Central Bedfordshire

NHS
Bedfordshire
Clinical Commissioning Group

Central Bedfordshire Integration and Better Care Fund Narrative Plan

2017-2019

Hub

Contents:

Alignment of BCF Narrative with the Key Lines of Enquiry

KLOE	Page Number(s)	KLOE	Page Number (s)
1	5	20	48-49; Appendix 5
2	5,37	21	36-37
3	38	22	36-37
4	38	23	36-37
5	38	24	36,39; Appendix 2a&b
6	38	25	Template
7	38	26	Appendix 2a and 2b
8	39	27	34
9	36	28	43-46; Appendix 3
10	36	29	43-46; Appendix 3
11	40-43	30	36; 39
12	40-43	31	47; Planning Template
13	7-12, 40-43	32	47
14	7-14	33	47-48
15	29-34; 7-4	34	47-48
16	19-34	35	47-48
17	15-18	36	23,27,29, 35
18	48-49	37	37
19	15-18	38	48

1. Introduction

This is the third Better Care Fund Plan for Central Bedfordshire. This Plan remains consistent with the priorities and outcomes of the Health and Wellbeing Board. It is focused on securing integrated outcomes for our residents through the Better Care Fund and the priorities of the Sustainability and Transformation Partnership for Bedfordshire, Luton and Milton Keynes.

Central Bedfordshire is an area of growth, with an increasing and ageing population. The challenges of an ageing population coupled with changing patterns of disease, with more people living with complex, multiple long-term conditions and rising public expectations mean that fundamental changes are needed to the way services are delivered. As with other health and care systems, we recognise that the key to delivering improved outcomes for people as well as maximising our resources for a sustainable health and care system is to organise care around the needs of the people by integrating primary, community and social care to deliver seamless physical and mental health care services.

This is particularly important for us, in view of the current local financial challenges faced by the Council and the CCG. The Council has to make significant efficiency savings and has sought to protect the adult social care budget. Our CCG is again in financial recovery with important challenges ahead. As health and social care are undoubtedly interlinked, we see integration as a key enabler to addressing some of these challenges.

We want to see a real shift in the balance of care from acute hospitals and institutionalised care to a more community based focus. Achieving this requires local health and care organisations to work together to design new care models with an important emphasis on prevention and delivering care closer to people's homes. Over the next two years and through our integration programme, there will be an increased focus on person-centred care. Working with individuals and the local community the aim is to promote an asset based approach and build on networks of support and capacity in our communities.

Our ambition for integrated solutions extends beyond health and social care. We wish to create an all systems partnership which includes housing, as well as with Independent, Private and Voluntary organisations. This is evidenced in the recent enquiry undertaken by the Health and Social Care Overview and Scrutiny Committee into Integration Approaches for Central Bedfordshire.

The preceding Better Care Fund Plans set out our vision and ambition for a 'Place based' approach with better care locally. To achieve this vision we have been implementing more joined up services with primary, community, mental health and social care teams working across our localities. We are implementing integrated discharge coordination and reablement as well as continuing to increase community capacity with the support of our effective volunteering base in Central Bedfordshire.

As one of the eight areas to become an Accountable Care System, we welcome the opportunity to bring together, at pace, a range of services to deliver integrated care for our local population as well as to begin the process of redefining relationships between Commissioners and Providers to focus on collaboration and service improvement in context of place based care.

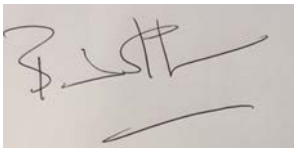
This 2017/19 Plan builds on the previous Plans and does not attempt to repeat all the baseline information that formed part of earlier plans. We recognise, however, the need for alignment of

Plans across local health and care agencies and the national strategic drivers that influence them. This document seeks to meet the national requirements for Health and Care systems to produce a short, jointly agreed narrative plan including details of how the national conditions and performance metrics are being addressed.

“The Central Bedfordshire Better Care Fund will create a pooled fund of £22.896m in 2017/18 and £24.312 in 2018/19 to support the delivery of integrated care. This is made up of a contribution of £5.536m and £6.511m from Central Bedfordshire Council; £15.549m and £15.844m from Bedfordshire Clinical Commissioning Group as well as the Improved Better Care fund of £1.810m and £1.956m respectively, over the two years of the Plan.

Our System ambition is for local people to be able to say.

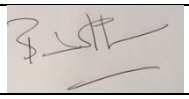
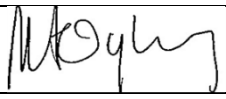
“My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes”



Cllr Brian Spurr
Chair
Central Bedfordshire Health and Wellbeing Board

a) Background and context to the plan

Local Authority	Central Bedfordshire Council
Clinical Commissioning Group	Bedfordshire Clinical Commissioning Group
STP Footprint	Bedfordshire, Luton and Milton Keynes
Boundary Differences	Bedfordshire CCG's boundaries are coterminous with Bedford Borough and Central Bedfordshire Councils.
	There are no district general hospitals within Central Bedfordshire. Local residents use up to seven different hospitals.
Date agreed at Health and Well-Being Board: Delegated sign by Health and Wellbeing Board. http://centralbeds.moderngov.co.uk/ieListDocuments.aspx?CId=829&MId=5215&Ver=4	
Date submitted:	**11 September 2017**
Minimum required value of BCF pooled budget: 2017/18	**£15,549,369**
2018/19	**£15,844,807**
Total agreed value of pooled budget: 2017/18	**£22,895,736**
2018/19	**£24,312,228**

Signed on behalf of the Health and Wellbeing Board	Central Bedfordshire Health and Wellbeing Board
By Chair of Health and Wellbeing Board	
Date	11 September 2017
Signed on behalf of the Clinical Commissioning Group	Bedfordshire Clinical Commissioning Group
By	
Position	Sarah Thompson. Accountable Officer
Date	8 September 2017
Signed on behalf of the Council	Central Bedfordshire Council
By	
Position	Julie Ogley. Director of Social Care, Health and Housing

Date	8 September 2017

Related documentation

Document or Information title	Synopsis and links
Health and Wellbeing Strategy	http://www.centralbedfordshire.gov.uk/modgov/documents/s39990/CBC%20HWB%20Strategy%20Final.pdf
Central Bedfordshire Joint Strategic Assessment (JSNA)	https://www.jsna.centralbedfordshire.gov.uk/ Executive Summary – 2016/17 **https://www.jsna.centralbedfordshire.gov.uk/jsna/downloads/file/28/jsna_executive_summary_201617**
Bedfordshire CCG Operating Plan 2017-2019 Narrative Plan December 2016	https://www.bedfordshireccg.nhs.uk/page/downloadFile.php?id=16197
Commissioning for the future. Commissioning intentions 2017 - 18 September 2016 Final version	https://www.bedfordshireccg.nhs.uk/page/downloadFile.php?id=15625
STP	https://www.bedfordshireccg.nhs.uk/page/?id=3591
GP Forward View	https://www.bedfordshireccg.nhs.uk/page/downloadFile.php?id=16106
OSC Enquiry	http://centralbeds.moderngov.co.uk/ieListDocuments.aspx?CId=644&MId=5377&Ver=4
Market Position Statement	http://www.centralbedfordshire.gov.uk/Images/121213MarketPositionStatementweb_tcm6-37596.pdf#False
CBC Investment prospectus	http://www.centralbedfordshire.gov.uk/housing/independent-living/dev-accom-older-people-bedfordshire.aspx?utm_source=website&utm_medium=shortcut&utm_campaign=opip
Central Bedfordshire Local Plan	http://www.centralbedfordshire.gov.uk/planning/policy/local-plan/local-plan.aspx

2. The vision and approach for health and social care integration

Our 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 must be centred on the integration of health and social care through a whole systems and seamless approach to improving physical and mental health, so that people can experience "care without organisational boundaries" and 'better care, locally'.

Integration offers the opportunity to improve outcomes for people as well as ensuring better use of resources, financial, estates and workforce. Crucial to this is making better use of public assets to deliver new models of care and is a key ambition of our Sustainability and Transformation Partnership. In this context, our approach in Central Bedfordshire is to focus on the 'Place'.

The vision for more local and joined up services was set out in our Better Care Fund Plans. http://www.centralbedfordshire.gov.uk/health-social-care/better-care-fund/developing.aspx . At its heart, is an ambition to secure access to the right care, in the right place and at the right time. Central to this, is a drive for transformational change across health and social care based on integrated and seamless care pathways at locality levels. Care should be coordinated around an individual's needs with prevention and support for maintaining and maximising independence at its core. This should be 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.

These principles are importantly centred on our local ambition for the development of an integrated health and care hub in each locality in Central Bedfordshire as a focal point for joining up health, social care and other council services and the delivery of care closer to where people live.

Integrated Health and Care Hubs are crucial to shifting the balance of care from acute hospitals to a more community-led approach as well as helping to reshape the primary model which delivers primary care at scale. A locality based integrated health and care hub approach improves cooperation and joined up working which improves the access and quality of care provision. It also leads to a reduction of inappropriate hospital admissions and importantly supports the vision for integrated primary and community services at scale as set out in the General Practice Forward View.

Central Bedfordshire's population distribution and its relation to secondary care providers make it important that the primacy of the Integrated Health and Care Hubs approach is sustained. Services will be more accessible to people, especially in predominantly rural areas, and will meet the requirements for delivering health and care services to an expanding and ageing population. The Integrated Health and Care Hubs will be the main centres for providing proactive and preventative care, out of hospital services and care packages for people who are vulnerable or have complex care needs. The Hubs will provide support to children with complex health needs and the transition from children to adult services.

By developing greater range and capacity in community-focused care it will be possible to deliver improved health and care experiences as well as more effective use of resources by:

1. **Reshaping the model for prevention and early intervention** – through an integrated approach to primary, secondary, and tertiary prevention to stop or reduce deterioration in health.
2. **Supporting people with long term conditions through multi-disciplinary working** – focussing services around general practice in locality networks and helping people to manage their own conditions in the community.
3. **Expanding the range of services that support older people with frailty and disabilities** – integrating the range of housing, mobility, carers and other services that wrap around older people with specific conditions and issues and helping to manage new demand including through the Care Act.
4. **Restructuring integrated care pathways for those with urgent care needs** – ensuring that these are seamless, clear, and efficient to help deliver the clinical shift required to move care away from acute settings, where appropriate, as well as building future resilience for the responsibilities of the Council under the Care Act 2014.

The multiplicity of inputs to health and social care, with different agencies and commissioners, represents a major challenge to the development of integrated and joined up services. Our vision for integration sees the development of jointly commissioned services as an important mechanism for overcoming those challenges and securing more cost effective and coherent services.

We wish to see a changed relationship between the Council, Health Commissioners and Provider organisations to enable a greater focus on meeting the needs of the local population. The STP through the 'place based' approach provides a platform for bringing together strategic decision making between the Council and the Clinical Commissioning Group and at a 'cluster' level between medical health, social care and the wider community based practitioners. This will translate into:

- simpler means of aligning our resources;
- collaborative commissioning
- integrating hospital services with GP, community health and social care
- building capacity and resilience in our communities to be self sustaining
- expanded use of assistive technology

Our vision for out of hospital services recognises the importance of high quality and accessible secondary and tertiary health care to our population through better and more cost effective use of hospital services. Local access to appropriate services would prevent people, especially frail older people, making unnecessary journeys to hospitals and would make important difference in care outcomes, quality and experience, particularly for those with long term conditions. Only those people requiring the use of highly specialist diagnostic equipment or acute hospital facilities would need to be travel out of their local areas.

However, it is important that community based care is underpinned by integrated multi-disciplinary teams working together within a planned whole systems approach to care delivery. The co-location of health and care teams in fit for purpose facilities is central to managing demand and ensuring the future sustainability of our health and care systems.

This approach is consistent with our STP's Primary Care Home model, through a 'cluster based' approach with health and social care teams working collaboratively with community and voluntary groups to empower people to increasingly self-care, improve wellbeing and to use their own informal and existing networks of support.

As an integrated health and care economy, our vision is that over time discrete silos of current health and care provision will be replaced with an integrated model of care aimed primarily at

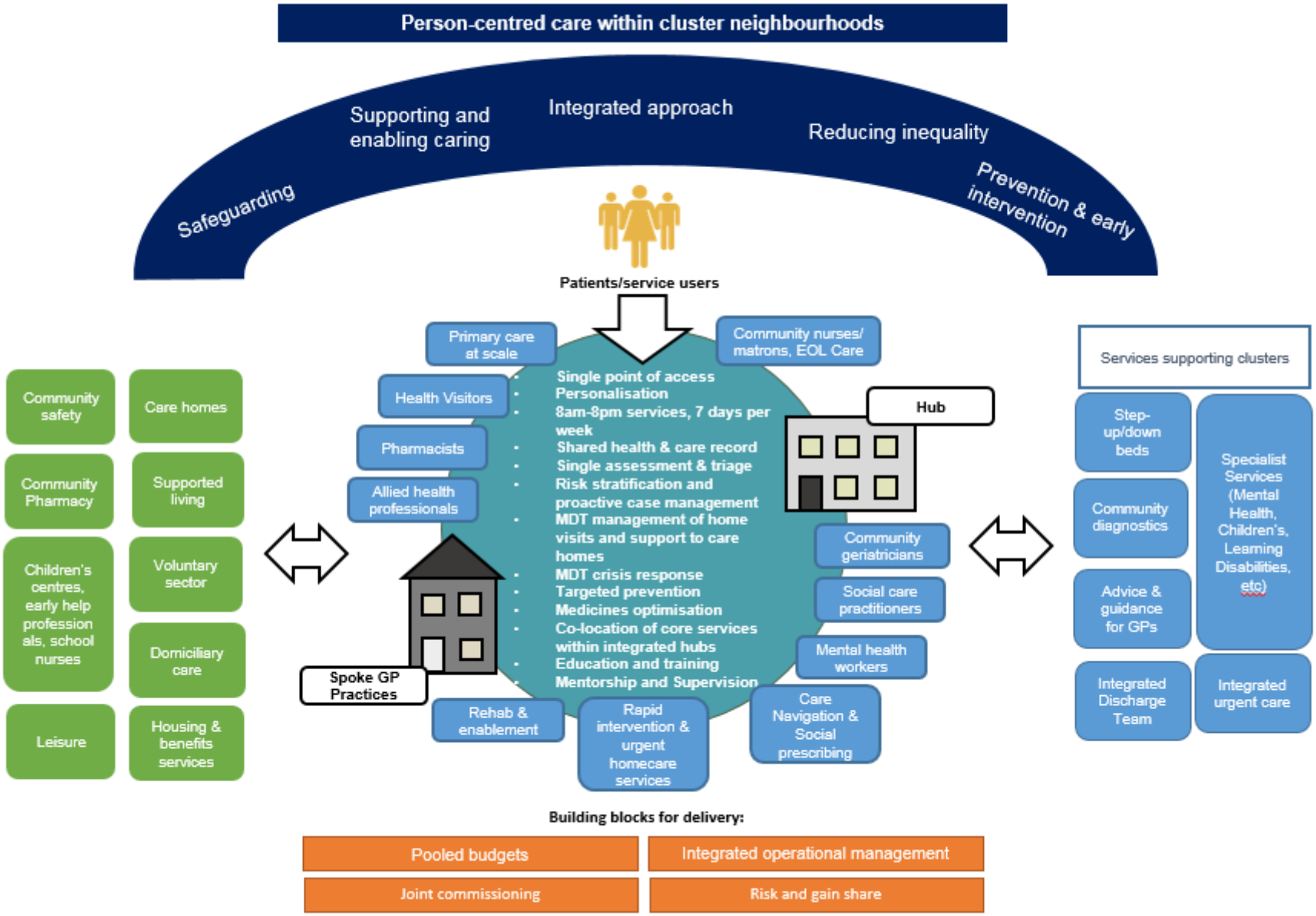
supporting patients to be self caring, independent and less reliant on acute or specialist intervention. There will be better, more timely and accessible information and community services, enabling people to have healthier lifestyles and manage their long term conditions more effectively. Unplanned emergency admissions would be avoided and quality of life would be improved with people supported to live independently in their own homes for as long as possible.

