The Central Bedfordshire Better Care Plan
Our approach to Better Care Fund Planning

Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group's Better Care Fund plan is based on accelerating our progress towards delivering the priorities and outcomes agreed by the Health and Wellbeing Board.

Central Bedfordshire Health and Wellbeing Board's overarching vision is well understood and will be further articulated in the refreshed Joint Health and Wellbeing Strategy. Our vision is to ensure that Central Bedfordshire is "a place where everyone can enjoy a healthy, safe, and fulfilling life" and that the area is "recognised for its outstanding and sustainable quality of life". The strategy makes clear that this will be achieved by "working in partnership with our communities and residents to improve the opportunities open to them to improve their health and wellbeing".

Our Better Care Fund plan sets out a shared vision for health and social care in Central Bedfordshire, rooted in a locality-based delivery model. It describes the agreed strategic approach based on four key priorities for delivering integrated care at scale and pace, and therefore achieving the key outcomes expected by the Health and Wellbeing Board and the people of Central Bedfordshire.

We recognise the challenges in delivering the Better Care Fund programme in the context of a rapidly growing and ageing population, located in a predominantly rural area across the catchment areas of seven acute hospitals – none of which is within the Central Bedfordshire Council area. The number of residents is set to increase from 255,000 to 287,000 by 2021. A particular challenge will be the increase of older residents, with the number of over 65s rising by 35% over this period, from 40,275 to 54,420, and the proportion of over-85s increasing by 53%, from 4,770 to 7,317. Our priorities are targeted at transforming our services jointly to contend with this increase in demand and complexity, as well as current pressures on our social care services through the Care Act. Our plan sets out the immediate actions we will take to deliver longer term sustainability in the system as a whole.

All of this works well because in Central Bedfordshire there are four existing and well-defined population centres based around the towns of Dunstable/Houghton Regis, Leighton Buzzard/Linslade, Ampthill/Flitwick, and Biggleswade/Sandy. These population centres form the basis of well established localities (Chiltern Vale, Leighton Buzzard, West Mid Beds and Ivel Valley) that are to be the focus of developments in health and social care. The Council's older peoples and disabilities services are coterminous with the localities and we have already established integrated health and social care locality arrangements in the Chiltern Vale area and plan to expand this approach across the locality and then the rest of Central Bedfordshire, with a

particular focus on improving outcomes for older people. Locality arrangements are central to responding to local demographic pressures and the increasing complexity of existing pathways within health and social care.

We will build on our existing locality structures to address each step of the care pathway, from prevention and early intervention right through to integrated pathways and support for people at home. In doing so, we will address multiple issues, including support for carers, intervening at the right point to maintain independence, physical health and mental wellbeing, and using housing options and equipment to ensure that we respond effectively to the increasing volumes and complexity of older people's conditions, such as dementia, heart disease, stroke, associated dependency, and social isolation.

The Better Care Fund will create a minimum pooled fund of £15.144m in 2015/16 to support the delivery of integrated care to which it is proposed that additional funding of £146k of CCG and £3.417m of Adult Social Care resource will be committed making a total of £18.707m. Consideration will be given to expanding this pooled resource particularly in the context of Continuing Health Care Funding.

In setting out the four priorities below, we recognise the importance of shifting resources from hospital settings to more community-focused care to deliver improved health and care experiences as well as more effective use of resources:

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 emerging statutory requirements on the Council.

The Better Care Fund Plan in Central Bedfordshire will be ambitious for its residents taking forward a shared approach which builds on work already completed including the Community Bed Review, Joint Health and Well-being Strategy, Integrated Care Pioneer bid, South Bedfordshire Demonstrator project and investment in Prevention Services. It is intended that this approach can be applied across all customer groups including children and young people.

The Better Care Plan will also be informed by the Review of Health Services in Bedfordshire and Milton Keynes. This review will also inform the future commissioning of community services in

the delivery of out of hospital care. Central Bedfordshire Council is actively contributing to the on-going review and has produced a position statement setting out its vision for health and care provision based on integrated locality based multidisciplinary approaches. A copy of this is attached to this submission for information.

