduce hospital admissions for people with diabetes, reduced length of stay and reduction in foot amputations

Priority 3 – Sustainable Secondary Care

CB's approach (what)

1. Support the delivery of high quality and sustainable secondary (hospital) care services, across the BLMK footprint in conjunction with other STPs which reflects the wider use of hospitals outside of BLMK. Working with Acute hospitals to support delivery of out of hospital services in Integrated Health and Care Hubs.
2. The merger of the Luton and Dunstable and Bedford Hospitals, working together as a bigger, stronger organisation, means the two hospitals will be able to expand the range of services and support delivery of out of hospital services to meet the extra demands of an ageing and growing population. A key focus for Central Bedfordshire residents in in managing frailty (complex care) to deliver streamlined integrated care.
3. A focus on shifting the balance of care to the community will help towards secondary care resilience and sustainability.

Lead and partners(who) Acute Trusts; ICS PMO

High level actions (how and when)

Cancer

BCCG is lead CCG for Cancer across the STP and as such will continue to work with the Cancer Alliance to develop the EoE Cancer ambitions across the STP In 18/19 the CCG will focus on performance, improving 1 year survival, implementing national best practice pathways for Breast, Lung, Colorectal and Urology services and developing a strategy for Cancer as a long term condition. The STP Cancer Delivery Plan and NHSE Cancer Transformation Funding will support delivery against the plans, which cover Early Diagnosis and Living with and Beyond Cancer

Maternity

Delivery of Local Maternity Services Plan. In line with 'Better Births' the LMS is the basis on which future BLMK maternity services will be taken forward as shown in detail on slide 31. In summary priorities include *Improve the safety of maternity services; Create a joined-up approach to workforce planning; Develop and implement standardised pathways; Improve choice and personalisation of maternity services.* Place based workstreams are focussed on effective service user co-production and the establishment of independent, formal, multidisciplinary "Maternity Voice Partnerships" to influence and share decision making. Service quality in order to show that by 2020/21 BLMK maternity services have made significant progress towards the "halve it" ambition to reduce still births and neonatal deaths, maternal death and brain injuries during birth by 50% by 2030. A newly developed Maternity dashboard to monitor progress against Better Births Standards has been added to BHT contract this year .

Alignment of Local Maternity Services in Integrated Health and Care Hubs.

Additional resources requirement - TBA

Impact

Through the integration of clinical services and teams, it is anticipated the merged Trust will deliver high standards of inpatient care that is safe, timely, effective, efficient and patient focused, and can be used to drive a system-wide approach to the delivery of streamlined integrated care

System Enablers – Priorities 4 and 5

Priority 4 – Digitisation

CB's approach (what)
Place based implementation in conjunction with Digital Transformation workstreams. Key delivery focus are as follows:

- **Implementation of Shared health and Care Records:**
- Data sharing agreements and IG agreements between Practices and with STP Providers supporting development of shared care records across clusters and Place.
- **Rollout of SystmOne** to ELFT PC link workers, Clinical System Reviews and template alignment for multidisciplinary teams and primary care
- Care Homes undertaking IG toolkit readiness and **assessment to expand on the LGA funded pilot**.
- **Delivery of Bronze and silver levels for digitisation in Care Homes**
- Social care workforce primed for agile working.
- Remote monitoring in Care Homes Tele-health Phase 1
- **Central Bedfordshire commissioning case management system (SWIFT replacement)**
- Whole population health analytics – for risk stratification

Priority 5 – System Redesign

CB's approach (what)
During 2018/19, continue the work to design the place based framework for Central Bedfordshire and support key transitional steps to progress the journey towards an ICS including:

