Central Bedfordshire Council
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Executive update in respect of those recommendations of the Integration of Health and Social Care in Central Bedfordshire Phases I and II that were accepted

Date received by Executive:	**15/05/17**	Date of response by Executive:	**20/06/17**
And Date received by Executive:	**03/04/18**	Date of response by Executive:	**12/06/18**
Date of update to OSC:	**28/01/19**		
Executive Member(s) responsible for providing update:		Cllr Carole Hegley Cllr Brian Spurr	

Ref	Recommendation	Previous response of Executive	Updated response further proposed action(s)	Lead Director(s)	Deadline

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1.	That all partners of the health and social care sector adopt and demonstrate a commitment to delivering the five principles • Our residents will be at the centre of decision making • Health and care will be accessed as close to home as possible • Residents will be able to self serve and manage their health and care • Funding and resources should be available at the right time and right place, particularly in relation to locality working. • Health, care, and housing colleagues will work together to deliver one plan to meet the needs of our residents	Multi-disciplinary working in the Localities/Quadrants to include: social care, housing, community health, mental health, and primary care services. Planning is underway for an interim co-location of the Ivel Valley Place Based Team at the Biggleswade Hospital site by 30/11/17. Multidisciplinary place based working will be embedded in Chiltern Vale, West Mid Beds and Leighton Buzzard localities over the next two years.	The principles set out by the Enquiry remain central to delivering improved and integrated outcomes for our residents. These principles form the basis of key strategic plans for Central Bedfordshire, including the Better Care Fund Plan 2017/19; Central Bedfordshire's Place Based Plan and adult social care transformation. Although co-location has not yet happened, multidisciplinary working, including Housing and the voluntary sector is in place across all Central Bedfordshire localities and there is more integrated working between community health and social care teams delivering care for people outside the hospital.	Director of Social Care, Health and Housing (CBC) Director for Out of Hospital and Primary Care (BCCG	Ongoing

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2.	Services should be developed to support people to stay well and take increased responsibility for their own health and wellbeing.	The Council has a strong focus on helping people to help themselves. This approach extends into supporting people to self-manage and to improve their health and wellbeing. More focus on early intervention and prevention, particularly through promotion of healthy lifestyles. Further development of Village Care type approaches with primary care	There is a continuing focus on an asset-based approach. A Public Health led focus on promoting healthy lifestyles is continuing. Prevention and early intervention initiatives such as health screening, stopping smoking and increasing uptake of vaccination programmes are ongoing. There has been further investment in social prescribing, aligned with the village care scheme, and is supporting people with non-medical needs to access supportive services and/or information and advice services.	Director of Social Care, Health and Housing (CBC) Director for Out of Hospital and Primary Care (BCCG) AD Public Health	Ongoing

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3.	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).	Developing multidisciplinary working is important to secure integrated outcomes. This will be achieved through the Integration and Better Care Fund Plan priorities, as well as the STP Primary Care Home model – which is promoting more person-centred approach to care.	There has been real progress embedding a multidisciplinary approach. It that brings together primary care, community health, social care, mental health, housing and the voluntary sector and aligned to primary care clusters, is in place. In addition, the joint appointment of an Associate Director for Community Health Services and Social Care is enabling further joint working and integrated approaches. There is now an Integrated Triage Team that provides a single point of access for both the Community Health Services Rehabilitation and the Council's Reablement service. As well as an integrated discharge team with a single management lead across community health services and social care. his is enabling a joined-up approach to care and helping to secure improved outcomes for residents.	Director of Social Care, Health and Housing (CBC) Director for Out of Hospital and Primary Care (BCCG)	Ongoing

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4.	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.	See 2 above. There will be a focus on public health interventions; use of social prescribing and assistive technology to help people remain healthier and independent for longer.	See 2 above. The Council has also provided funding to the voluntary sector to support community-based initiatives that help to keep people well and independent in their communities. Social prescribing, with Community Wellbeing Champions, has been launched and is accessible all the four localities. Although recently launched, early indications are that social prescribing is a much-valued resource which will work with the locality multidisciplinary teams to support people who may benefit from non-medical interventions.	Director of Social Care, Health and Housing (CBC) AD Public Health	Ongoing