The Central Bedfordshire Better Care Plan is supported with an action plan for delivering on the programmes of work identified and benefits modelling to ensure successful delivery of the vision. The benefits modelling takes account of:

- Demographic demand and increasing number of people requiring services through early intervention and prevention;
- The need for productivity and efficiency savings; and
- The impact on services of redesign and re-specification.

This work is underpinned by strong governance and accountability arrangements, exercised through a robust performance framework overseen by the Health and Wellbeing Board

Updated November 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

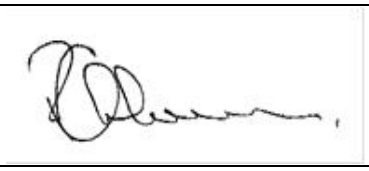
1) PLAN DETAILS

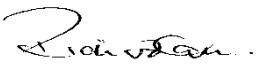
a) Summary of Plan

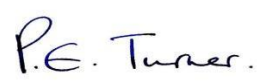
Local Authority	**Central Bedfordshire Council**
Clinical Commissioning Groups	Bedfordshire Clinical Commissioning Group
Boundary Differences	Bedfordshire CCG's boundaries are coterminous with Central Bedfordshire and Bedford Borough Councils. The focus of the

	BCF Plan is on Central Bedfordshire residents based on four localities. Patients who live outside Central Bedfordshire but registered with GP in Central Bedfordshire will be covered by the schemes proposed in the Plan.
Date agreed at Health and Well-Being Board:	15 September 2014
Date submitted:	19 September 2014
Minimum required value of BCF pooled budget: 2014/15	**£3.969m**
2015/16	**£13.954m**
Total agreed value of pooled budget: 2014/15	**£3.969m**
2015/16	**£18.707m**

Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Paul Hassan
Position	Accountable Officer / Chief Clinical Officer Bedfordshire Clinical Commissioning Group
Date	19 September 2014

Signed on behalf of the Council	
By	Richard Carr
Position	Chief Executive Central Bedfordshire Council
Date	19 September 2014

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Mrs Tricia Turner, MBE Central Bedfordshire Health and Wellbeing Board
Date	19 September 2014

b) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Joint Health and Wellbeing Strategy	The JHWS outlines our vision for improving health and wellbeing and reducing health inequalities in Central Bedfordshire. Informed by the JSNA, we have identified three cross-cutting priorities where we want to make progress fastest: • Improved outcomes for those who are vulnerable; • Early intervention and prevention; and • Improved mental health and wellbeing. These are underpinned by nine priority work programmes all of which have indicators to measure our progress. http://www.centralbedfordshire.gov.uk/modgov/documents/s39990/CBC%20HWB%20Strategy%20Final.pdf
Central Bedfordshire Joint Strategic Assessment (JSNA)	The JSNA brings together what we know about the health and wellbeing of the people living in Central Bedfordshire. http://www.centralbedfordshire.gov.uk/health-and-social-care/jsna/default.aspx Executive Summary – 2013 http://www.centralbedfordshire.gov.uk/Images/CB%20JSNA%20Summary%202014%20(2)_tcm6-58568.pdf#False
Bedfordshire Plan for Patients 2014-2016	https://www.bedfordshireccg.nhs.uk/page/?id=3591
Your Health in Central Bedfordshire	Our plans for the people of Central Bedfordshire 2014-16 https://www.bedfordshireccg.nhs.uk/page/downloadFile.php?id=12834
Strategic Plan Bedfordshire Health and Social Care System 2014-2019	System planning has been undertaken in the context of the review of healthcare services in Bedfordshire and Milton Keynes. The review aims, process, current considerations and timescales are outlined within the plan. All options under discussion as part of the review are