2.1 Our Locality Based Delivery Model

The emerging model sees healthcare being delivered through a number of integrated health and care hubs based on the four localities in Central Bedfordshire. These would provide a focal point for the provision of out of hospital care services in each locality. Within each locality there will be an integrated multidisciplinary approach, with 'one team' working across organisational boundaries. The focus of the team's work will be on a local population covering a GP grouping or clusters with populations of 40 – 50,000.

As a minimum these hubs are expected to serve as a base for the multi-disciplinary teams (adults and children's) being established as part of the community services redesign programme, including general medical services where possible.

These Hubs will enable the development of new models of care where general practices, particularly groupings of Practices (Primary Care Networks), will be more effectively and flexibly integrated with community, mental health and social care, as set out below.


Person-centred care within cluster neighbourhoods
Supporting and enabling caring
Integrated approach
Reducing inequality
Safeguarding
Prevention & early intervention
Patients/service users
Primary care at scale
Community nurses/ matrons, EOL Care
Health Visitors
Pharmacists
Allied health professionals
Single point of access
Personalisation
8am-8pm services, 7 days per week
Shared health & care record
Single assessment & triage
Risk stratification and proactive case management
MDT management of home visits and support to care homes
MDT crisis response
Targeted prevention
Medicines optimisation
Co-location of core services within integrated hubs
Education and training
Mentorship and Supervision
Hub
Spoke GP Practices
Community geriatricians
Social care practitioners
Mental health workers
Care Navigation & Social prescribing
Rapid intervention & urgent homecare services
Rehab & enablement
Community safety
Care homes
Community Pharmacy
Supported living
Children's centres, early help professionals, school nurses
Voluntary sector
Domiciliary care
Leisure
Housing & benefits services
Services supporting clusters
Step-up/down beds
Community diagnostics
Advice & guidance for GPs
Integrated Discharge Team
Specialist Services (Mental Health, Children's, Learning Disabilities, etc)
Integrated urgent care
Building blocks for delivery:
Pooled budgets
Integrated operational management
Joint commissioning
Risk and gain share

2.2 What will this mean to local people?

Local people will have access to more joined-up health and care services closer to home. People will experience real improvements in primary care and community based support, when it is needed.

By 2019, our journey from fragmented working to an integrated and person-centred approach will be fully embedded. These changes in the way services are organised will mean our population will:

- Experience **seamless access to a timely, coordinated offer of health and care support**.
- Have **access to a wider range of support to prevent ill-health**, with increased emphasis on early interventions supported by voluntary, community and long-term condition groups, enabling them to stay healthier for longer;
- Be **supported to remain independent with integrated GP and community multidisciplinary teams** delivering care directly **within their own home** wherever it is possible to do so;
- 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 lifestyle 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**.

2.3 Principles for delivery

- To ensure that the voice of local people is heard and supports the modelling and implementation of this strategy by engaging with patients to ensure the views of our public are taken into account, especially when redesigning pathways.

- All services will ensure early identification of people (children and adults) at risk of early abuse at the earliest opportunity, ensuring that appropriate action is taken. Continually seek to increase awareness of vulnerabilities and ensure safeguarding becomes a core part of everyone's service delivery, embracing community responsibility within this.

- Supporting and enabling formal and informal caring

- Over the next five years we will have transformed the pattern of services delivered through an integrated health and social care hub, which is primary care led offering risk stratification with targeted prevention to the most vulnerable people.

- Seamless care provision through multidisciplinary and multi-organisational teams including the community and voluntary sector
- People will be supported with wrap around care in their own home or wherever they may be.

2.4 Delivery Model

Commissioners have agreed initial key priorities to creating an integrated health and care system, which will bridge provider boundaries to deliver joined up care without the need for people to tell their story multiple times, up-skill teams to undertake single assessments on behalf of multiple providers thereby reducing the number of referrals between services and the number of individual interventions. This is currently being progressed through a joint Associate Director post between Essex Partnership University Trust Community health services and Central Bedfordshire Council's Social Work practitioners.

The key elements for successful delivery are:

- Shared care records
- Primary care operating in clusters or networks and 'at scale'
- Development of Multi-disciplinary teams within cluster neighbourhoods
- Specialist services designed to support cluster teams
- Co location or flexible/shared working locations
- Joint Risk Stratification
- Pooled budgets (where appropriate)
- Joint commissioning (where appropriate)
- Integrated operational management

Services will be shaped around local populations and commissioners have agreed to adopt the National Association of Primary Care model (NAPC), Primary Care Home (PCH). This will ensure that services are developed around a 30,000 to 50,000 population with the GP being at the centre of (but not necessarily co-ordinating) the patient's care.

2.5 Enablers

There are a number of key work streams working locally and at scale across Bedford, Luton and Milton Keynes (BLMK) to deliver this ambitious programme, ensuring our local (place based) strategies benefit from at scale solutions which will help to create a seamless pathway for patients registered with GPs or being treated outside of Bedfordshire; this cohesion will also provide access to subject matter experts for IM&T and workforce to create strong and sustainable infrastructure for our population. Key enablers for at scale delivery include workforce, IM&T and population health management and medicines optimisation.

3. Strategic Alignment of BCF Plan

Our Central Bedfordshire Integration and BCF Plan is directly aligned and contributes to the delivery of the Five Year Forward View through **Sustainability and Transformation Partnerships** (STP) and as set out in the Next Steps document published in March 2017.
https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/

The NHS Five Year Forward View said: *"The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. Increasingly we need to manage systems – networks of care – not just organisations. Out-of-hospital care needs to become a much larger part of what the NHS does. And services need to be integrated around the patient."*

In meeting the requirement for transition to population-based health and care systems, the Bedfordshire, Luton and Milton Keynes (BLMK) STP has adopted a Place-based approach to health and social care integration, building on the Better Care Fund to meet the challenge of shared local health, quality and efficiency, with five key priorities (http://www.blmkstp.co.uk/about/stp-priorities/) to deliver the future vision for health and social care. The development and transformation of primary care is a core strategic aim of Priority 2 of the STP.

BLMK
Sustainability & Transformation Plan

Priority 2 Primary, Community and Social Care (Out of Hospital)

Aim:
Build high quality, resilient, integrated primary, community and social care services across BLMK

P2 Strategic Goals

1. Strengthen primary care services to ensure sustainability and enable transformation
2. Increase the health of the population by maximising prevention and self-care
3. Shift activity away from acute services to out of hospital care, closer to the patient
4. Ensure that people are able to access appropriate urgent care services, reducing reliance on A&E and reducing avoidable unplanned admissions
5. Achieves the integration of health and social care services
6. Supports the transformation of services for people with Learning Disabilities
7. Helps to integrate physical and mental health services and achieve parity of esteem

Our BCF Plan is aligned to these, and directly supports delivery of all its goals, as well as to other programmes of work including the new models of care and a programme of transformational change. It has a 'Place Based' out of hospital approach focused on the needs of people with long term conditions and delivers a journey for the integration of health and social care services. Area specific plans for Primary Care and out of hospital services are described at local authority and CCG level and set out within our Better Care Fund Plan and Integration Plan. This is particularly relevant for Central Bedfordshire's population in view of patient flows to hospitals outside of the local STP footprint.

In addition to the Priority 2 objectives and alignment described above, the BLMK STP has also created a programme of work for 2017/18 and 2018/19 focussing on 4 'priority interventions' that we believe the system can have the biggest impact on quality and sustainability. They are:

1. Primary Care Home – accelerated implementation of the model of care as an enabler of stronger, integrated out of hospital care.
2. Complex Care, with a focus on care homes
3. Transitions of Care, focussing on admission and discharge pathways
4. Paediatric non-elective admissions

Our BCF plan directly supports the implementation and delivery of these STP wide plans at a place based level.

Our local health and care system leadership is focused on securing a whole system approach from 2017-20. As an accelerated **Accountable Care Systems** (ACS), the emphasis is on developing a concept and model in BLMK that enhances delivery of continuous improvements in care quality, population health and value for money. Our ACS will enable us to create an effective collective decision making and governance structure, to provide clinically networked services. The aim is to remove barriers and create new relationships between hospital, GP, mental health, community health, social care and voluntary/charitable services. It will also adopt a rigorous approach to prevention and population health management and to ensure patient choice and personalised care drives informed health and wellbeing choices for local people.

This clear focus on 'Place' is also reflected in our **GP Forward View** document, which sets out a plan for the establishment of clusters or networks of GP practices around populations of at least 30-50,000 to serve as the footprint for collaborative working between practices, delivery of extended access, and as the footprint for the local implementation of the Primary Care Home model (multi-disciplinary working). Working around the GP Clusters aligns with our plans for establishing integrated health and care hubs, which will serve as a focal point for a wider integrated multidisciplinary approach. The primary care clusters in Central Bedfordshire have all been accepted onto the National Association of Primary Care (NAPC) Community of Practice programme and so all the practices covering the CBC population will have the opportunity to access and share the learning and development from the Primary Care Home national model.

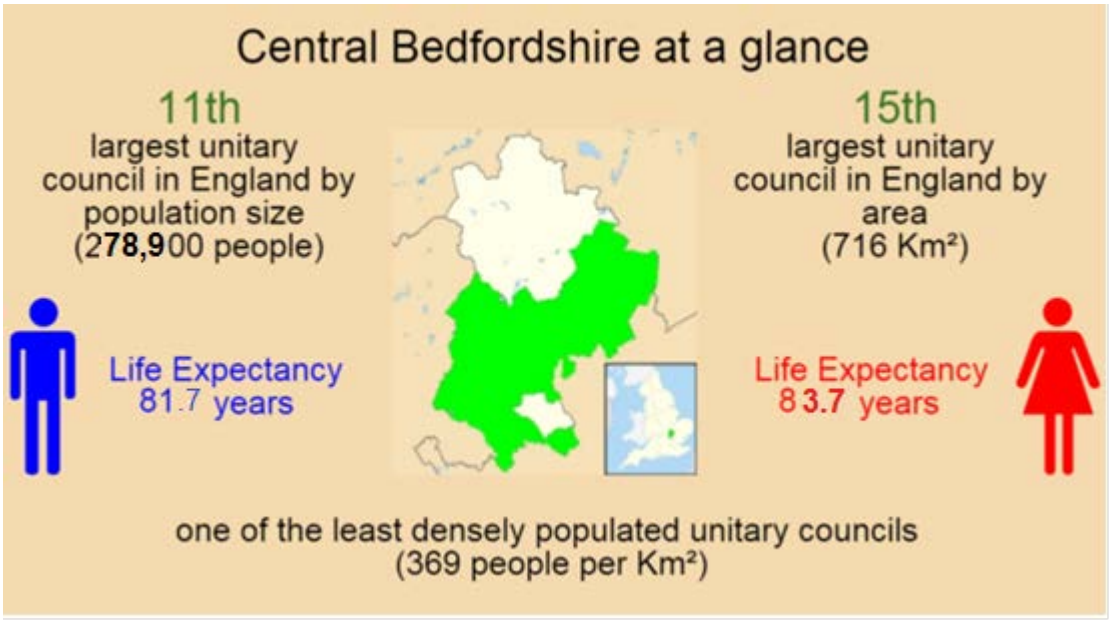
OSC Enquiry into Integration - In September 2016 the Social Care Health and Housing Overview and Scrutiny Committee (SCHHOSC) agreed to undertake an enquiry to support the Council to deliver one element of the Five Year Plan relating to Protecting the Vulnerable; Improving Wellbeing. The enquiry sought to understand the national strategic drivers, barriers and risks and receive evidence, advice and information from sector experts to agree an emerging approach to redesign how residents access health and care services.

170515 - Principles and Recommendation

4. The Case for Change

4.1 Population and Health Indicators

Central Bedfordshire, a predominantly rural area in the East of England, is considered to be a highly desirable place to live and work. As a consequence the population is growing, rising from 254,400 in 2011 to approximately 278,900 in 2016. Further estimated growth of 19% will see the population rise to 332,000 by 2031.



The health of people in Central Bedfordshire is generally better than the England average. The population is ageing as well as growing. Between 2016 and 2031 the number of people aged 65 and over is forecast to increase from 48,500 to 73,500, a 52% increase.

Life expectancy for both men and women is higher than the England average. Life expectancy is 5.8 years lower for men and 5.0 years lower for women in the most deprived areas of Central Bedfordshire than in the least deprived areas.

Our Joint Strategic Needs Assessment (JSNA) provides a comprehensive picture bringing together intelligence about the health and wellbeing of the people living in Central Bedfordshire.
There are a number of common themes which have emerged from the JSNA:

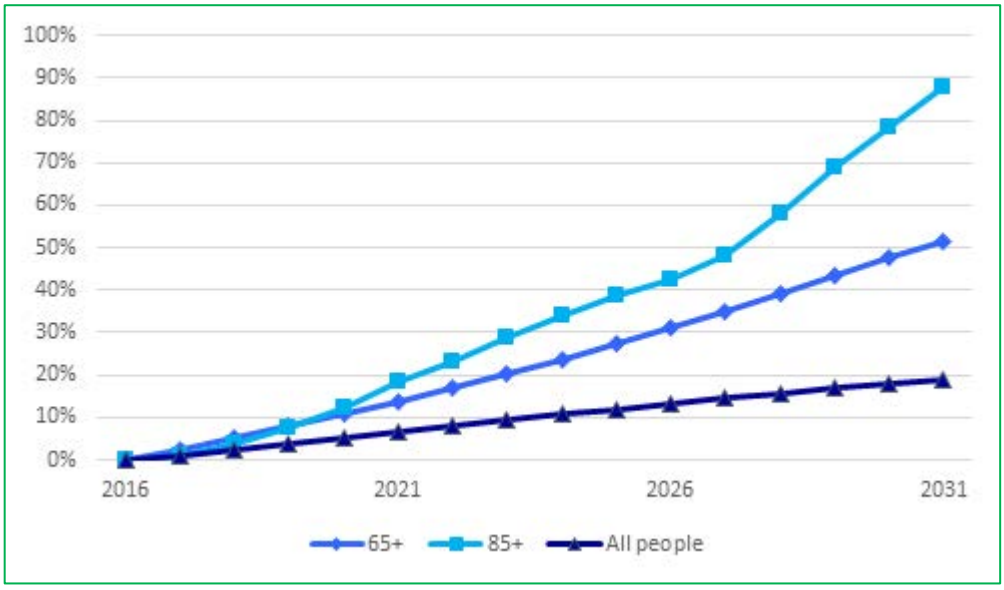
- The need to increase healthy life expectancy and promote independence by increasingly 'mainstreaming prevention'. This is important to both local residents and to the health and care system that will need to meet rising demand if healthy life expectancy does not improve.
- The need to reduce inequalities and disadvantage which can start from birth – so giving every child the best start in life is essential.
- Parity of mental and physical health – there is no health without mental health.
- The need to be ambitious – whilst outcomes in Central Bedfordshire appear better than average – they should be as it is a relatively affluent area – so we should aim to be among the best.

A summary of the principal demographic and health characteristics are described below:

- Growing population due to increasing life expectancy, a birth rate higher than deaths and inward migration
- In 2016 the population was estimated at 278,900 with an increase of 6.6% expected by 2021. Older age groups will increase at a much faster rate (65+ by 13.8%, 85+ by 18.3%) (Sources: ONS, 2016 mid year estimate and 2014 ONS Sub national population projections)
- Average life expectancy is 81.7 years for men and 83.7 years for women), better than the national average. Life expectancy is increasing at the rate of about 4.0 years for men and 2.1 years for women each decade.
- The main causes of death under 75 are cancer, heart disease, stroke and lung diseases (predominantly chronic obstructive pulmonary disease).
- 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).
- The population is 89.7% White British, with White: Other White (2.8%), White: Irish (1.2%) and Indian 1.0%.
- The number of people registered with Central Bedfordshire General Practices in April 2017 was 280,040

The figure below shows the overall expected population growth between 2016 and 2031 which will have a significant impact on health and care services in Central Bedfordshire.

Percentage increase in Central Bedfordshire population between 2016 and 2031



Source: Office for National Statistics, 2014 Sub National Population Projections, 2016-2031

4.2 Future Changes in Demand for Health and Social Care

Central Bedfordshire is an area of significant economic opportunity with planned housing and employment growth and is a desirable place to live. (See Local Plan) Although Central Bedfordshire is a relatively affluent area with life expectancy greater than the national average, there are significant challenges resulting from an ageing population and pockets of urban and rural deprivation.