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5.	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.	This recommendation emphasises the importance of integrated health and care hubs in each of our localities supported with multidisciplinary working across the range of professionals involved in health and care services. See 1	As a precursor to the delivery of integrated health and care hubs, multidisciplinary working is in place across Central Bedfordshire localities.	Director of Social Care, Health and Housing (CBC) Director of Community Services (CBC)	Ongoing
6.	Complexity of access to hospital services should be addressed through development of more local and appropriate health and social care services that are less dependent on acute hospital provision.	The strategy setting out a Central Bedfordshire approach on Out of Hospital Services is being produced.	More emphasis is placed on proactive care, early intervention and self-management initiatives. There is closer working in primary care to provided enhanced and extended hours services, based on the out of the hospital strategy, the GP Forward View and the Primary Care Home model.	Director of Social Care, Health and Housing (CBC) Director for Out of Hospital and Primary Care (BCCG)	Ongoing

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7.	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.	Executive members agree with this recommendation. The range of hospitals accessed by Central Bedfordshire residents often presents challenges in understanding and managing patient flows into and out of hospitals. This can lead to variations in quality and ease of access to the supporting range of health and care options for people. Integrated Health and Care Hubs in each locality aligned to Spokes will best meet the health and care needs of the Central Bedfordshire population. Ivel valley Hub – funding to be determined by: November 2017 Chiltern Vale Hub – funding to be determined by November 2017	Integrated Health and Care Hubs remain a key enabler for securing sustainable, high quality, resilient, integrated primary, community, mental health and social care services in each locality in Central Bedfordshire to meet the current and future demand on health and care services. An established programme of work underway to deliver Hubs in accessible locations for all localities. Development of the Hubs for Dunstable (Chiltern Vale) and Biggleswade (Ivel Valley) are at advanced stages. Strategic outline cases are being developed for the hubs in Leighton Buzzard, West Mid Beds and Houghton Regis. This work is also considering the role of Spokes which takes into account the housing growth in Central Bedfordshire and current state of primary care estates.	Director of Social Care, Health and Housing (CBC) Director of Community Services (CBC)	Winter 2021 and ongoing

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8.	The Council and the CCG should explore the opportunity to use local assets to support the development of Integrated Health and Care Hubs.	The Council is already working with the CCG to explore the use of local assets to deliver the integrated health and care hubs. Officers have already secured some funding from the One Public Estate and NHS England to produce the Business Plans for the Hubs in Central Bedfordshire. Require the Directors of Community Services and Directors of Social Care, Health and Housing to produce a plan for delivery of the hubs in conjunction with NHS colleagues. Timetable to be determined.	Work is ongoing on the development of integrated health and care hubs. A programme of work is in place to develop five hubs across Central Bedfordshire is in place. Options appraisals on publicly owned sites across the local authority and NHS have been undertaken. The Council has identified a site in Dunstable for the location of the Hub for Dunstable. NHS England has provided some additional funding to support the development of the business cases for Dunstable and Biggleswade which are both at Outline Business Case stage. The Council is also consulting on a capital allocation to support delivery of the Hubs as part of the its Budget proposals. Delivery of the Dunstable and Biggleswade Hubs is being led by the Council's Major Projects and Construction Team.	Director of Community Services Director of Social Care, Health and Housing Director for Out of Hospital and Primary Care (BCCG)	Ongoing

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9.	Integrated Health and Care Hubs should provide services across the age spectrum and other community related services for children and older people.	The Integrated health and care hubs will be focal points for local communities accessing services, potentially including wider community/neighbourhood services across the generations. Further work will be undertaken with Children's Services and wider Council colleagues to establish what each Hub will provide.	Approaches to developing the integrated health and care hubs takes account of the whole life course and are reflecting the importance of wellbeing, community participation through the community and voluntary sector alongside statutory health and care services.	Director of Social Care, Health and Housing Director for Out of Hospital and Primary Care (BCCG)	Ongoing
10.	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.	Officers will engage NHS Partners to determine the potential for an integrated approach to community and patient transport.	Patient Transport services have been recommissioned by the Clinical Commissioning Group.	Director for Out of Hospital and Primary Care (BCCG)	Concluded