	subject to an ongoing formal public consultation. The plan reflects the foundation of sustainable change that is influencing our Better Care Fund Plan. https://www.bedfordshireccg.nhs.uk/page/downloadFile.php?id=13057
The future of health services in Bedfordshire. A case for change	A case for change (published on 8 April 2014) is the midway report from the review of healthcare services in Bedfordshire and Milton Keynes. It sets out in detail the challenges facing our local NHS services and the opportunities available to us. http://www.yourhealthinbedfordshire.co.uk/modules/downloads/download.php?file_name=37
Central Bedfordshire's Vision for Integrated Health and Social Care – Pioneer Bid	http://www.centralbedfordshire.gov.uk/modgov/documents/s44907/item%207%20EXPRESSIONS%20OF%20INTEREST%20FOR%20HEALTH%20AND%20SOCIAL%20CARE%20INTEGRATION%20appendix%201.pdf
Review of Community Bed Provision in Central Bedfordshire Recommendations for Improvement – January 2014	http://www.centralbedfordshire.gov.uk/modgov/documents/b5188/Item%2010%20Community%20Bed%20Review%20Monday%2010-Jun-2013%2010.00%20SOCIAL%20CARE%20HEALTH%20HOUSING%20OVERVIEW%20SC.pdf?T=9
Market Position Statement	The Market Position Statement brings together, in a single document, intelligence from the Joint Strategic Needs Analysis (JSNA), our commissioning strategies, and the preferences of different service user groups, including those who fund their own care, to help shape the future of the care and support market. It suggests some of the necessary changes and innovations required to design and deliver services in the future. Providers of adult social care and housing-related support services can learn about Council's intentions as a purchaser of services and its vision for how services might respond to the personalisation of adult social care and support. http://www.centralbedfordshire.gov.uk/Images/121213MarketPositionStatementweb_tcm6-37596.pdf#False
Improving Outcomes for Older People in Central Bedfordshire Joint Commissioning Strategy 2011 – 2014	This is Central Bedfordshire's first strategy for older people. The strategy addresses the care and support needs of older people and also reflects the views of older people locally. It outlines the main challenges, priorities, and commissioning intentions for health and care of older people in Central Bedfordshire over the next three years. It also sets out the intentions for joint commissioning and an integrated approach to the delivery of services for older people, focusing on establishing care and support priorities and opportunities

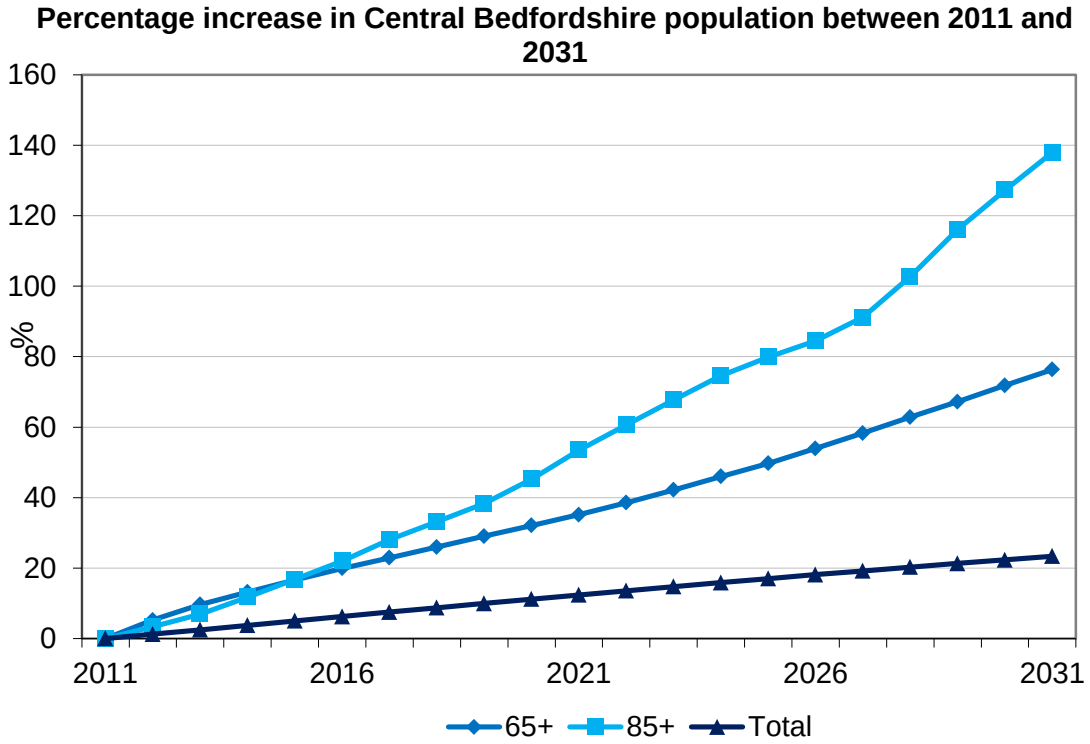
	for a more joined-up approach to achieving better service outcomes. http://www.centralbedfordshire.gov.uk/Images/OlderPeopleJointCommissioningStrategyv5%20-260112_tcm6-28420.pdf#False
Healthier Communities and Older People Partnership Board	The Healthier Communities and Older People Partnership Board brings together representatives from organisations across the area to help deliver the health and wellbeing agenda and improve quality of life. http://www.centralbedfordshire.gov.uk/health-and-social-care/adult-care/healthier-communities-older-people/hcop-board.aspx
Joint Strategic Approach to Prevention and Early Intervention across Central Bedfordshire	Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group believe that 'Prevention is never too early and never too late'. Our vision for prevention is one that promotes people's independence and wellbeing so they can live a full and healthy life. http://www.centralbedfordshire.gov.uk/health-and-social-care/prevention/prevention.aspx
Joint Commissioning Strategy for Mental Health Services for Adults & Older People in Central Bedfordshire 2011–2014	The aim is to commission services which promote good mental health and focus on achieving positive outcomes for the individuals who use them. We will fully engage with the Personalisation Agenda and support individuals to identify opportunities for their own care. http://www.centralbedfordshire.gov.uk/Images/27102011AmendedJointCommiStratrAdultsOPMHandWBSvcsinCB_tcm6-28423.pdf
Mental Health Strategic Objectives 2013-2016	This document sets out Bedfordshire Clinical Commissioning Group's (BCCG) strategic plans for improving mental health services over the next three years. https://www.bedfordshireccg.nhs.uk/page/downloadFile.php?id=12673
Draft Communications and Engagement Strategy 2013-2016	**https://www.bedfordshireccg.nhs.uk/page/downloadFile.php?id=11995**
Strategic review of health services in Bedfordshire and Milton Keynes Stakeholder and Communications Strategy	**http://www.yourhealthinbedfordshire.co.uk/modules/downloads/download.php?file_name=93**