Demands on services for older people with disability and frailty will increase. Mental health problems, particularly depression and dementia, are more common and have a worse outcome in the 60% of older people who suffer from long standing illnesses. Under-detection of mental illness

in older people is widespread, due to the nature of the symptoms, the belief that it is an inevitable consequence of ageing, and the fact that many older people live alone.

Older people are at an increased risk of depression due to factors such as retirement, social isolation, bereavement and, long-term illness and disability. Depression in people aged 65 and over is under-diagnosed and this is particularly true of residents in care homes where symptoms of depression are present in between 20–50% of residents.

The prevalence of dementia across the UK is estimated at over 700,000. In 2015, it was estimated that there were 3,000 people with dementia in Central Bedfordshire including almost 300 people under the age of 65. By 2030, it is estimated that there will be 5400 people with dementia, an increase of 67%. Approximately 245 people are diagnosed with dementia via the memory assessment service in Central Bedfordshire every year.

Evidence suggests that early diagnosis and treatment is important and can improve the quality of life for people and increase their independence as the condition progresses.

Additional key factors that influence potential changes in demand for health and social care in people aged 65 and over living in Central Bedfordshire are set out below:

	2011	2015	2020	2025	2030
People living with dementia	2,634	3,031	3,677	4,516	5,440
		15%	40%	71%	107%
People living with a limiting long term conditions	17,288	20,098	23,061	26,620	30,528
		16%	33%	54%	77%
People unable to manage at least one personal care task	13,131	15,077	17,578	20,648	23,936
		15%	25%	57%	82%
People unable to manage at least one domestic care task	16,010	18,379	21,530	25,294	29,240
		15%	34%	58%	83%

Falls are a major cause of disability and the leading cause of injury related mortality in people aged over 75 years, and osteoporosis increases the likelihood of serious injury. Up to 10% of falls are likely to result in serious injury, of which 5% are fractures. In 2015, approximately 12,205 people aged 65 and over were estimated to have had a fall. It is important to note that this is the number of people that fall and not the number of falls. Since 2010-11 injuries due to falls in people aged 65 and over have risen. Consequently, Central Bedfordshire outturn changed from being significantly better than the England average to being statistically similar. There have been concerted efforts to reduce falls through falls awareness training to Care Homes and a strong Public Health campaign. Local initiatives to reduce conveyance to hospital following a fall have also proved effective with timely support from the Urgent Homes and Falls Response Service.

4.3 Reducing Reliance on Hospital Services for less Complex Care

A major challenge within our BCF Plan is to reduce Non-Elective Admissions, which has increased in 2016/17 as reflected in the BCF quarterly performance reports. Developing services that reduce reliance on the hospital sector for those with urgent but less complex care needs that could be provided in out of hospital settings, is a key priority in our Plan. We have carried out a review of admissions for Central Bedfordshire residents and some of the findings are set out in the Performance Metrics section.

We do not underestimate the scale of change that is required to ensure that people are cared for in the most appropriate setting. This is key to sustaining our health and care economy and central to our Sustainability and Transformation Plan. Our Better Care Fund plan and the emerging Out of Hospital Strategy will be key in taking forward the transition to more local care.

Delivering this vision for integrated care means overcoming barriers between primary and secondary care, physical and mental health, and health and social care. Our Better Care plan brings resources together to address immediate pressures on services and establish a foundation for a much more integrated system of health and care delivered at pace. Accessibility to health and social care services is important and timely response particularly in a crisis, play a major role in reducing admissions to secondary care, maintaining people at home and in the community. An important part of the intermediate care and rehabilitation of course is access to community beds. We are investing additional resources to create more bed capacity to support early discharge from hospital and step up provision where necessary.

Admission avoidance is a key function of Intermediate care services. Consequently, the multidisciplinary approach, which aligns with the STP's Primary Care Home model is about embedding a new delivery framework for joint working across partners and client groups to deliver the full continuum of health and social care support.

A robust integrated intermediate care service is also key to expediting early discharge from hospital and reducing length of stay. We are implementing an integrated discharge coordination service for Central Bedfordshire as well as closer monitoring of patient flows across the seven hospitals used by our residents to ensure that they are better supported. Key projects related to these initiatives are set out in later sections of this plan.

This approach, which includes prevention and early intervention, self-management, reablement and independence, will also close the gap between access to physical and mental health services

4.4 Current state of the health and social care market

The health and social care market in Central Bedfordshire is complex and fragmented. Joint commissioning, cohesion in contracting and monitoring arrangements are limited. This has important implications for cost effectiveness and use of resources. Developing a whole systems, place based approach to shaping the health and care market is pivotal to ensuring that people can access the right care and the right time, with greater coordination of planning and commissioning arrangements.

The adult social care market in Central Bedfordshire is under pressure and sustainability, particularly the Home Care market remains a concern. The Council has a strong partnership with local care providers and is working with them to ensure sustainability as well as broader engagement with the market.

We are working to support residential and nursing homes providers to deliver enhanced care to their residents. This includes complex care support, pharmacist review of medications and increasingly links into the multidisciplinary teams. Much of these initiatives will be taken forward as part of the 2017/19 Plan. We would expect these initiatives which form part of the High Impact Change Model, to help reduce emergency admissions; reduce delayed transfers of care and overall pressures on the acute hospitals.

There are of course areas of risk in the care market. There are significant workforce capacity issues across all providers of health and social care both in terms of carers but also in leadership and management resources. Using the strong relationship with Providers, the Council has re-commissioned its Domiciliary Care framework contract using feedback from providers to address Providers' concerns about financial sustainability and to promote the development of a local workforce. This has involved changing the geographical coverage of the contract to support shorter travel distances, support more focussed recruitment and retention of carers. The Council has also introduced an incentive scheme to support more timely discharges from hospital.

For Residential and Nursing care provision, the Council, along with the Clinical Commissioning Group are recommissioning the current framework contract. The focus of this work will also address some of the gaps in the short term provision needed in the care market to support timely discharge from hospital but also prevent people being admitted to hospital in the first place.

The overall financial sustainability of the care market remains a concern and Central Bedfordshire Council participated in a Laing Buisson research into adult social care markets, carried out on behalf of the County Councils Network (CCN) of the Local Government Association. This report and a further update provide useful intelligence and an evidence base which will underpin our market position statement. Providers have received above inflationary uplifts in the past two financial years reflecting the need to address the National Living Wage impact and in addition a Fair Cost of Care exercise has been undertaken in Domiciliary Care to understand 'Units' rate of care. This work will also be undertaken within the Residential and Nursing Care for Older People with Learning Disability services to follow.

5. Progress against BCF Plan 2016/17

In this second year of our BCF Plans, there is demonstrable evidence of the impact on the health and care system. We have made good progress on a number of key projects such as multidisciplinary working in our localities and relationships with care providers, particularly Care Homes. Local partnerships are strengthened and there is greater collaboration across services to deliver integrated and improved outcomes for people. We have been working together on key areas to enhance joint care delivery and integration.

The Social Care, Health and Housing Overview and Scrutiny Committee concluded its enquiry on the local approach to integration and integrated health and care hubs. Their recommendations will help to shape the future direction of health and care services in Central Bedfordshire.

An LGA Peer Review into Reablement and Rehabilitation took place in October 2016 and recommendations from the Review will be taken forward in an action plan which will form part of the 2017/19 BCF Plan.

Clearly challenges remain and the 2017/19 BCF Plan, alongside the STP priorities will ensure a system-wide approach and solutions of some of these challenges.

5.1 Locality Based Integrated Health and Social Care Services

The 2016/17 BCF Plan set out our local vision for locality based delivery model for health and social care, in our four localities. These population centres of Chiltern Vale, Leighton Buzzard, West Mid Beds and Ivel Valley form the basis of well-established localities that have become the focus for multidisciplinary working and partnerships for delivery of health and social care services.

We have built on the Caring Together project, which was set out in the 2015/16 Plan, with establishment of integrated health and social care locality arrangements in the Chiltern Vale area. We introduced Multi-Disciplinary Team (MDT) working to provide an integrated response to those patients most at risk of admission and other people who would benefit from a more joined up response. The experience gained from a review of this work was used to develop the multidisciplinary approach which is now being rolled out across the rest of Central Bedfordshire.

These locality arrangements, which now form part of the Cluster arrangements, are central to responding to local demographic pressures and the increasing complexity of existing pathways within health and social care. We have made some progress on the framework for achieving this locality focus through development of Integrated Care Hubs that are based, in the first instance on our four Localities.

As an area of significant growth in housing and population, we also recognise that the number of hubs, which would be needed to serve an area without an acute hospital, is likely to increase in line with housing and population growth. Further information on the Integrated Health and Care Hubs is set out in the 2016/17 BCF Plan.

Since submitting the 2016/17 Plan, we have secured funding through One Public Estate and the Estates and Technology Transformation Fund to develop business cases for the Hubs. So far, we have developed an Outline Business Case for the Dunstable (Chiltern Vale) Hub and a Strategic Outline Case for the Biggleswade (Ivel Valley) Hub. We are now in the process of commissioning the strategic outline case documents for the remaining hubs as well as how other local health and care premises will interrelate with the Hubs as Spokes.

We have had on going discussions with NHS Property Services to secure the Biggleswade Hospital Site asset which is critical to meet the ambition for the Ivel Valley Hub. In addition to this, we are working with NHS Project Appraisal Unit, Community Health Partnerships and through our STP to progress our ambitions for the locality based integrated health and care hubs which represent a key part of the STP vision for out of hospital services and key also for the implementation of the GP Forward View.

In 2016/17, we committed to seven key schemes within the BCF Plan. Performance against these schemes has been regularly monitored, through the Better Care Fund Commissioning Board and reported to the Health and Wellbeing Board. Highlights and successes of key schemes in the 2016/17 plan are summarised as follows:

5.2 Multidisciplinary Working – supporting more people closer to home

We have made real progress towards delivering integrated outcomes for people. We have established a ‘place based' multidisciplinary approach, with staff from community, mental health and social care, bringing care close to people in their localities. This work started in Ivel Valley and now being progressed across the remaining localities in Central Bedfordshire. This multidisciplinary approach is being led by senior operational managers, who are now meeting on monthly basis. A staff directory has been produced. This test bed for a place based team is being supported by Health Education East who has provided important insights into the experiential learning from this way of working. Work is also ongoing to facilitate interim co-location of the team at the Biggleswade Hospital site. Plans are underway to roll out this approach across Central Bedfordshire from November 2017. This place based focus aligns with the STP vision and work packages for primary, community and social care priority.

Partnership working with the Community Health Services Provider has improved significantly and a joint associate director post has been established. The first 6 months of the role have focused on the development of an integrated value based leadership approach across Social care and Community Health Services to give permission within the system to deliver integrated outcomes for the residents of central Bedfordshire. Progress has been made in the joint approach in relation to access and assessment. This includes closer alignment of intermediate Care and reablement, roll out of Multidisciplinary approach across localities and new arrangement at the Luton and Dunstable relating to discharge planning.

Further progress has been made through joint work on the approach towards DTOC with the development of tracker, Hospital discharge service and contributing to the development and implementation of discharge to assess model within Central Bedfordshire. Additional capacity has now been funded through the IBCF to facilitate the sustainability of the early progress made. This includes the funding of 2 Locality integrated system managers who will work within their respective localities to ensure transformation is delivered. The investment will have a focus on both reducing DTOC and admission avoidance across the whole of Central Bedfordshire.

Our ambition is to implement a multidisciplinary approach with place based teams across Central Bedfordshire. 'One team' working across organisational boundaries to improve the health and care of the local population, with a clear focus on the 'Place' bringing together primary, social, community and mental health services and when fully socialised will work to a common set of outcome measures.

This is a re-alignment of existing community based services. The focus is on new ways of working to maximise the workforce, reduce duplication to create a more efficient and sustainable health and care system. We have just reorganised community services on a place based model and the intention is to develop ways of working that take this integration further through the autumn, building on the initial focus on Ivel Valley. It brings together primary, social, community and mental health services with a network of support from the community and voluntary sector. Drawing together the skills and resources within the locality to provide high quality coordinated care, cluster teams will form strong working relationships to provide care and improve outcomes for their population.

These cluster teams will have closer connection to their communities, understanding the needs of the locality population and working with the communities to deliver care and support. This model focuses on teams working, as 'one virtual team' centred on their local population/place, (clusters/locality) with a set of common goals.

As part of the progression of this Multidisciplinary Approach in Ivel Valley, community, mental health and social care colleagues have expressed a wish to co-locate to enhance joint working and arrangements are being made for an interim co-location of the teams on the Biggleswade Hospital site as a precursor for when we have the Integrated Health and Care Hub in place.

The teams that will be co-locating on the site are the Older People Mental Health Teams; Adult Social Care Teams and the Community Health Services Teams. These are essentially the Ivel Valley Teams who will have an overview of the health and care needs of the local population.

5.3 Information Sharing - SystmOne Viewer Access and NHS.net

We are also in the process of securing viewer access to SystmOne for social care colleagues as well as NHS.net to enhance joint working. We are continuing to match adult social care records with

NHS numbers as a unique identifier across health and social care. Pseudonmyised data is being used to understand cost of services.

We are actively involved in the STP Digitisation programme which aims to deliver shared care records across health and social care.

5.4 Risk Stratification

The Caring Together MDT meetings in Chiltern Vale have continued and the number of GP Surgeries now participating has increased. Proactive care and risk stratification approach is continuing. The Luton and Dunstable Hospital Consultant Geriatrician is providing input into the meetings and supporting case management.

A risk stratification tool based on pseudonmyised data has been developed and is in use. The pseudonymisation at source (P@S) tool uses a combination of primary, secondary and social care data to select those who are highest risk of hospital readmission. Using targeted case management on those people who are like to benefit from further intensive support, promotion of self management or social prescribing. It is likely that this tool will also extend to those in Care Homes as part of the enhanced care in care homes work and the High Impact Change Model.

5.5 Community Assessment Pilot

As part of a recent workforce review and a review of the customer journey, we have made a number of changes to the way integrated services approaches adult social care. A key driver for these changes has been the Care Act 2014.

As part of these changes, we carried out a successful pilot of a Community Assessment Officer Role. This role enables unregistered practitioners to undertake assessments and reviews under the Care Act 2014 with the oversight of a qualified practitioner. This enables the customer journey within integrated services to operate a proportionate approach to customers needs. It was identified as part of the review of the customer journey that customers valued having a consistent worker and not continually being passed from one worker to another. It was also clear that depending on level of complexity that not all customers required the assistance of a registered practitioner. The pilot clearly identified that the unregistered workforce offered our customers a wealth of skills and competence and continuity.

Following the successful pilot, consultation period and recruitment each locality team now has Community Assessment Officers as part of the team. In addition, the workforce review made it possible for Central Bedfordshire Council to enhance its career progression scheme to include a Senior Assessment Officer role which enables unregistered practitioners to further enhance their skills and abilities. This in turn further benefit the customers experience by having consistency from a motivated workforce.

5.6 End of Life Care:

With support from the LGA BCF Advisors, we carried out a review of End of Life (EoL) and Palliative Care Services. The review demonstrated fragmented pathways with patient handoffs across the system. A revised model of care was developed in partnership with existing providers to encourage integrated working and increased capacity across the system as well as a proactive approach to the management of service users at the end of life to prevent avoidable admissions, which are often in contrast to the wishes and preferences of people whose preferred place of death is at their usual place of residence.

During 2016/17, the EoL Local Implementation Group (LIG), attended by health and social care colleagues, produced a Bedfordshire wide Advanced Care Plan (ACP) document and supporting leaflet. Training to professionals was rolled out and reporting demonstrates a significant increase in the number of ACP discussions with service users. Further training and awareness of the ACP document will continue throughout 2017/18 across health and social care.