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11.	There should be closer alignment of mental health with physical health care and the relationship between health providers and social care/mental health teams must be enhanced through improved communication and joint care delivery.	The importance of mental wellbeing and link to physical health is recognised. Community, mental health and social care colleagues are forming the multidisciplinary place-based teams working together to deliver seamless care to people. The alignment of mental health and physical health care will be further set out in the BCF Plan.	Mental Health Practitioners are a key part of the multidisciplinary teams. There is closer working between Mental Health services and Housing Services colleagues as well. The close alignment of mental wellbeing and physical health is central to all to the key strategies, including the Health and Wellbeing Strategy, the Better Care Fund Plan and the Place Based Plan for Central Bedfordshire.	Director of Social Care, Health and Housing Director for Out of Hospital and Primary Care (BCCG)	
12.	Continue to involve the public in managing their own care through public health information on lifestyle, health and wellbeing.	See above The BCF Plan for 2017/19 will include a focus on self management and the promotion of healthy lifestyles.	Work is ongoing to promote self management and there is continuing investment in prevention and early intervention programmes.	AD Public Health	Ongoing

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13.	A single point of contact for residents to ensure that care needs can be assessed once and save patient time should be established.	Implementation of place-based multidisciplinary teams and later, the Integrated Health and Care Hubs will support this ambition. Work is also ongoing to develop integrated care pathways. Discussions with CCG and other health partners to determine potential for SPOC and timeline completed.	The new community health services provider is working on developing a single point of contact (SPOC). This will be further enhanced through proactive care management of people with long term conditions.	Director of Social Care, Health and Housing Director for Out of Hospital and Primary Care (BCCG)	Ongoing

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14.	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.	We are expanding the use of assistive technology to promote self-care and independence and will continue to work with CCG/STP partners to further this. It is important to facilitate greater awareness of the range of assistive technology opportunities amongst health and care professionals and customers. There will be investment in developing and promoting the use of assistive technology through the Better Care Fund Plan. A Market Position Statement is also being produced. The Council's and Health's digitisation journey is to deliver self-service/self management for residents.	There is a continuing focus on the use of telemedicine and telecare. There has been investment in use of telemedicine to support Carers and also Care Homes. Work is ongoing through a systemwide digitisation programme.	Director of Social Care, Health and Housing Director for Out of Hospital and Primary Care (BCCG)	Ongoing

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15.	Explore the potential added value of universal services, both council led and voluntary sector, to support social prescribing.	It is important to use the wide range of services delivered and commissioned by the council to promote wellbeing and support independence. Officers are working across directorates to join up opportunities. Discussions underway to determine a Central Bedfordshire approach for social prescribing supported by the Council and BCCG. In interim pilot in Ivel Valley Locality/Quadrant	Promotion of wellbeing and independence is central to council commissioned services. This is also a key duty under the 2014 Care Act. The Council and Care providers work together to promote wellbeing and independence. People are supported to remain active in their communities. Social prescribing has been launched in Central Bedfordshire. Currently, four Community Wellbeing Champions are working closely with the GP Practices alongside the Village Care Scheme.	Director of Social Care, Health and Housing Director for Out of Hospital and Primary Care (BCCG)	Ongoing

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16	Address the issue of data sharing to enable integrated working.	This work is now being led through the STP to develop integrated shared care records across the system. The work will also address the challenges of data sharing and information governance. Phase 1 which includes an options appraisal will conclude in Qtr3. LGA funding has been secured to work with some Care Homes in Central Bedfordshire on Sharing information and integrating services. This will include mapping the state of readiness of Care Homes for digital systems. This work will begin in September 2017.	A digitisation programme for Bedfordshire, Luton and Milton Keynes Integrated Care System is in place and is progressing the development of integrated shared care records across the system. There has been ongoing support to Care Homes to increase their level of compliance with data security and information governance. This is a key requirement to enable Care Homes to have access to shared records. A data sharing agreement is now in place between Primary care and the health and care system.	Director of Social Care, Health and Housing Director for Out of Hospital and Primary Care (BCCG)	Ongoing

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17.	Through the STP, continue to focus on increasing investment in community based interventions and the development of integrated health and care hubs.	An STP wide approach has been adopted to support the delivery of Integrated Health and Care Hubs. Officers have applied for additional capital funding through the STP.	See above		
18.	The Council and CCG should explore the opportunity of joint commissioning to deliver improved and integrated outcome for people.	The Directors of Social Care, Health and Housing; and Director of Commissioning at the CCG are pursuing this. Proposals agreed October 2017 .	A Strategic Commissioning Group between the CCG and the Council has been established. A joint review of some services is underway.	Director of Social Care, Health and Housing Director for Out of Hospital and Primary Care (BCCG)	Ongoing