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

The Joint Strategic Needs Assessment (JSNA) provides a comprehensive picture bringing together what we know about the health and wellbeing of the people living in Central Bedfordshire. Its key messages have been considered in shaping our whole systems response, more recently as part of the review of health care services in Bedfordshire and analysed alongside a range of pressures that currently challenge our local health care services. A full account of these challenges is described within the review midway report a Case for Change . This report sets out in detail the challenges facing our local NHS services, and the opportunities available to us. A higher level summary of the drivers for change include:

Demographic – Central Bedfordshire is an area of significant opportunity with planned housing and employment growth and is a desirable place to live. The population has risen to around 264,500 by 2013 and is expected to increase further to 287,300 by 2021 (an increase of 12.4% since 2011). Between 2011 and 2021 the 65+ population is predicted to increase by about 35%. The population aged over 85 years is projected to increase from 4,770 in 2011 to 7,317 in 2021, which equates to a 53% increase. This poses a significant challenge for our local health and care economy. There are significantly more births than deaths and net migration is also playing an important role in the rising population. People are living longer with corresponding increased requirements for health and social care. The number of people registered with Central Bedfordshire General Practices in early 2014 was 282,059. As the graph below shows, the overall population is expected to grow by over 23% between 2011 and 2031 compared to the number of older people aged 85 and over which will grow by 138% by 2031.



Breakdown of Population by Older Age Group

	2011	2016	2021	2026	2031	% change 2011-2031
65-69	12,682	15,603	14,495	16,870	19,531	54.0%
70-74	9,482	11,947	14,745	13,775	16,066	69.4%
75-79	7,841	8,493	10,808	13,418	12,628	61.1%
80-84	5,500	6,429	7,055	9,137	11,438	108.0%
85-89	3,196	3,757	4,585	5,125	6,820	113.4%
90+	1,574	2,062	2,732	3,674	4,529	187.7%
65+	40,275	48,291	54,420	61,999	71,012	76.3%
Total	255,644	271,640	287,288	301,977	315,329	23.3%