Pathway Re-design: A facilitated large scale workshop took place on 24th May 2017 to identify interfaces between health and social care across the end of life pathway. The aim was to identify solutions to areas / processes which need improving to ensure service users receive the right services at the right time. The main areas requiring improvement and integration were around training, support to care homes and end of life fast track processes. As a result of this joint working, there is now greater integrated working, increased capacity and a more proactive approach to care management. Implementation of Advanced Care Plans and training is continuing. The work with the Ambulance service has seen a reduction in the number of conveyances to hospitals with more calls to the Partnership for Excellence in Palliative Support (PEPS) Service. Up to 12 Care Homes in Central Bedfordshire have appointed an EoL Champion to work with professionals.

As a result of this work, the next phases of the improvements to end of life pathways through 2017/18 will focus on further embedding an integrated care pathway. Discussions are underway to introduce an integrated fast track pathway across health and social care using substantive Palliative Support Workers trained in end of life care instead of the current pathway which uses agency workers. Implementation of the new model began on 1st July 2017 and further planned elements of the model will continue to be implemented in succession to enhance the provision of end of life services across the system.

5.7 Delayed Transfers of Care:

We carried out a deep dive into delayed transfers of care in 2016 to provide greater insight into patient flows and delays. This was followed by a further programme of work through Public Health Intelligence work mapping out patient flows for Central Bedfordshire. This work provided a clearer and evidence based understanding of our system. Both of these pieces of work underpinned the case for additional investment and realignment of staff to support early and coordinated discharge from all hospitals used by Central Bedfordshire residents. Through this additional investment and resources, we have established closer working with all acute trusts to improve support for early discharge and reduce delays

Social care related reasons for delayed transfers of care reduced in Central Bedfordshire and is one of the best performers in the Eastern Region. Delay due to health reasons are also improving. Additional intermediate care beds for step down have been made available for patients, including those patients who can be discharged but remain non-weight bearing.

We completed the self assessment on High Impact Change areas and an action plan is being developed to address the key areas identified in the process. These will be taken forward as part of our 2017/19 Plan.

5.8 Stroke and Early Supported Discharge (ESD):

The Early Supported Discharge initiative went live in March 2017 and referrals have been received from the Luton & Dunstable, Bedford and Lister Hospitals. The stroke tracker developed by the team to monitor impact of the service on length of stay and access to community stroke

rehabilitation, showed that in the first month of the service there were 19 referrals for Central Bedfordshire residents and all referrals were seen within 24 hours. Recruitment to the team has been completed and is fully mobilised.

A Care Pathway for ESD has been developed and implemented across the acute sector mainly the Luton & Dunstable, Bedford, Milton Keynes and Lister Hospitals. An average of 5 spot purchase beds avoided per month which realised savings of £371K for 2016/17.

There were some challenges, such as delayed implementation of the ESD service for approximately 7 months. This was due to staff recruitment, availability of suitable care packages and delay in getting care packages for eligible patients. Closer working with social care colleagues is helping to address some of these challenges. For 2017, as part of ongoing service development, psychology services support will be explored to see how the team can integrate within current resources.

Supportive Technology: Disabled Facilities Grants – We have adopted an approach for more flexible use of resource to support early discharge from hospital and promote independence through wider use of assistive technology.

5.9 Falls

The project to train 'Falls champions' in Care Homes has been successful, with Falls Champions now established in 94% of Care Homes in Central Bedfordshire. In 2016/17 Falls champions were invited to quarterly meetings for education, peer learning and support on falls prevention specific topics including Dementia, Medication, getting up safely following a fall. There has been a positive impact on the number of falls and individual residential and nursing homes have reported reductions in falls. Overall for Bedfordshire there has been a reduction in emergency admissions for falls by 8% based on 2015/16 outturn against a predicted 2% increase. A falls seminar was held in July 2017, 12 months after the launch of the programme, over 50 Care home staff attended this event.

In 2017/18 the falls champion meetings will continue on a 4 monthly basis providing a forum for education and peer support. There will be a focus on extra care housing with the aim of identifying and training falls champions in all extra care housing provision in Bedfordshire.

A model for the provision of strength and balance training for CBC residents is to be developed and commissioned. The offer of strength and balance training needs to be available to residents attending the FLS service; this is an important element of secondary prevention.

A business case for fracture liaison service to commence at Bedford Hospital was approved. Individual care home providers are purchasing equipment to help get people up safely following the ISTUMBLE seminar.

5.10 Enhanced Care in Care Homes

We completed a self assessment against the **enhanced care in care homes** framework and identified key priority areas. Community nursing service specifications have been updated and include nursing homes having access to community nurses. In addition:

- We now have actuarial analysis on non-elective admissions from Care Homes and lengths of stay.

- Current support to care homes in Central Bedfordshire has been assessed against the enhanced care in care homes framework produced from the learning of the care home vanguards.
- Stakeholder engagement activities have been undertaken through a care home task and finish group to gather intelligence on the local experience of accessing services to support the care home population
- A Central Bedfordshire care home stakeholder working group has been established and has been determining the priorities for delivering enhanced care in care homes. These include: commissioning complex care team to enhance primary care support to care homes, piloting the Red Bag scheme and Trusted Assessor model, developing a comprehensive training offer to support care homes.
- The principle that care home residents should access health services in the same way as the population living in their own home has been built into the model of community services being developed for the community service procurement and some of the changes planned with the current community provider for 2017/18. This includes MDT working on a cluster basis, identification and case management of high risk patients using risk stratification, rapid response to support admissions avoidance.
- We are participating in an 'Assess to admit pilot', trialling new ways of working with the acute trust to reduce A&E attendances and hospital admissions. This pilot isn't yet live due to recruitment challenges.
- Successful bid application to pilot technology and digital solutions to enable Residential and Nursing Homes to access electronic shared care records with health services.
- Increase in clinical pharmacy support to care homes.

NHSE EHCH benchmarking tool v6

A joint approach to enhancing care in care homes is being proposed via the STP, working with the BLMK STP programme manager for complex care. This workstream includes training needs assessment; digitisation and delivery of enhanced care. A workshop with Care Homes is being planned.

We secured LGA funding in conjunction with Luton Borough Council to support information sharing and integration of services with Care Homes.

Webpage.docx

5.11 Carers' Support

'Carers in Bedfordshire' provide support to Carers and is a jointly commissioned service across Bedfordshire organisations. The service administers and runs:

- A carer support service from 8.30am to 5pm on weekdays from their Bedford office and at least one base in Central Bedfordshire. Carers are supported in community locations and where required at home, hospital, workplaces and school.
- Carers' groups – for socialising and support.

- Counselling for carers – in partnership with Bedford College with student counsellors gaining experience whilst helping carers.
- Carers' Magazine – now reaching over 5,000 carers four times a year.
- Adult carer training – on a wide variety of topics.
- Support for carers who care for those living with dementia.
- Carers' Rest – weekly group for attendance by carer and cared for (dementia support)
- Carers' Cafes – there are 6 cafes for socialising, well being therapies, advice and support
- Identifying carers in a hospital setting - Carers' Lounge at the Luton and Dunstable hospital opened September 2016.
- Carers' Break Funds – an NHS initiative offering carers' grants.
- Advice and information to all carers (including veteran and former carers) of all age groups and all caring conditions.
- Memory Navigation Service and Memory Gateway for people worried about their memory or living with dementia, and carers.

In addition to this, Central Bedfordshire Council Carer's offer includes the following: assessment of Carer's needs through a Lead Practitioners and Community Assessment Officers, Carers' breaks via direct payments or carers' vouchers; Residential respite breaks where the cared for person temporarily goes into a residential care setting; Support and information groups for carers of adults with a learning disability and a Carers Helpline via the Council's Customer Contact Centre.

In 2017/19, a local Carers' Strategy will be developed when the imminent National Strategy is published. From October 2017, Age UK will begin to offer respite to Carers aged 50 and over. Furthermore, our emerging Market Position Statement for Learning Disabilities, due to published in autumn 2017 will also consider the requirements for more respite services for carers.

5.12 Meeting the Accommodation Needs for Older People

For an older person having suitable housing can be a very significant contributor to ageing well. Homes in which older people have successfully raised a family can become a burden in later life but those who wish to move to more suitable homes (sometimes referred to as 'downsizers') often struggle to find something suitable, especially if they are keen to stay in a particular locality in order to retain existing social contacts. There is now good evidence that in later life unsuitable housing can contribute to physical and social isolation, the consequences of which can be an avoidable deterioration in both physical and mental health.

To address these and other issues, a range of solutions is required and during 2016 Central Bedfordshire Council published its Investment Prospectus for Meeting the Accommodation Needs of Older People which sets out for the first time the range of accommodation required in each locality in the period to 2020.

In 2016, the Council opened two extra care schemes – Priory View in Dunstable and Greenfields in Leighton Buzzard. Each scheme delivers over 80 apartments for older people along with communal facilities and, most importantly, the availability of personal care at all times. In addition to this a new care home opened in Dunstable, this allowed the closure of one of the Council's outdated homes. Priory View also provides enhanced care to residents.

5.13 Outturn on Performance Metrics for 2016/17 BCF Plan

5.13.1 Non elective admissions

There was no marked improvement against the BCF Target. Reducing non-elective admissions (NELs) remains a challenge and we are working closely with the A&E Boards to mitigate this. We are continuing to review the reasons for the increasing figures and have recently undertaken a Public Health led review which will help to ensure that local plans are focused to deliver improvements.

5.13.2 Delayed transfers of care

This measure was reported as being on track for improved performance but not to meet full target. Social Care reasons for delay decreased over the year. The challenge of NHS reasons for delay is being addressed. The additional community beds commissioned to support timely discharge from hospital are having some impact. A discharge to assess model is being developed. The Council has increased capacity within the hospital social work team to provide greater oversight and timely support to coordinated discharge from hospital and reduce DTOCs.

5.13.3 Emergency admissions due to falls

This measure is on track for improved performance but not to meet full target. We have implemented an integrated approach to reduce falls. There is a more joined up and collaborative approach to improve the falls pathway. Delivery of falls awareness and training to care homes have had a real positive impact and non-elective admission for falls showed an 8% reduction in 2016/17 against a rising trend in NELs overall.

5.13.4 Permanent admissions to care homes are on track. Use of residential care has reduced and is below the BCF Target.

5.13.5 Reablement, patients/customers still at home 91 days after discharge is on track for improved performance and current level of performance remains above the England average.

5.14 What lessons were learned and what will change?

We have continued to review our progress against the 2016/17 Plan with the BCF Commissioning Board and the Health and Wellbeing Board.
http://centralbeds.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=829

The Health and Wellbeing Board has remained mindful of the challenges facing the health and care system in Central Bedfordshire and whilst we remain ambitious it is important to focus on securing improved outcomes for patients and on key areas which have impact on the national conditions and performance metrics. This is particularly so in relation to reducing unplanned admissions to hospitals and Delayed Transfers of Care. As in the previous year's update report, although there has been important progress in all scheme areas, there have been a number of factors that have impacted on the overall pace of delivery of the BCF Schemes. The Clinical Commissioning Group's financial recovery and changes in leadership has also had an impact on the delivery of the BCF Plan and schemes.

We are currently in the process of recommissioning community health services across Bedfordshire and through the process have ensured that the vision for locality based

multidisciplinary approaches is shared with the bidders. The majority of the schemes set out in the BCF Plan require new ways of working and in particular integrated services to facilitate seamless and timely care pathways. Through on-going dialogue we can be satisfied that the potential providers have understood this vision for integrated, place based care.

In recognition of the financial challenges within our local health and care system, there is a clear focus across the system on achieving financial stability and sustainable health and care services, through transformation and integration. In order to secure a system-wide approach we contributed to the STP Plan ensuring that the priorities for action align with the BCF Plan, the CCG's Commissioning Intentions, the GP Forward View and the Council's Five Year Plan.

We recognise that integration is key to delivering improved outcomes as well as addressing the issues of quality and sustainability. We engaged the Kings Fund on System Leadership and also in supporting the Overview and Scrutiny Committee enquiry on Integration in 2016. The Kings Fund shared with our elected members evidence from other areas which reinforced the impact that integration can have on people as well as helping to maximise resources in a health and care system. The following case study typifies the lessons we have learnt and how we expect through a more joined up and integrated approach we can delivery significant improvements in our system.

Local case study: How can a more joined up approach managed at locality level improve care for patients?

Let's consider Mrs Jones' story. She is 77 years old, lives at home alone (following the death of her husband a few years ago) and is generally well. Following a fall, she is admitted to hospital and diagnosed with a simple fracture to her lower leg, dehydration and possible early dementia. While in hospital, Mrs Jones becomes confused, struggles with getting around and develops a urinary tract infection, which means she ends up spending almost two weeks in hospital. She is keen to return home as soon as possible and arrangements are made to assess her need for home support. However, Mrs Jones son, who lives and works in London, is worried that his mother shouldn't remain at home alone and requests information from the social care team on local care homes. Whilst waiting to be discharged from hospital, Mrs Jones is convinced by her doctors, son and daughter who is living abroad, that the safest place for her to be is a nursing home, so she reluctantly agrees. A place is found for her in North London, near to her son, but she never really adapts to life in a care home. Without the familiarity of her own surroundings and routines, she becomes lonely and depressed. Gradually her health deteriorates and 18 months after the initial fall, she passes away in her sleep.

Throughout, Mrs Jones has many people making decisions about her health and wellbeing and the care she receives. From the initial assessment by paramedics, to the A&E/ ward consultants and doctors/ medical team at Lister Hospital (she moves wards three times), the hospital social work team, physiotherapist, Central Beds Council rehabilitation team, Occupational therapists (one to assess home equipment requirements and one to assess her need for home adaptations), her family and eventually the nursing home manager.

What would be different if there was a more integrated approach to Mrs Jones health and social care?

Following her fall, Mrs Jones would be assessed through the ambulance call centre and her case would be passed to the Integrated Health and Care Hub. A clinical nurse lead would be assigned to liaise with her family and all other health and care workers regarding her care and treatment e.g. fracture clinic technicians, rehabilitation and therapy team, GP, community assessment officers

and physiotherapist. Working with a local charity they establish a Care at Home team that can support Mrs Jones rehabilitation at home and she is able to return home, fully supported, in 3 days. 10 years later, Mrs Jones is still at home and considering a move into Extra Care.

Our 2017/19 BCF Plan takes forward the developments that will make a significant contribution towards the priorities of the foregoing strategic plans and delivering the vision set out in the Five Year Forward view.

5.15 Challenges

Integration aims to overcome the substantial organisational, professional and regulatory boundaries within the health and social care sector to ensure that patients receive the most cost-effective care when and where they need it. Our Plans are ambitious and we appreciate the important system challenges, such as the significant local financial pressures faced by our CCG. Changes in leadership and workforce in our health systems has important implications for building partnerships and developing productive relationships.

Central Bedfordshire is not coterminous with an acute hospital and our residents use up to seven hospitals in surrounding local authority areas. These considerable organisational boundaries and competing priorities to achieve financial balance means that delivering integration has proved a major challenge and progress has been slow. Understanding the impact that these constraints will have in the short term is important.

We have an ageing population which indicates increasing demand for health and social care. Public expectations are also rising. The broad patient flows and footprint for Central Bedfordshire residents which requires working with several acute trusts, particularly in relation to delayed transfers of care and engagement in A&E delivery Boards where Central Bedfordshire residents are in a minority has been challenging. Ensuring that system responses reflect the wider patient flows and footprint of Central Bedfordshire residents, beyond the three acute hospitals in the STP footprint is a challenge. With the additional investment in social care practitioners, there is now capacity to work directly with those hospitals in coordinating care for Central Bedfordshire residents. Ongoing work on developing integrated care pathways through multidisciplinary working across the systems will help to deliver improved outcomes as well as ensuring better use of resources.

Another challenge is insufficient and fragmented capacity within the community to respond appropriately to local needs. Recruiting and retaining sufficient care workers, particularly in the domiciliary care sector, has been a key issue for our system. This has an impact on ability to deliver timely care in a predominantly rural area.

A shared system for Information and records to facilitate timely transfers of care and joint care planning are an important challenge. 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. Securing a shared care record remains a key focus and we are working with the STP Digitisation workstream to address these issues. We recognise also the need to develop capacity for business intelligence and analytical expertise, alongside support from Public Health.

To meet the immediate challenges, within our local health and care system, this BCF Plan builds on the work from previous plans and focuses on five key Schemes below which align with local strategic drivers and will help to deliver improvements, cost efficiency and more streamlined pathways of care to meet the national conditions and improve performance against the four metrics.