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19.	Using the STP priorities to transform services and free up hospital based specialist resources to provide complex care and support in the localities.	We are working closely with the STP, particularly in key priorities areas for primary, community and social care to determine what services can be delivered out of hospital and from the integrated health and care hubs.	This work is ongoing through the service models for integrated health and care hubs and as a part of the STP priority which is reviewing provision of acute services.	Director of Social Care, Health and Housing Director for Out of Hospital and Primary Care (BCCG)	Ongoing
20.	Provide community geriatrician in put into the multidisciplinary place based or neighbourhood teams.	The CCG has provided additional investment to facilitate Geriatrician support into the localities. This will continue to form part of the Out of Hospital Strategy and Primary Care Home model with a range of specialist input to support community based care.	Community Geriatricians now contribute to multidisciplinary working in localities. This approach to complex care management for frail older people is continuing to evolve.	Director of Social Care, Health and Housing Director for Out of Hospital and Primary Care (BCCG)	Ongoing

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21.	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.	This is ongoing.	This is ongoing.		
22.	Continue to educate staff, professionals and residents in the change of culture and new approach to health and social care services.	This is ongoing.	This is ongoing.		
23.	Ensure that appropriate Governance arrangements and negotiations with partners are developed	The landscape for health and care services is changing. With the STP, the focus is now on the 'Place'. Place being local authority footprint. Consequently a 'Place based' Central Bedfordshire Transformation Board has been established. The Board will oversee the delivery of Integration and integrated outcomes on behalf of the Health and Wellbeing Board, as well as, delivering the outcomes of the BLMK STP.	The Central Bedfordshire Transformation Board continues to maintain oversight of integration and transformation plans on behalf of the Health and Wellbeing Board.		

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24.	Use funding across the health and care and system to drive a greater investment in prevention	Prevention is a key priority for the Council and the CCG. Prevention is also a key priority for the STP. We are working in partnership with the CCG and Public Health colleagues to invest more in prevention.	See above		
25.	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.	There is real opportunity to expand the concept of the Village Care Scheme to work more closely with GPs and the local communities. Through the Improved Better Care Fund – additional investment has been set aside to develop this approach. See 2 above.	The Village Care/Good Neighbour Scheme is now closely aligned with the Community Wellbeing Champions in the delivery of social prescribing in primary care.		
	Phase II Recommendations				

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26.	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.	Executive members agree with this recommendation. The principles set out by the Enquiry remain central to delivering improved and integrated outcomes for our residents and are also reflected in Central Bedfordshire's Integration and Better Care Fund Plan. The Delivery of Out of Hospital Services, and a locality based approach is one of the priorities for the Integrated Care System across Bedfordshire, Luton and Milton Keynes. Multidisciplinary working based on Locality teams is now in place across Central Bedfordshire and is now being expanded to align with the new Primary Care Home model.	See above and ongoing		

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27.	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.	Executive members agree and will, in conjunction with officers, support Enquiry Members, in leading a conference. External partners will also be invited to continue to build on the shared vision.	Postponed		
28.	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.	Ongoing MANOP Team will continue to work with Planning Colleagues to secure appropriate accommodation for older people across all tenures.	MANOP team actively contributed to the development of the Local Plan. Involvement in this work in helping to shape the accommodation needs of older people is continuing.		

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29.	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	The Integration and Better Care Fund Plan 2017/19 sets out the vision for delivery of out of hospital services centred on integrated health and care hubs in each locality across Central Bedfordshire. The vision sees integrated Health and Care Hubs as a mechanism for shifting the balance of care from hospital to appropriate community settings. This approach has also been adopted by the STP as a key mechanism for delivering out of hospital services. The Directors of Social Care, Health and Housing and Director of Community Services are leading on the delivery of Integrated Health and Care Hubs. The Director of Social Care, Health and Housing (CBC) and the Director for Out of	There is a clear vision for delivery of out of hospital services and is helping to shape the development the integrated health and care hubs. See earlier comments. The STP priority is also focused on out of hospital services with		

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	commissioning for CBC in light of the STP within the framework of the new accountable care system.	Hospital and Primary Care (BCCG) are taking this forward as part of the wider STP initiated reconfigurations of commissioning across the three CCGs, incorporating the four local authority areas.	integrated health and care hubs as focal points for accessing services.		