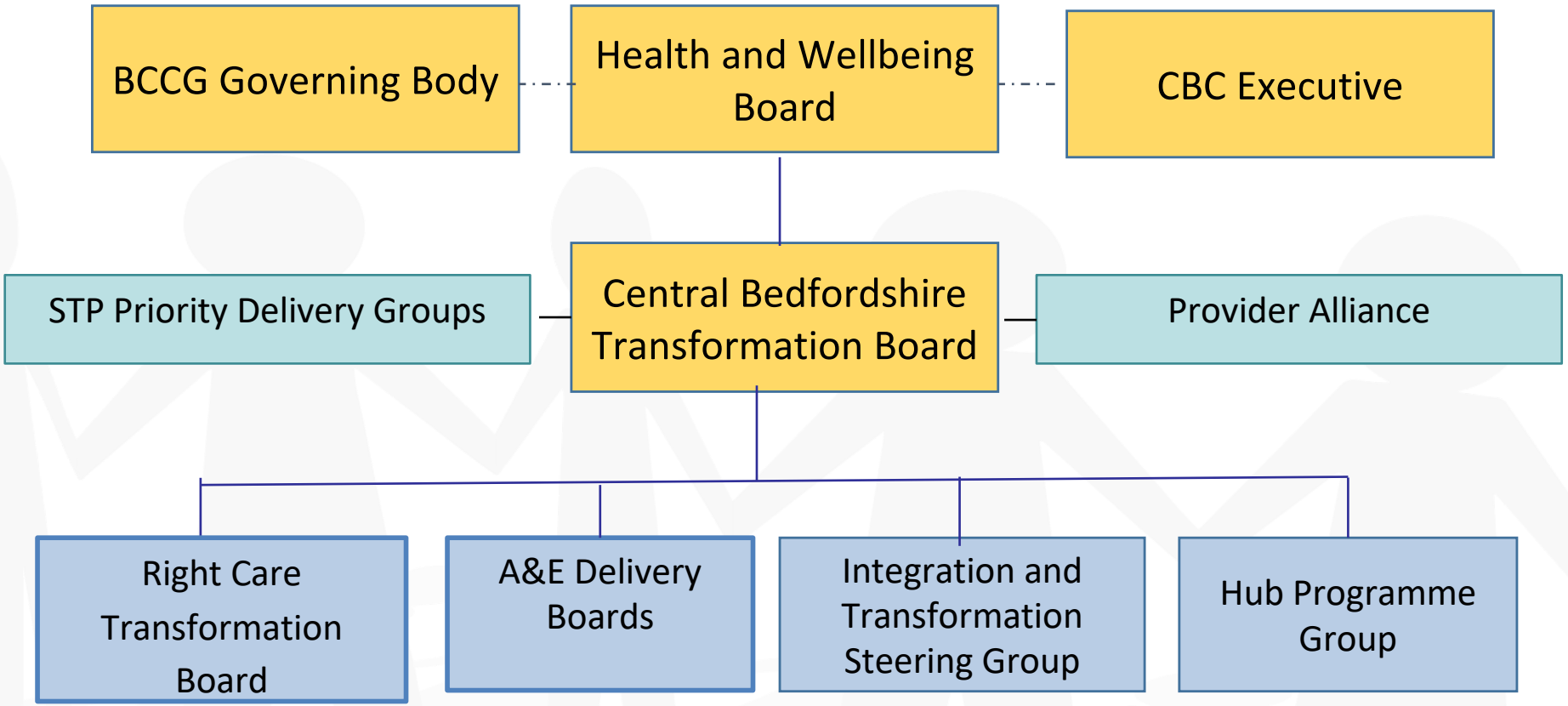
- The implementation of new CCG Leadership arrangements that support greater integration of **commissioning at scale and at place**
- Building the ICS infrastructure
- **Refreshing the partnership governance** for Central Bedfordshire Health and Wellbeing and Transformation Boards for a whole systems approach
- **Consolidating the established Provider alliance** partnerships and networks to progress greater integration between health and social care.
- Establishing an **understanding the collective resource for Central Bedfordshire** as part of the maturing collective financial management arrangements across BLMK, including managing and delivering the BLMK system control totals
- Implementing whole population health management capability as a key enabler to the ICS becoming operational