6. BCF Plan 2017 -2019

Our Integration and Better Care Fund Plan is focused on putting people at the centre of the design and delivery of health and care services in order to improve outcomes, satisfaction and value for money. We have made significant improvements in partnership working across the system. Over the next two years, our aim is to overcome the organisational, professional and regulatory boundaries within the health and care sector to ensure that people receive integrated cost-effective care when and where they need it.

The schemes and projects we will focus on are set out in the planning template and accompanying project plans (Appendices 1a-e). These schemes build on previous BCF Plans and are influenced by the systematic review and performance monitoring of delivery against the BCF Plan for 2016/17. Bedfordshire Clinical Commissioning Group, in partnership with the two local authorities is currently re-procuring Community Health Services. The specific requirements for Central Bedfordshire population which reflects the wider patient flow for our area, have been set out in service specification. These specifications have been influenced by wide ranging engagement with stakeholders and local residents.

The 2017-19 Plan will have five broad Schemes:

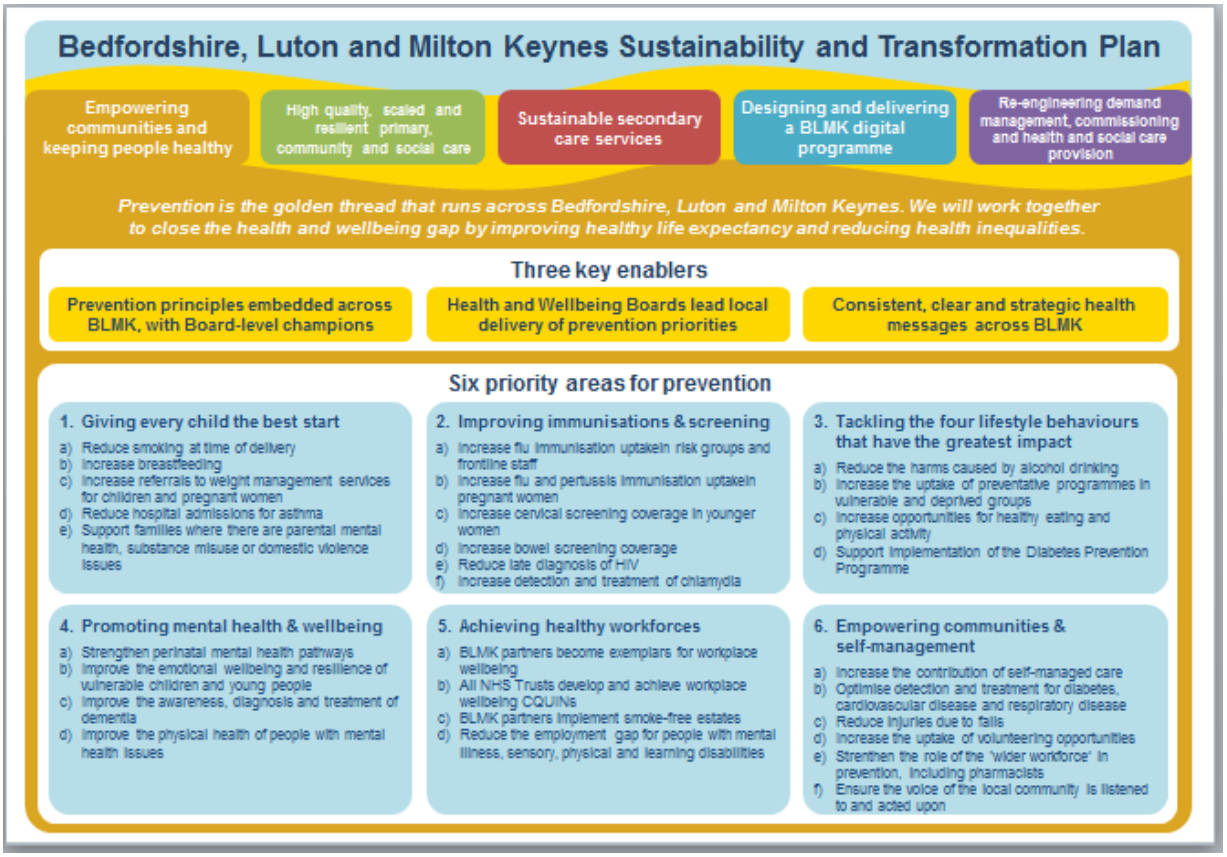
- Prevention and Early Intervention
- Delivering Integrated and improved Outcomes through Out of Hospital Services
- Integrated health and care hubs
- Enhanced care in care homes
- High Impact change model

6.1 Prevention and Early Intervention

Over the next two years, our BCF Plan and schemes will continue to focus on preventing illness and disability and maximising independence and wellbeing. (Appendix 1a) Our focus on multidisciplinary and integrated solutions will help to improve the effectiveness and efficiency of the ways in which services are delivered. The need for a system wide response to wider system issues around prevention and early intervention is recognised in our STP Plan.

Priority 1 of the STP “aims to improve healthy life expectancy and reduce health inequalities across BLMK, and thereby reduce avoidable pressures on health and care services. This will be achieved by embedding a culture of prevention and early intervention across BLMK. The main goals are tackling lifestyle behaviours, promoting mental health and wellbeing and empowering communities and self management.

Our 2017/19 BCF Plan is aligned to the system wide priorities for the prevention and include fracture liaison, social prescribing (one of the GP Forward View ‘10 High Impact Areas’), increasing the contribution of self managed care (empowering service users and family carers to do more through measures including active patient programmes, health coaching and easier access to shared care records) and extending the role of pharmacists in care management. See Plan on a Page below:



The scheme will also expand the use of assistive technology, telemedicine and the disabled facilities grant to enhance self management and promote independence, ensuring that people can remain at home or in their usual place of residence in the community, where appropriate. Local investment in prevention initiatives are set out in the Planning template and builds on the key initiatives commenced as part of the 2016/17 BCF Plan.

A planned initiative for 2017/18 is using telemedicine to support complex care management in Care Homes. A telemedicine service can help to improve the quality of care available to care home residents through a single point of contact providing timely and responsive assessment of needs 24/7. This will help to reduce avoidable admissions to secondary care and improve care experience for frail older people.

Mental Health and wellbeing is also a key focus of our Plan. Investment in liaison psychiatry is continuing and the promotion of self help guides will continue as part of the wider wellbeing and promoting independence programmes.

For social prescribing, we plan to develop a service that works in conjunction with primary care and complements existing initiatives. Our social prescribing initiative will be Public Health led and will work closely with the multidisciplinary teams and the voluntary and community sector to link people with services in the community that can help influence wider determinants of health.

6.2 Improving out of Hospital Care to deliver integrated outcomes

Robust and appropriate out of Hospital services are essential to providing health and care closer to home. Better Care, locally is key to reducing the financial and activity pressures experienced in secondary care and importantly securing improved experience of care for local people. A strategy for Out of Hospital Services is being developed. This strategy which focuses on delivering

integrated outcomes includes delivery areas which begin to integrate health and social care teams; integrates approaches to assessment and care planning and implementation of integrated care pathways.

Our plans for improving out of hospital care align closely with the STP. The Primary Care Home model and will support the development and co-ordination of the professionals within localities to manage, co-ordinate and extend access to care outside of hospital.(Appendix 1b) As a prelude to Primary Care Home, our multidisciplinary approach which is being rolled out across the rest of our localities will focus on universal proactive and preventative care; early engagement of people with long term conditions and those with chronic, complex care needs. The Primary Care Home model has four defining characteristics:

1. Provision of care to a defined, registered population of between 30,000 and 50,000 (BCCG propose to extend this where it makes sense to provide care to a slightly larger population) where professionals can work together to support an improved and proactive model of care.
2. An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care inclusive of patients and the voluntary sector; therefore primary care is described in its broadest sense and broader than General Practice.
3. A place based focus on person-centred care and co-ordination of care with improvements in population health outcomes through advanced care planning, risk stratification and MDT working within the locality based populations described above.
4. Aligned clinical and financial drivers through a unified, whole population budget with appropriate shared risks and rewards.

The cluster based teams will provide the multidisciplinary environment for delivering seamless care. This multidisciplinary approach has been developed and is being led by provider organisations. These 'cluster teams' will provide complex care management of frail older people with an emphasis on Care at Home. The focus has been on activating staff to become the drivers for new ways of working. This bottom up approach will facilitate greater ownership of the vision and ensure a faster pace of delivery.

Our projects will increasingly help to shift in the balance of care from hospital to intermediate, community and home based care with more person centred solutions. Primacy is being given to maintaining independence and choice for individuals supported by community network of support through the voluntary and community sector, as evidenced in our IBCF investment. In shifting the balance of care to local levels to reduce dependency and pressures in the system, we will be strengthening our rehabilitation and reablement offer through joint working and integration between local authority reablement services and intermediate services.

In order to ensure the right support is available, there will be more investment in community based options including additional community beds focusing on rapid access to intermediate care and assertive in-reach to facilitate timely discharge from hospital. Community support arrangements will be strengthened to minimise the need for re-admission to hospital. The Council is also continuing its investment in alternative forms of accommodation for older people to reduce the need for permanent admissions to residential and nursing homes.

6.3 Integrated Health and Care Hubs

Integrated Health and Care Hubs and Spokes are a key part of our locality based delivery model for A 'Place based' approach to Integration and is in line with our STP Plan for care closer to home and

the Primary Care Home model. The core vision is for the development of an integrated health and care hub in each locality in Central Bedfordshire as a focal point for joining up health, social care and other council services and the delivery of care closer to where people live. These Hubs will enable the development of new models of care where general practices, particularly groupings of Practices, will be more effectively and flexibly integrated with community, mental health and social care. (Appendix 1c)

Services will be more accessible to people, especially in predominantly rural areas, and will meet the requirements for delivering health and care services to an expanding and ageing population. The Integrated Health and Care Hubs will be the main centres for providing proactive and preventative care, out of hospital services and care packages for people who are vulnerable or have complex care needs.

Each Hub will provide local access to a range of general, medical and nursing, therapy, specialist and social care services with supporting information and advice systems.

The hubs may also develop a range of additional or enhanced services in line with the needs of the local community. Enhanced services might include:

- Extended GP services on a 7 day basis
- Enhanced services delivered by and across practices, e.g. minor injury and minor illness services, clinics to support patients with long-term conditions
- Face-to-face out of hours consultations
- Community pharmacy
- Rehabilitation and reablement facilities
- Outreach services from local acute hospitals and specialist services, e.g. outpatient appointments and other specialist consultations
- Less complex diagnostics
- Public Health and prevention services, e.g. smoking cessation, NHS Health Checks, lifestyle hubs
- Wellbeing Services and community mental health services
- Voluntary and Carer support services.

We will continue to work in conjunction with the STP Estates workstream to develop the Business cases for the Hubs and to secure the required capital for delivery.

6.4 Enhanced Care in Care Homes

Older people living in care homes have some of the most complex health needs, yet successive studies have shown that they have variable access to health care and, as a result, high rates of unscheduled admissions to hospital. Better integration between care homes, primary care, community services and hospitals can improve health outcomes and costs and lead to better experiences for care home residents and for staff.

It involves GPs and other health professionals providing services in care homes and developing a partnership with care home staff. Together, they manage residents' care needs prospectively – helping them to keep well, not just reacting to ill-health – and the health professionals support care home staff to develop their confidence and skills in providing health care.

This scheme aligns with the STP P2 work focusing on those individual with complex health and care needs, particularly concentrating on the nursing and care home population. Nearly all of these residents will have age-related disability, frailty, multi-morbidity, and cognitive impairment.

There are several initiatives targeted at residential and nursing homes. We have completed actuarial analysis on non-elective admissions from Care Homes and length of stay and will use this information to plan targeted support to care homes.

There is ongoing development of community services through high impact and rapid response teams and complex case management to keep residents out of hospital and in their usual place of residence. EOL programmes are targeted at better training and communication amongst care homes staff and ambulance services to decrease unwarranted admissions and support individuals dying as per their wishes.

The STP's priority four programme on Digitisation aims to improve digitisation in Care Homes to secure channels for information sharing and shared care records. We have mapped the state of readiness across all our Care Homes and appreciate the size of the task at hand to implement a robust information sharing system. The Funding from the LGA will help to develop some of the instruments required. Output from this work will be shared across the STP footprint.

We will work with our local Care Provider Forums to develop an enhanced care framework (See High Impact Change – national condition 4 and IBCF Investment), which includes maximising the use assistive technology and digitisation in Care Homes.

The Council is currently in the process of re-procuring the Care Home Framework and will seek to work with providers to improve the Care Offer. Key projects which will be delivered under this scheme are set out in Appendix 1d.

6.5 High Impact Change Model

This Scheme focuses on the delivery of the High Impact Change Model and related initiatives funded through the Improved Better Care Fund. We have undertaken a self assessment against the High Impact Change model and set out an action plan for delivery in key priority areas. The model identifies eight system changes which can have the greatest impact on reducing delayed discharge and includes:

1. Early discharge planning
2. Systems to monitor patient flow
3. Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
4. Home first/discharge to assess
5. Seven-day services
6. Trusted assessors
7. Focus on choice
8. Enhancing health in care homes.

Our BCF Schemes for 2017/19 will have an impact on the actions arising out of the self-assessment. Some of these actions will be further developed under the specific scheme area e.g. out of hospital services and enhanced care in care homes. Appendix 1e

7. Improved Better Care Fund (IBCF)

There is broad understanding that the iBCF is in addition to the BCF Pool and provides opportunity for additional investment in line with the conditions of the grant. We have set out in the planning template the key initiatives funded through the IBCF which also seek to meet the requirements of the national conditions, particularly the High Impact Change Model (condition 4).

Central Bedfordshire Council agreed that the iBCF investment, albeit time limited, should be used to 'transform' the health and social care system in Central Bedfordshire and therefore will not be used to offset the underlying over spend within Adult Social care, as this will be met from Council resources. The social care precept has been targeted towards increasing capacity and sustaining the care market. The expected positive impacts of the iBCF will lead to reducing pressure on the NHS and help people to stay at home for longer.

Additional intermediate care beds have been commissioned to support discharge of patients who require further assessment or therapy to optimise their independence. These beds will support more people to be discharged from hospital when they are ready and without delay and ensure that local social care provision is supported appropriately. Key areas of investment, which also enhances the GP Forward View Transformational funding, are as follows:

- Investment in additional social care and housing resources to support timely discharge from hospital,
- Increasing Voluntary Sector and community capacity
- Adult Social Care market sustainability – Trusted Assessor model
- Complex Care Management through support to care homes and Care for the frail elderly, including home visiting services
- Out of Hospital, investment in Community Beds & Assistive Technology - Six additional intermediate care beds to support bed-based rehabilitation of non-weight bearing patients who are fit to be discharged from hospital.
- Supporting early discharge from hospital and investment in technology to enable health and care support to promote self management and independence.
- Additional investment to support integrated teams (across adult social care and community health) and joint commissioning
- Additional investment in Home Care - Increased capacity to support timely discharge from hospital

The additional investment should support the delivery of the high impact change areas - national condition 4 - and will be monitored as part of the BCF metrics. In addition to having an impact on delayed transfer of care - we anticipate additional output as follows:

- Reduction in emergency service use, and hospital admissions.
- Less volume and cost of emergency admissions to secondary care and emergency bed days.

8. Overview of funding contributions

Funding contributions for the 2017/19 BCF Plan has been agreed in line with national guidance and are set out in the Planning Template.

8.1 Financial Risk Sharing and Contingency

The total BCF Pooled Fund is £22.896M for 2017/18 and £24.312M for 2018/19. Appendix 2 (a&b) shows the sum of expenditure against Scheme Types for 2017/18 and 2018/19 respectively.

8.2 Risk Share

Our Plan is focused on Integration and the improvements in quality of life for people with long term conditions and older people with frailty. For each of our schemes we will measure the impact on non elective activity. Our BCF Plan continues to build on current programmes to focus care out of hospitals.

As a system we recognise that failure to meet the BCF targets will have an impact on the quality of life and experience of our population, when they need to make use of health and care services. This failure would lead to an increasing reliance on use of institutional care and non-elective admission. In addition, failure to increase use and effectiveness of Reablement and Intermediate services could impact on the recovery and ability to regain important life skills following an episode of ill health.