Increased life expectancy – Life expectancy is increasing and is better than the national average. In 2010/12 life expectancy was 80.5 years for men (79.5 in 2008/10) and 84 years for women (83.6 in 2008/10). Life expectancy is increasing at the rate of about 3.5 years for men and 2.5 years for women each decade. There is however a range of life expectancy within Central Bedfordshire, there is a statistically significant gap between the most deprived 20% and the least deprived 80% of the population. There has been a reduction in the life expectancy gap for both men and women in the most deprived areas (2010-12). Life expectancy is now 6.6 years lower for men (8.0 years in 2009-11) and 5.4 years lower for women (6.3 years in 2009-11) in the most deprived areas of Central Bedfordshire than in the least deprived.

A growing and ageing population means that there are increased numbers of people, with often multiple, long term conditions such as diabetes. Modern lifestyles e.g. obesity, smoking and alcohol misuse are placing an extra strain on the public sector, especially in socio-economically deprived areas and a growing level of inequality in life expectancy in deprived parts of the area create challenges which cannot be resolved by simply doing more of the same. Addressing the causes of premature death is essential to managing the pressures of increased life expectancy and the focus of self-care and ill health prevention.

Health inequalities are widening because life expectancy in the deprived 20% is static whereas it is improving year on year for 80% of the population. The biggest causes of death under 75 are cancer, heart disease and stroke. The Longer Lives analysis (June 2013) revealed that although the residents of Central Bedfordshire had lower rates of premature mortality (deaths under 75 years of age) compared with England, they were not as good as other relatively affluent areas.

More people are living longer and, importantly the demand for health and care services for older people is set to increase. There are several key factors which are central to an effective response to this challenge which is both affordable and protects individual dignity, independence and choice. Our case for an integrated care response is reinforced by the need to develop whole-system approach to meet the challenges for health and care services arising from an ageing population and increasing numbers of people with long-term conditions. The majority of our population live in rural settings clustered around market towns, with urban conurbations in Dunstable and Houghton Regis; Leighton Buzzard and Linslade. In some of the more deprived areas, over 30% of older people are living in poverty and over half live in rural settings. These

pressures combine and generate a commissioning landscape that is constantly evolving, buoyed by high levels of inward migration, a mixed picture of deprivation, the inaccessibility of some residents and communities because of their rurality, and variable quality in our housing stock. Associated with this increase in population, we have anticipated increasing demand for health and social care services.

The lack of an acute hospital within our boundaries means residents travel to seven hospitals in surrounding areas, resulting in care variations and challenges to effective provision of coordinated and integrated care before and after discharge from hospital. Much greater cooperation and integration is required between partner agencies to avoid duplication and to improve quality. There needs to be a shift in the balance of care from hospital to intermediate, community and home based care. National and local evidence indicates that significant benefits are gained when organisations work together to co-ordinate care both for individuals and for populations.

The wider determinants of health - There are a number of factors which will impact upon an individual's health and wellbeing such as their income, employment, education and the place in which they live. Therefore understanding the local position and what needs to be done is crucial to improving health and wellbeing across Central Bedfordshire. This is particularly important for those areas and populations that are more deprived. A recent review to assess the impact of the welfare reform on residents showed an impact on resident's lifestyles, eating habits and mental health, all attributable to increasing financial pressures. Possible increases to the already high rates of migration into the area, and increases in demand for smaller, cheaper housing, will also have an impact on demand for services.

Income deprivation affects 13% of older people in Central Bedfordshire, compared to 18% in England, although in some of the more deprived areas over 30% of older people are affected. Older people are also more likely to suffer from fuel poverty; with four areas in Central Bedfordshire in the worst 30% in England for fuel poverty. These include part of Cranfield (including the University), the area around Woburn, Southill and Old Warden, and Studham and Whipsnade. Fuel poverty tends to be more of an issue in rural areas, and those areas with high levels of private rented accommodation.

People's homes are an important factor in their health and well-being. Poor housing quality leads to a higher risk of accidents, as well as a greater likelihood of illness related to cold and issues such as damp, mould and poor hygiene. General "mould and cold" within damp homes in particular has been shown to increase the rates and severity of respiratory infections, asthma, allergic rhinitis and atopic dermatitis.