Lead and partners(who) Programme Boards and ICS PMO

Additional resources requirement

- Understanding of Place based resource
- Transformation fund
- Capacity to support 'Place' based delivery

Central Bedfordshire's Governance



Key Deliverables and Milestones

	Milestones	2018/19			
Prevention		Qtr1	Qtr2	Qtr3	Qtr4
	Deployment of social prescribing				
	Implementation of health coaching and navigation				
	Flu campaign and vaccination				
	Effective use of information & guidance and digitised solutions.				
	Develop customer insight into health, well-being and growth				
Primary, Community, Social Care and Mental Health					
	Level 2 of ICS Primary Care maturity matrix				
	Integrated teams operating in each network (cluster) with practice participation and proactively managing patients				
	Information Sharing Agreements for practices, clusters and health and social care partners in place				
	Clusters working collaboratively to deliver services out of hospital and extended access to primary care.				
	Engagement by all clusters with NAPC support programme				
	Implementation of extended access requirements (GPFV)				
	Development of Business Cases for Integrated Health and Care Hubs.				
	OBC/FBC for Dunstable and Biggleswade Hubs				
	Complex Proactive Care: High Intensity User programme delivery – implementation of service model to deliver care to agreed cohort				
	Implementation of Discharge to assess model at Luton & Dunstable and Bedford Hospitals				
	Identification of patient cohort and design of model to support proactive care to high risk patients				
	Children and Young people – 2018/19 initiatives to focus on reducing NEL activity and providing care closer to home and transformation of CAMHS				
	Implementation of telemonitoring support to care homes (Airedale model)				
	Redesign children's community services				
	Embed programme of dementia services support to care homes				
	Improved and seamless specialist mental health pathways				

Key Deliverables and Milestones

	Milestones	2018/19			
Primary, Community, Social Care and Mental Health					
	Diabetes				
	Increase provision of DESMOND courses 20-30 per year				
	Implement training for community staff to improve knowledge, skills and confidence in delivering care to patients with diabetes				
	Medicines Optimisation Team to monitor appropriate use of medication				
	Respiratory conditions				
	Ensuring all Practices have access to paediatric oxygen saturation monitor with the necessary equipment and training				
	Comprehensive review of Respiratory pathways in line with NHS right care – COPD, Asthma, Pneum/Flu				
	Bronchiolitis pathway developed/agreed and circulated across system including GPs				
	Cancer				
	Agree pathways and process for Collaborative Commissioning (NHSE and CCG)				
	Urology unit offering daily one stop shop model at BHT and L&D				
	Further improve results of National Cancer Patient Experience Survey				
	Improve 1-year survival rates				
	Improve lung cancer screening uptake				
	Digitisation				
	Technology: SMS messaging in practices rolled out across STP; Development and procurements for online consultations; Telehealth monitoring pilots begin in Care Homes.				
	All Care Homes to achieve Bronze level in digitisation				
	Central Bedfordshire commissioning case management system (SWIFT replacement)				
	System Redesign				
	Continue the work to design the place-based framework for Central Bedfordshire				
	Consolidating the Provider alliances/partnerships and networks to progress greater integration between health and social care.				
	Establish understanding of the collective resource for Central Bedfordshire as part of the maturing collective financial management arrangements across BLMK				