Key performance and quality outcomes have been agreed with providers as part of the local CQUIN targets. Both the Council and the Clinical Commissioning Group have a clear understanding of the challenges of reducing non-elective admissions and are in a better position to manage the trend currently being experienced.

The Central Bedfordshire Transformation Board provides the leadership for addressing system-wide issues. As an emerging Accountable Care System, our BCF Plan and schemes are strongly focused on reducing pressure on the acute hospitals and securing capacity for out of hospital services. The Transformation Board, which includes all our key providers, will monitor performance against the plan and take action to mitigate any emerging issues.

Consequently, whilst a formal risk share agreement is not deemed necessary at this stage, our expenditure proposals do contain a contingency element which will be used to address any emerging issues across the programme.

8.3 Risk log

Overall Integration and BCF Plan risks are described.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**	**Risk Owner**
Finance. As a result of the current financial position of the CCG and its immediate focus on financial recovery, there is a risk that resources and pressure of other competing priorities will negatively impact on delivery of the integration agenda.	4	4	16	1. Systems Leadership 2. Transparency and partnership working 3. Wider STP Priorities for delivery as a Accountable Care System 4. Clear alignment of funding for delivery of BCF projects 5. Alignment with Out of Hospital Strategy implementation and STP's Collaborative Investment and Savings Programme 6. Robust performance framework to ensure monitoring of performance and prompt action to mitigate under performance including discontinuing those not realising expected benefits.	Central Bedfordshire Transformation Board
Due to the increased complexity and demand for services on adult social care there is a risk that the market is not sufficiently robust to meet demand.	4	4	16	1. Development of a Market Position Statement 2. Financial incentives have been included in recently re-let Home Care Framework to support timely discharge from hospital 3. Focus on early intervention and prevention to moderate progression to severe need.	Central Bedfordshire Council

				4. Robust monitoring of performance and continuous revision of care packages 5. Development of more integrated approaches within the care market 6. Acceleration of integrated and joint working across all agencies. 7. Greater involvement of the Voluntary sector	
DTOC Both the council and CCG are under increasing financial pressures and have been advised that should delayed transfers of care targets not be met, this may potentially result in a reduction of iBCF funding allocation for 2018/19, adding additional financial pressure within the system	3	4	12	1. Partners continue to work together to develop and implement a number of system changes and specific projects to assist in achieving DToC reductions. 2. A local tracker has been developed for patients in all 7 hospitals discharging into CB to maintain overview of performance and early notice of issues. 3. Self assessment against High Impact Change Model and draft implementation Plan produced.	Central Bedfordshire Transformation Board A&E Delivery Board
NEL/Capacity There is a risk that demand for crisis services residential/hospital will not reduce because of insufficient capacity of community and primary services and non elective activity will not be contained within the agreed target.	3	4	12	1. New models of care being introduced to enable a more proactive, multidisciplinary approach to patient management. 2. Re-commissioning community services contract based on delivery of outcomes with focus on transformation, prevention and admissions avoidance 3. Working with Health Education England to recruit more GPs. 4. Implementation of primary care home model. 5. Engagement and partnership working with Care Homes on complex care management. 6. Implementation of the framework for Enhanced Care in Care Homes.	Central Bedfordshire Transformation Board
Reputational Risk	3	4	12	1. Appropriate governance and system leadership structures in place with provision of regular,	Central Bedfordshire Transformation Board

Reputational risk to all partner organisations in the event of failure to meet statutory duties occurs.				timely and accurate information to support monitoring of services ongoing. 2. The BCF Plan development has involved all our key providers, including Private, Voluntary and Independent (PVI) sector who have signed up to the plan.	
Workforce There is a risk that the current workforce capacity is insufficient to meet the new models of care, particularly in relation to Home Care in the Domiciliary Care Market.	4	4	16	1. Council awarded fee increase to mitigate impact of National Living Wage increases and moved from 4 to 6 zones to reduce travelling for care staff 2. Developing career pathways for Carers to make caring an attractive profession. 3. Development of the Super Carer roles 4. Progression through the Apprenticeship Framework	Central Bedfordshire Council
Implementation There is a risk that implementation may not proceed at the required pace due to the complexity and number of initiatives in progress through, STP, BCF, iBCF, Out of hospital strategy	3	3	9	1. Robust reporting and performance management framework overseen by the STP Place Based Transformation Board accountable to Health and Wellbeing Board. 2. A Central Bedfordshire Transformation Programme has been established to bring cohesion and alignment across all the key delivery areas.	Central Bedfordshire Transformation Board
Prevention and Early Intervention 2017/19					
Fracture Liaison S service for south Bedfordshire requires joint working with LCCG; if they do not wish to pursue this model it will cause inequity of access for residents	3	3	9	1. Continued engagement with colleagues at LCCG by BCCG commissioners. 2. Potential merger of acute trusts enables exploration of outreach service from BHT	BCCG

Delivering Integrated and Improved Outcomes through Out of Hospital Services:					
Availability and capacity of workforce resource across health and social care addressing the issue of capacity to make the required shift	4	4	16	1. CCG commitment to out of hospital services and multidisciplinary approaches 2. Engagement in procurement process and definition of expectations in service specification.	Central Bedfordshire Transformation Board
Integrated Health and Care Hubs 2017-19					
• Ability to assure affordability to local system through high quality cost-benefit analysis within business cases • Appropriate design and scale of buildings • The requirement for a separate options appraisal by NHS Property Services will delay progress and subsequent timely delivery of the IHCH (Ivel Valley) • The description of the S106 for HRN1 stating "the developer is required to secure approval of a healthcare facility marketing	3	4	12	3. STP Strategic Estates Group has been established. 4. Oversight of Hub development in Central Bedfordshire by a Director level Hub Steering Group. 5. Central Bedfordshire Council commitment to support Hub development with Council assets/resources 6. One Public Estate Funding and support for Hub Development in Central Bedfordshire 7. Business cases being developed alongside STP-wide activity modelling and actuarial analysis. 8. Accommodation schedules and designs for Hubs developed in partnership with providers. 9. Continuing to engage with NHSPS and plan to escalate as appropriate. Explore opportunity to influence through the One Public Estate vision. 10. Opportunity to revisit and amend the legal obligations on HRN1 – due to other discussions going on around Education requirements.	Central Bedfordshire Transformation Board

strategy prior to 200 homes being occupied" could constrain wider strategic plans for health and care provision in Houghton Regis. • The lack of legal obligations for healthcare in HRN2 limits potential funding opportunities to provide infrastructure for this new development (Houghton Regis) • S106 funds may be withheld due to lack of delivery of the project. (Leighton Buzzard and West Mid Beds)				11. Planning colleagues would welcome a steer to retrofit/rework the requirement to secure funding instead of the "community facility". 12. Review of S106 funds and conditions associated with them to be established and ensure time critical resources are committed to the Hub development.	
Enhanced Care in Care Homes 2017/19					
• Lack of care home sign up to the initiatives • Digitisation agenda will not progress with sufficient pace • Lack of geriatricians to provide community based support	3	3	9	1. Working with Bedfordshire Care Association to extend their membership and develop the initiatives with their core members 2. Enhanced partnership working and co-production with Care Home Providers. 3. Working on local solutions in the first instance, such as Wi-Fi coverage for care homes , as a staged approach to digitisation 4. Complex care offer to care homes will be multi-disciplinary and therefore not solely dependent on the recruitment of geriatricians	Central Bedfordshire Transformation Board

High impact change model – managing transfers of care between hospital and home					
• Securing funding for primary care home model • Availability and capacity of workforce resource across health and social care • Stakeholder buy in.	4	4	16	1. As an Accountable Care System, Central Bedfordshire is part of the communities of practice to implement the Primary Care Home Model with access to some transformation resources to support implementation 2. Strong stakeholder engagement. Provider Alliance established. 3. Partnership and co-production of solutions with Providers.	Central Bedfordshire Transformation Board

9. The National Conditions

9.1 National Condition 1 - Plans to be Jointly Agreed

This BCF Plan builds on previous two years and aligns with our STP priorities; the CCG's commissioning intentions, the targeted reductions in non-elective admissions for A&E Boards and delayed transfers of care. The Health and Wellbeing Board has overall responsibility for both operational and financial delivery of the Better Care Fund, totalling £22.896m in 2017/18 and £24.312m in 2018/19 and will maintain oversight of the outcomes. In addition the CCG and the Council through existing, robust governance mechanisms will ensure there is appropriate oversight and decision making.

The Central Bedfordshire BCF Plan has been jointly agreed. All key partners are represented on the Health and Wellbeing Board and both the CCG and the Council are agreed on our BCF Plan. The Central Bedfordshire Transformation Board, which includes Acute Hospital Providers, will oversee operational delivery of the BCF Plan on behalf of the Health and Wellbeing Board, monitoring progress and reporting to the Health and Wellbeing Board. Local care providers recognise the challenges and target requirements for reducing non-elective admissions and delayed transfers of care. A key goal of the STP' Priority 2 is to ensuring that people are able to access appropriate urgent care services, reducing reliance on A&E and avoidable unplanned admissions are priorities in our GP Forward View.

The vision for integration and priorities set out in our BCF Plan has been shared widely with partners, including local care providers in both the voluntary and private sector. We held specific engagement with Care Providers on our plans for the IBCF. We will continue engagement with key stakeholders and partners, using existing forums, such as our Older People's Network as the projects are mobilised. There is also ongoing engagement through Healthwatch, as a member of the Health and Wellbeing Board, and systematically through service development initiatives.

9.1.1 Disabled Facilities Grant

Central Bedfordshire is a unitary council and has responsibility for disbursement of DFGs. DFGs will continue to be used, in conjunction with the Council's housing assistance policy, to secure early discharge from hospitals and reduce non-elective admissions. The focus of the DFG capital grant will be on expanding the use of Assistive technology to promote independence, self management and continue to reduce reliance on institutional forms of care.

9.2 National condition 2 - Maintenance of Social Care Services

Our BCF Plan reiterates the interdependence of health and social care in avoiding unnecessary hospital admissions, facilitating earlier discharges from hospital and avoiding institutional care for frail older people. We are committed to protect those services that enable people to have the best outcomes and spend the least time, if any, in acute/institutional care. With the increasing demand for services, it is important to continue to develop effective solutions for the provision of timely care and support to adults and older people. This is particularly relevant given the increasing complexity of need and an ageing population.

The Council has continued to protect social care services through a succession of efficiency programmes and overspend of £0.6M in 2016/17. The Council recognised the pressure on the social care budget around increasing numbers; complexity and pressure on the care market, as well as an on-going over spend and agreed increased funding of £6.6M set against efficiency targets of £2.5M for 2017/18. A decision was also made by the Council Executive to increase the social care precept to 3% for 2017/18 and 2018/19 - £1.3M and £1.4M respectively. Additional resources through the IBCF will be used to 'transform' the health and social care system and reduce delayed transfers of care.

An amount of £5.145m and £5.243m has been assigned out of the CCG minimum allocation for the protection of adult social care services for 2017/18 and 2018/19 respectively. This level of spend is an increase on 2016/17 allocation and meets the requirement of the national condition. A total allocation of £11.3m and £12.5m has been allocated to support adult social care services, which includes a further sum of £5.5m and £6.5m from the Council, for the two years of the plan. This allocation will mitigate the demographic pressures of an increasing ageing population and greater complexity of need, particularly in the frail elderly; and for people with learning disabilities.

The Social care allocation will support a range of services, including step up/step down provision, equipment, telecare, integrated hospital social work teams and care packages where residential care admissions are directly from hospital or respite. Services will focus on reducing delayed transfers of care, and delivering timely and integrated care packages, including domiciliary care. Pathways for coordinated discharge from hospital will ensure that people leave hospital with support to maximise their independence back in their own home. This will continue through reablement, Disabled Facilities Grants/Minor works, targeted provision of community equipment, community alarms, and other telecare solutions, as well as investment in support to local communities to increase social capacity, such as, good neighbour/village care schemes.

Central Bedfordshire Council's eligibility criteria remains set at moderate. This ensures timely care and support to more people and is consistent with the local priority on prevention and early intervention.

9.2.1 Embedding the Care Act

Timely access to reablement services is a key duty of the Care Act and a sum of £604,990 for 2017/18 and £611,040 for 2018/19 has been allocated for Care Act duties. Requirements of the Act include provision of universal assessments for all those in need of care and for carers. The provision of enhanced information and advice, signposting, and promotion of wellbeing and independence is central to our approach as well as a focus on identifying and supporting carers. Our approach to implementing the Care Act was set out in the 2015/16 Plan. Central Bedfordshire residents continue to receive up to six weeks reablement services with access to aids and adaptations to promote independence and help sustain people at home.

9.2.2 Provision of Carer-specific support

The value of the fund directly allocated to Carer Support is £537,585 in 2017/18 and £545,319 in 2018/19. Carers will also benefit from a wide range of investments through the fund activities, including support for people caring for Dementia sufferers.

9.3 National Condition 3 Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

The vision for Central Bedfordshire is for a whole system, person-centred and outcome focused community service which provides care closer to home, reduces reliance on hospital based care and ensures that people have access to good quality, safe, locally delivered health care services including primary care and health and social care across both towns and rural areas.

An out of Hospital Strategy is being developed. It will set out the framework for delivery against the vision set out in BCF Plan and our STP's Priority on Primary, Community and Social Care. These are also a constituent part of the service specification for Community Health Services which has been discussed in dialogue with bidders. We are progressing with a programme of transformational change that focuses an out of hospital strategy around the needs of people with long term conditions and delivers a journey to integration of health and social care services

Investment in NHS Commissioned out of hospital services will increase over the two years of the BCF Plan. As this Plan continues to build on the previous years, all key projects mobilised by the BCF Plan will contribute to the overall ambition to reduce non-elective admissions, reduce delayed transfers of care and provide timely and proactive care for people with long term conditions and other vulnerable groups. We have made progress in realigning our community health and social care workforce to clusters.

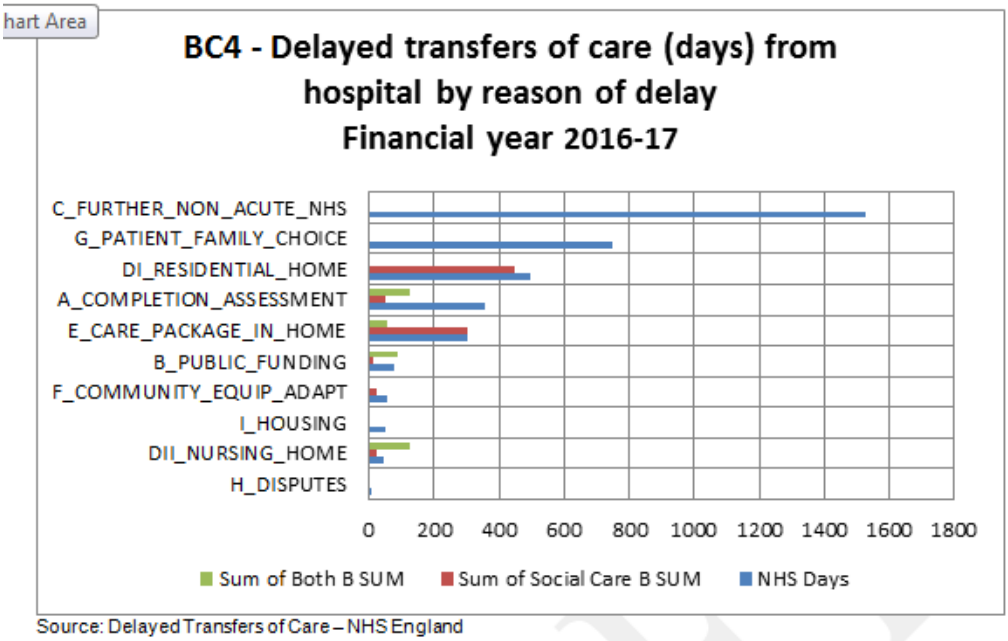
We are working closely with the A&E Boards and System resilience to ensure sufficient capacity is planned to cope with surges in demand for services.

As earlier stated reducing non elective admissions remains challenging and whilst we are investing in community based services, we have not set an additional target above the one set by the CCG in its Operating Plan. The key projects for out of hospital services are set out in the Planning Template. It is also a key Scheme for our Plan. Our overall approach to out of hospital services is also linked to High Impact Change model and Enhanced Care in Care Homes.

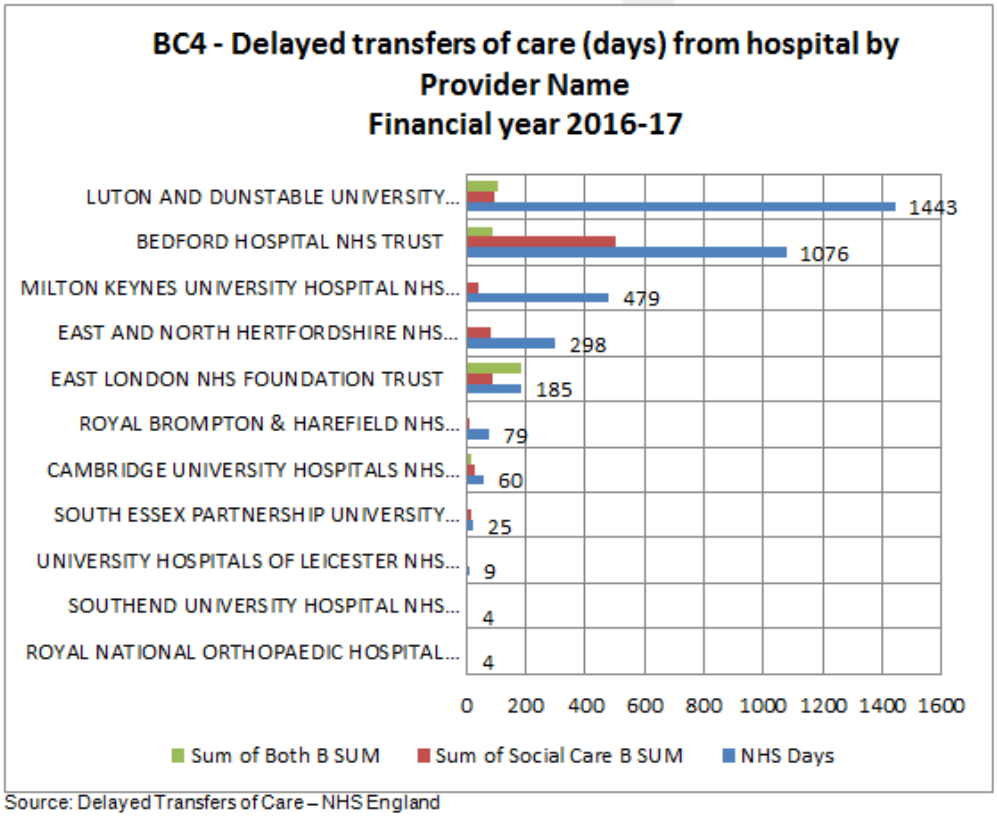
The Council is working with Care Providers to ensure capacity and stability in the Care Market, particularly in domiciliary care. We are also increasing capacity in community beds to facilitate early discharge from hospital.

9.4 National Condition 4: Managing Transfers of Care

Health and social care partners are committed to delivery of the 8 high impact change model. Delayed Transfers of Care are monitored through the two local A&E Delivery Boards at Bedford Hospital and the Luton and Dunstable Hospital; Central Bedfordshire is represented at these two boards. In addition there is engagement with other hospitals outside the area that care for Central Bedfordshire residents. Overall CBC saw an increase in DTOC days in 2016/17 with a downward trend for social care attributable delays. NHS attributable delays continue as the most significant challenge representing more than 70% of all DTOC days.



Source: Delayed Transfers of Care – NHS England



Source: Delayed Transfers of Care – NHS England

Key elements of the high impact changes sit within the integration transformation plan and within the A&E Delivery Board operational plan. In addition a Central Bedfordshire DTOC plan is in development and a Central Bedfordshire DTOC board involving all acute Trusts caring for Central Bedfordshire residents has been established to support delivery of this plan. We have undertaken a self assessment against the High Impact Change model and set out an action plan for delivery in key priority areas.

A draft copy of the High Impact Change Tracker is attached below for information. This tracker, although still in development in some areas, is also being updated as initiatives are mobilised.

CBC tracker for high impact change model

Some of the key actions are being funded through the IBCF and these are set out in the Planning Template Expenditure Tab. The following work will support delivery of the high impact change model.

9.4.1 Early Hospital Discharge Planning

We will work with all acute providers to ensure pre-admission elective pathways and protocols for setting non elective discharge dates within 48 hours of admission are in place. Additional social workers are being funded through IBCF to support timely discharge and recruitment to these posts is progressing well.

The capacity of the integrated discharge planning team at Bedford Hospital Trust is being expanded through CCG investment in additional discharge staff, hospital at home team and Geriatrician support; this will increase virtual ward capacity.

9.4.2 Monitoring Patient Flow

The discharge pathway for intermediate care and reablement will be streamlined and intermediate care will be accessed through a single point of contact at the Luton and Dunstable Hospital and Bedford Hospital. IBCF investment in additional social care and housing resources will support timely discharge from hospital. The local authority has designed a tracking tool that will monitor operational DToC and length of stay activity, support local and regional system escalation networks, and inform a monthly DToC system wide review process with partners and stakeholders.

The tracking process will be an integrated approach with the community services provider enabling a whole system approach to managing hospital and community service discharge activity.

9.4.3 Multi-disciplinary Teams

An integrated Central Bedfordshire Heath and Social Care Discharge Service will be established through IBCF investment in community discharge officers. In addition to this, the Integrated Discharge teams will work closely with the locality place based multidisciplinary teams which includes Housing officers. The multidisciplinary approach is being rolled out across Central Bedfordshire localities.

9.4.4 Home first / Discharge to Assess

A discharge to assess/ Home First model is in development. This requires additional investment to manage transfers of care between hospital and home and provide care outside of hospital.

The new model aims to provide additional Community Geriatricians, ECP/Paramedics, Community Matrons and Community Matron Assistants, Physiotherapists, Occupational Therapists and Pharmacists. The iBCF funding is being used to support additional social workers, single trusted assessors, Care Navigators and recovery beds.

9.4.5 Work towards a 7 Day Service

The aim is to improve 7 day access to community providers including domiciliary care and care homes. Introducing trusted assessors and ensure hospital services critical to discharge are available 7 days.

9.4.6 Trusted Assessors

The Trusted Assessor role for Central Bedfordshire is being defined with wide engagement with Care providers. Local Care Providers have been engaged and will be establishing a Trusted Assessor model based on the Hertfordshire Vanguard. In addition to this, we are working to develop a single assessment tool within the multidisciplinary framework for health and social care professionals to deliver a trusted assessor approach. A single assessment framework for CBC care homes will be established.

9.4.7 Focus on Choice

Work will be undertaken to get a better understanding of the discharge delays due to patient choice and the changes required to address this. A cultural change to 'Home First' will be fostered. IBCF investment in the voluntary sector will be used to support patient choice.

9.4.8 Enhancing health in care homes

A programme of work is being undertaken to support the delivery of enhanced care in care homes:

- Commissioning the complex care team (CCT) to provide enhanced nursing and pharmacy support to care homes in Ivel Valley and Leighton Buzzard localities. CCT may also act as trusted assessor.
- Increasing the BCCG pharmacist support for medication reviews
- Commissioning Community Geriatricians that will work with GPs to provide support to care homes
- Implementing the red bag initiative
- Involvement in STP digitisation workstreams
- Improving the training offer to care homes
- Community services provider to support care homes where appropriate, service specifications have been updated.
- Wellbeing programmes in Care Homes – OOMPH (Our Organisation Makes People Happy)

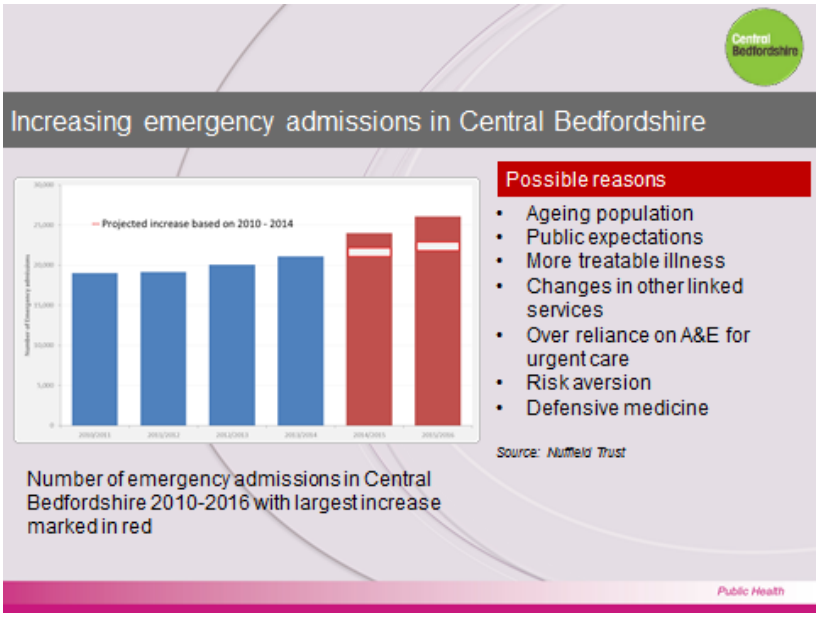
In addition the Council will continue to use DFGs, in conjunction with the Housing Assistance Policy, to support early discharge from hospital and help to promote independence by ensuring people can remain at home and in their communities thus reducing reliance on instructional forms of care. (e.g. residential and nursing homes) Timescales for implementation for new areas of work are set out in the Appendix 1e.

10 BCF Metrics and Performance Framework

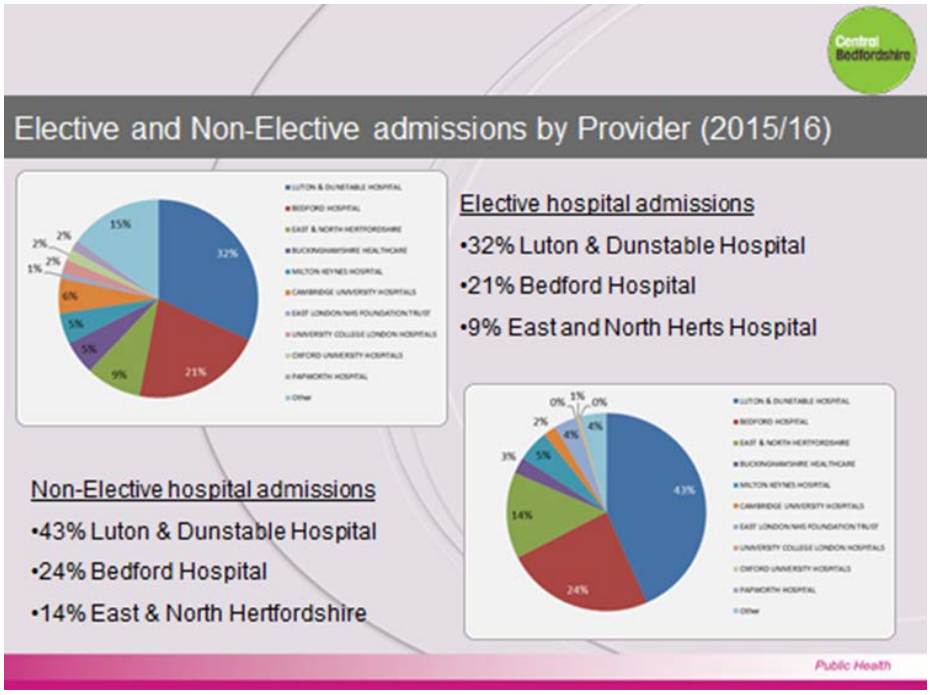
Delivery against the BCF national metrics remains challenging. A description of the targets for 2017/19 and the rationale and key drivers are set out below and in appendix 3.

10.1 Non Elective Admissions

The Central Bedfordshire non elective admissions plan for 2017/18 and 2018/19 is aligned with the Bedfordshire CCG plan and the A&E Delivery Boards. At a CCG level there is an overall increase of 1.7% each year based on the baseline of 2016/17 outturn. This is a challenging target given the year on year growth in non elective admissions over the last four years. The reasons for this are multifactorial including a growing and ageing population, increase in the number of patients with complex multiple morbidities and an over reliance on urgent care.

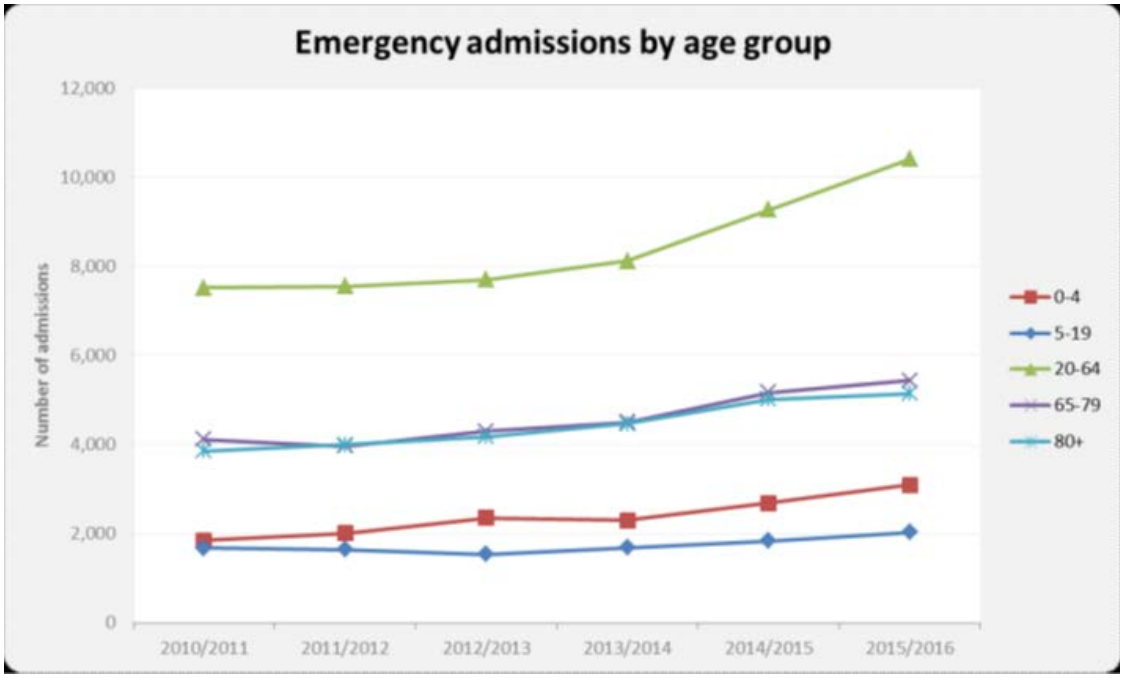


The largest proportion of emergency admissions for central Bedfordshire occur at the Luton and Dunstable Hospital (43%) followed by Bedford (24%) and East and North Hertfordshire Trust (14%).



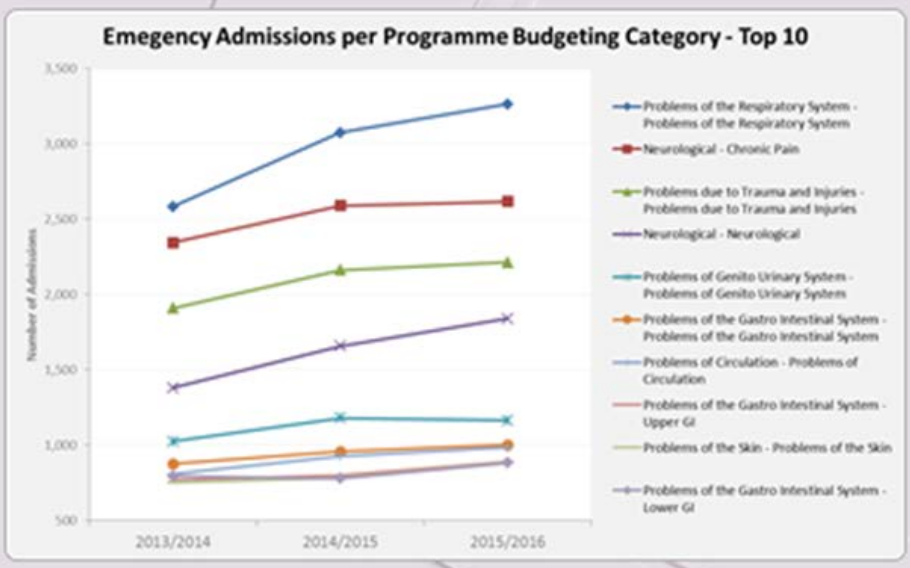
A review of non elective admissions for Central Bedfordshire has been updated and work has begun in areas with higher rates of emergency admissions with a focus around proactively managing people with long term conditions. A risk stratification model is being used to support the work of multidisciplinary teams as part of the Caring Together project and this is being extended to other locality based multidisciplinary teams. Investment in community capacity to support the primary care home model will enable a greater focus on early intervention and a proactive preventative approach to managing people in the community.