	Central Bedfordshire Place Based Progress Dashboard						
	Measure	Frequency of reporting	YTD Target (2017/18)	CBC progress as at end of Q3 (17/18)	CBC Overall Progress to end of financial year (2017/18)	RAG	Comments
Paediatric Non-Elective Activity	ED attendances, 0 - 4 for respiratory conditions	Monthly	No Target	246	567		The increase in figures from November 2017 is due to East & North Herts including the diagnosis code in their A&E data. This had previously not been coded. There has also been an increase at the Luton & Dunstable Hospital from December 2017 for attendances for respiratory conditions however the overall number of attendances has not increased. This could be due to improved diagnosis coding. April 2018 has seen a decrease in the number of A&E attendances for respiratory conditions. 64 of the 67 attendances were for non-asthma respiratory conditions and the majority of attendances
	NE admissions, 0 - 4 for respiratory conditions	Monthly	No Target	850	1,150		The increase in admissions in November and December 2017 are at Bedford Hospital for acute bronchiolitis and acute lower respiratory tract infections, Luton & Dunstable for acute bronchiolitis, upper respiratory tract infections and acute lower respiratory tract infections and Milton Keynes for viral infections, acute bronchiolitis and acute lower respiratory tract infections. April 2018 has seen a decrease in admissions with acute tonsilitis and acute upper respiratory infections being the main conditions for admission. The start if 2018/19 has seen a reduction on the previous two years; and is a greater reduction than previously observed.
Transitions of Care	A&E Attendance	Monthly	No Target	50,391	66,941		2017/18 saw a similar trend to 2016/17 with an increase in attendances of 1859 overall. 2017/18 followed a similar trend to 2016/17; however final outturn was higher in 2017/18 at 64,082, compared to 66,941. the start of 2018/19 has seen a reduction from the end of the previous year. this again follows the trend of earlier years. April and May are both higher than earlier observations.
	Non-elective admissions	Monthly	28,100	22,132	29,814		2017/18 saw an increase of 1,647 Non-Elective admissions compared to 2016/17. 2017/18 saw an increase in non-elective admissions on previous years, finishing the year nearly 2,000 more than 2016/17. 2017/18 also saw a somewhat insteady trend through the year with a sharp increase in the earlier months. Initial comparison of April and May with previous years identifies a similar trend to that seen in 2016/17 with a slight increase between the two months.
	30 day non-elective re-admissions	Monthly	No Target	3,052	4,056		2017/18 saw an increase of 134 30 day re-admissions compared to 2016/17. Overall, 2017/18 saw a slightly higher number of 30 day non-elective re-admissions but the increase has not been as great as previous years and is more in line with 2016/17.
	Delayed Transfers of Care	Monthly	5,737	4,958	5,058		2017/18 saw an increase of 1019 delayed days due to delayed transfers of care compared to 2016/17. Desite this increase on the number of delayed days, 2017/18 observed a downward trend when compared to 2016/17. April 2018 outturn is 443, much lower than the same period last year.
Care Homes	Care Home Call Outs	Monthly	No Target	1,340	1,876		Ambulance call outs to CBC care homes in 17/18 were on average lower than 16/17 however showed a slightly increasing trend with March 2018 been higher than the previous year. April and May 2018 show an increase on the previous year.
	Care Home Conveyances	Monthly	No Target	1,012	1,412		Conveyances from care homes show an upward trend for the second half of 17/18. There is variation month on month, overall there is a slight increase in 17/18 compared with 16/17. There were 123 conveyances from care homes in May 2018, an increase on the previous 2 years. Small increase identified between 2016/17 and 2017/18/; with April and May 2018/19 displaying a higher number of conveyances than previous years. .
	Admissions to Hospital from Care Home	Monthly	No Target	793	1,074		There is a slight upward trajectory in care home admissions in 17/18 with a slight increase on total numbers for 17/18, 1074, compared with 1049 in 16/17. There is variation month on month comparing the last 2 years, with no consistent pattern of higher or lower. May 2018 shows a decrease on 2018 with 79 admissions (first cut data). The complex care team have been supporting Ivel Valley locality with a week day service since October 2017, a paramedic service supporting care homes has been in place for west mid beds also since October 2017, an additional paramedic will begin in August 2018, doubling the capacity of the service. 2017/18 saw a slight increase on the previous year with a slight upward trend. Initial observations from April and May 2018/19 appears to be in line with 2016/17.