Discussion of the pressures on emergency care within the NHS tends to focus predominantly on older people. This is understandable as the over 65s account for the majority of emergency bed days in NHS hospitals, stay longer in A&E than the rest of the population and are more likely to be admitted to hospital in an emergency. However, local data below shows that children and young people admissions have increased and admissions for adults aged 20-64 years are increasing at the fastest rate.



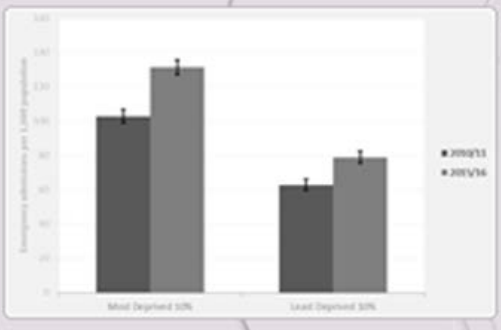
There is a strong positive relationship between rates of emergency admission and level of socio-economic deprivation, with rates of admissions in more deprived areas of central Bedfordshire increasing at a faster rate. Problems of the respiratory system account for the highest number of emergency admissions across all age groups. The graphs below show the reasons for admission and impact of socio-economic deprivation on emergency admission rates.

What is causing the emergency admissions?

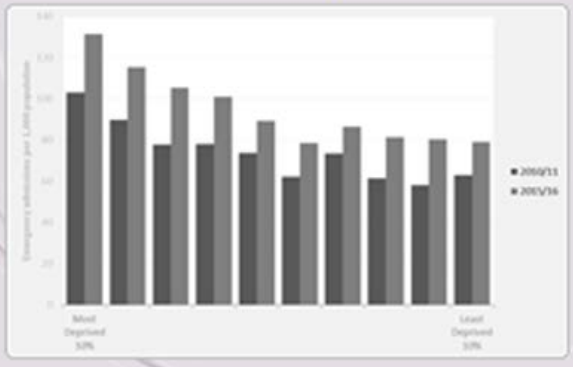


Public Health

Importance of socio-economic deprivation



Strong positive relationship between rate of emergency admission and level of relative socio-economic deprivation



Rate of emergency admissions is **nearly double** in those from most deprived areas, than those from most affluent areas of Central Bedfordshire

Public Health

10.2 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

In 2016/17 the use of residential care reduced and the BCF target was achieved based on local data collection. In 2017/18 & 2018/19 national SALT data will replace the local data collection. The automated SALT return is more accurate and has established higher levels of admissions than previously reported. As a consequence target rates for 2017/18 and 2018/19 show an increased rate of admission on previous years. The targets for 2017/18 are based on quarter one of the 2017/18 SALT data with a 3% increase for population growth.

The year on year 3% expected population growth for Central Bedfordshire is based on the BCF Planning template which indicates the 3% increase. For 2017/18 the Planning Template shows a 65+ population of 49,757 and 2018/18 is shown as 51,124. This clarifies the requirement to demonstrate the figures relied on and impact on forecasts. New SALT admissions for Quarter 1 2017/18 were 61 admissions. Full year projection equates to 244. This figure of 244 is inflated by the anticipated population growth of 3% which results in a projected outturn of 251 for 2017/18, and again 3% of 2017/18 which equates to 259 admissions for 2018/19. These are further broken down into monthly outturn which is a reporting requirement for Central Bedfordshire monitoring purposes.

Packages of care are scrutinised through a panel process to ensure that all alternatives have been explored and that the focus remains on helping people to remain in their own homes. Work is ongoing to improve hospital discharge coordination and reduce reliance on residential care. This will be supported through additional social work capacity and voluntary sector funding through the iBCF. Crisis prevention plans with carers are also being put in place. The Council's development of more independent living (extra care) accommodation will help to mitigate admissions into residential care.

10.3 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

In 2015/16 and 2016/17 this measure was reported using data from the Council's reablement service (a third of the cohort) and didn't include outcomes data in relation to rehabilitation/intermediate care provided through Community Health Services. Central Bedfordshire Council's performance is above the national average.

The 2017/18 target is set at maintaining performance greater than 90%. A method of reporting from the community provider has been established and is being validated; a combined measure will be monitored in 2017/18 with the aim of revising the target for 2018/19.

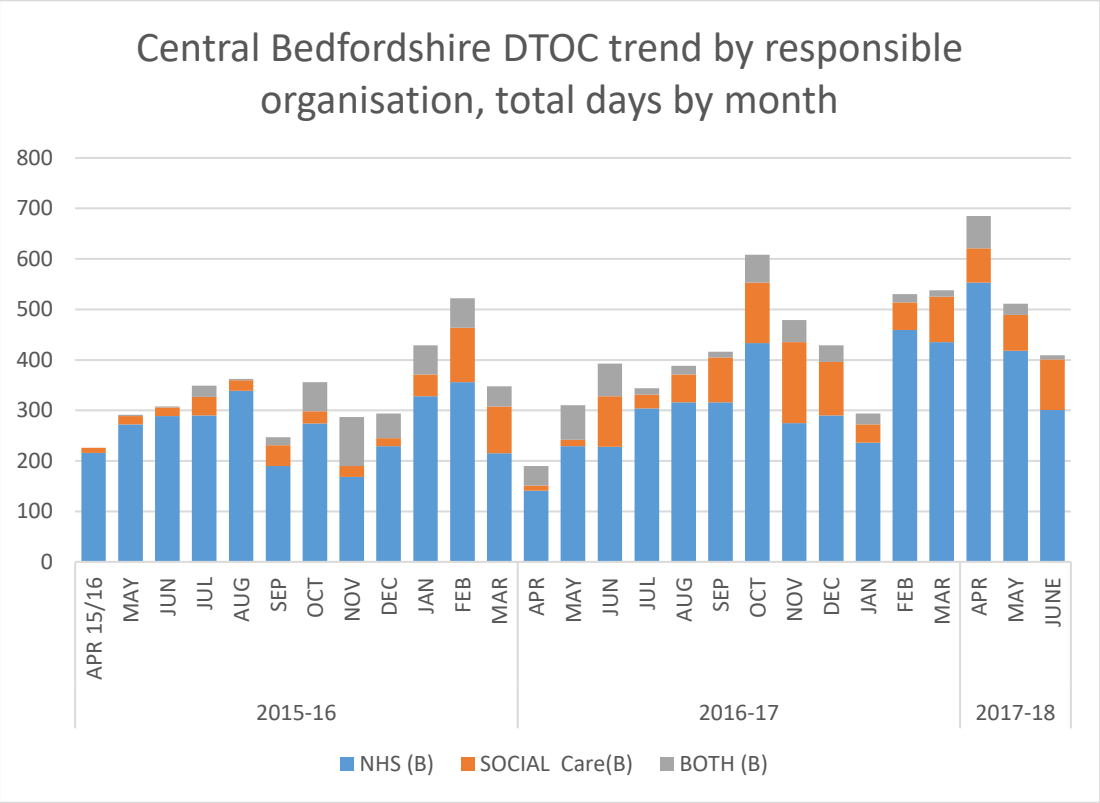
Local Authority reablement figures will be combined with Community Health Services data (EPUT). This requires validation to ensure the appropriate definitions are being used. It is unclear at present what impact the combined data will have on the overall performance of this metric; as such the target has been revised down to 90%. This is a cautionary approach and we would aim to increase the target during the life of this 2 year plan. The 90% target set remains higher than the national and regional averages.

The development of the primary care home model with locality based multidisciplinary teams will support maximising independence and admissions avoidance. In addition social

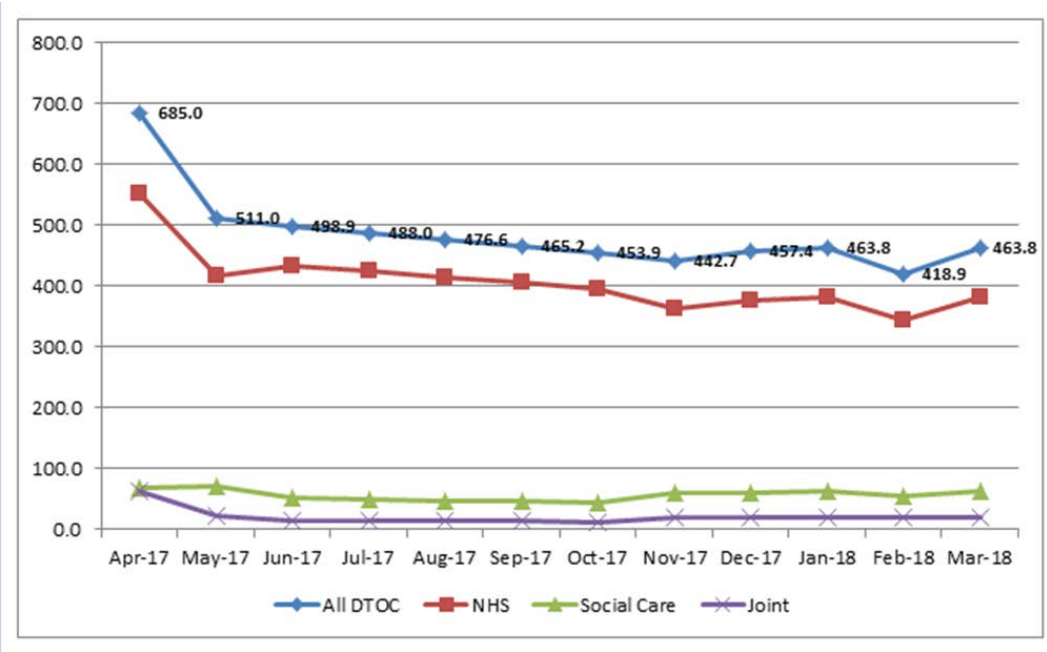
care and the community providers are working together to provide an integrated discharge pathway including a single point of assessment for, and offer of, rehab and reablement.

10.4 Delayed transfers of care (delayed days) from hospital per 100,000 population

Overall for 2016/17 Central Bedfordshire experienced an increase in delayed transfers of care (DTOC). NHS attributable delays represent more than 70% of total delays with further non acute NHS care and patient choice being the key reasons for this. Plans are in place to address these issues including, an increase in community bed capacity for recovery and rehabilitation, implementation of a discharge to assess model, funding for an increase in voluntary sector support on patient choice and foster a 'Home First' culture. Central Bedfordshire has several hospitals which discharge patients into the area, none of which are within its boundaries. There has been iBCF investment in additional social workers to improve the discharge pathway across all hospitals used by central Bedfordshire residents.



Expectations for reductions in daily delays on a local authority footprint have been set out. These include expectations for total, NHS and social care attributable delays. The local DTOC target reduction for 2017/18 is based on achieving the CBC contribution to the national target of no more than 3.5% of bed days being attributable to DTOC. For 2018-19 a 3.5% reduction has been applied to DTOC. **A revised DTOC Planning template has been submitted for September to reflect the newly revised targets.** These figures are based on the population figures supplied in the BCF Planning Template. We appreciate the challenge of realising these targets within the given timeframe but will work as a system towards delivering the targets by end of year outturn. (See graph below)



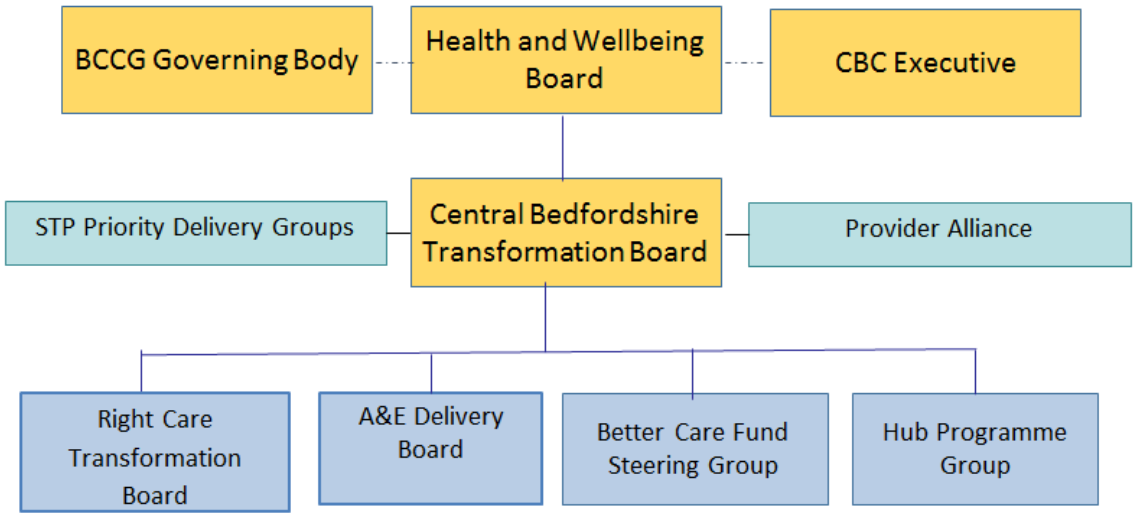
Performance will be monitored by a DTOC Board and through reporting to the Transformation Board and the Health and Wellbeing Board. Monthly monitoring reports are also circulated to the Council's Corporate Management Team, Political Leadership and the CCG's Governing Body.

The Better Care Fund Planning Template has been updated to reflect the revised DTOC trajectory template.

11 Governance and Joint Approach

The BCF plan and overall integration programme for Central Bedfordshire is overseen by the **Health and Wellbeing Board**. The HWB membership includes the executive members for Health, Social Care and Housing and the Chief Officers of the CCG and Council.

The overarching accountability and governance structure remains with the Health and Wellbeing Board in conjunction with the Place Based Transformation Board.



11.1 Management and oversight

A Central Bedfordshire Transformation Board will oversee the delivery of the BCF Plan on behalf of the Health and Wellbeing Board. The Transformation Board oversees the delivery of integrated outcomes for Central Bedfordshire's residents that are timely and make best use of available resources. It also provides local leadership and place based accountability for the delivery of the Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan priorities (STP). Membership includes senior representation from:

- BCCG
- Central Bedfordshire Council
- Mental Health services provider
- Community health services provider(s)
- Acute Hospital provider(s): Luton and Dunstable Hospital, Bedford Hospital, Lister Hospital, Milton Keynes Hospital
- Local Medical Council
- GP Locality representation
- HealthWatch Central Bedfordshire
- Representation from the Independent Care Sector

Our performance reporting framework has been updated to reflect the BCF targets and aligns equally to the Council and BCCG performance monitoring processes.

A programme management approach is in place, see appendix four. A BCF Delivery Programme Group will continue to provide operational oversight on the key projects and will reports progress on projects monthly to the Transformation Board. (Appendix 5) Our emphasis in devising these arrangements is to mainstream BCF governance to the greatest extent possible in order to achieve the maximum alignment of the programmes involved into existing change programmes.

Additional Documents

- BCF Planning Template
- BCF Narrative Plan 2017/19
- Appendices
    - *Appendix 1 – Boscards – Key Projects and Deliverables*
    - *Appendix 2 (a&b) - Financials against BCF National Conditions and Schemes*
    - *Appendix 3 – Performance Metrics*
    - *Appendix 4– High Level Programme Plan*
    - *Appendix 5 – Reporting Framework and changes for 2017/18*