Key Health Indicators

Our Joint Strategic Needs Assessment provides a strong evidence base which underpins our vision. Although life expectancy in Central Bedfordshire is above the national average, as our population ages, 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. The prevalence of dementia across the UK is estimated at over 700,000 and predicted to reach 3,600 in Central Bedfordshire by 2020. Only one third of sufferers receive any form of formal diagnosis

at any point in their care or during the progression of the condition. Evidence suggests that early diagnosis and treatment is vital and can improve the quality of life for people and increase their independence as the condition progresses. More locality specific **health and social care indicators are set out in our locality profiles** ~~**http://www.centralbedfordshire.gov.uk/health-and-social-care/jsna/locality-profiles.aspx**~~http://www.centralbedfordshire.gov.uk/health-and-social-care/jsna/profiles/locality-profiles.aspx

Key factors that influence potential changes in demand for health and social care in people aged 65 and over living in Central Bedfordshire:

	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%

There are some significant cost implications; the direct costs of Alzheimer's disease alone exceed the total cost of stroke, cancer and heart disease. Around 40% of NHS and social care budgets are spent on people over the age of 65. Older people living alone or in residential/nursing care and those with physical illnesses and/or disabilities are more at risk. Symptoms of depression are present in 20–50% of these residents. The management of behavioural and psychological symptoms of dementia presents a major challenge in this population. Since 2010, the prevalence of depression in those over 65 in Central Bedfordshire is estimated to have risen by 15%. Furthermore, approximately one third of older people with drinking problems develop them in later life and it is estimated that 1 in 6 older men and 1 in 15 older women are likely to be drinking enough to harm themselves. Social isolation is a causal factor linked to depression and alcohol misuse; higher levels of social isolation are characteristic of rural communities such as for many in Central Bedfordshire. Failure to tackle alcohol misuse in older people may contribute to alcohol related admissions.

There is a need to reduce the burden of disease and disability by increasing the promotion of health and wellbeing and by strengthening early intervention and prevention. When health and wellbeing breaks down, there is a need to provide timely, treatment, care and support services in ways which are effective, personalised and empowering to the user, thereby maximising independence. It is also important to focus on those most in need to reduce inequalities in health.

Early intervention and prevention can deliver better outcomes for older people as well as generate significant savings. To improve the management of stroke and other long term conditions, services need to be organised to respond promptly, locally and in a coordinated way. At present there is insufficient range of community based options for management. As an older person moves from healthy older age to becoming more vulnerable and frail there are opportunities to help them retain their independence as long as possible. The challenge is to

identify people before they reach a point of crisis e.g. unplanned admission to hospital. Case management helps to identify people at high risk of admission and provide intensive support to reduce their need for admission to hospital or care homes. Admission often occurs because good quality, intermediate or community based care services are not available. These will be further developed and will also support timely and effective discharge from hospital.

There is a strong need to increase the efficiency and effectiveness of service provision through greater alignment and integration of care across agencies, developing new ways of working, avoiding duplication, promoting cross sector training as well as clarity on quality standards. People with urgent care needs should have access to services which are responsive, delivered out of hospital and as close to home as possible.

Our Joint Health and Wellbeing Strategy supports this vision and sets out a cohesive and cost effective approach to service delivery for older people, particularly in relation to urgent care treatment and the management of long term conditions. There is also strong and consistent evidence from local opinion which supports the importance of maintaining independence, choice and control over the services they receive. These are reflected in the Engagement section of our Plan.

Rising patient and public expectations – Patients and the public rightly have high expectations for the standards of care they receive – increasingly demanding access to the latest therapies, information and more involvement in decisions about their care. People want better access to health and social care services that are more personalised and responsive, less fragmented and confusing, and available 24 hours a day, 7 days a week.

Service User Feedback

During the past year and as part of the review of healthcare services, there has been comprehensive engagement activities with local people, clinicians, organisations, communities and a range of sectors to understand what high quality, sustainable services will need to look like to support care needs into the future. Care closer to home has featured as a significant priority within the engagement we have undertaken in relation to the strategic review of healthcare services in Bedfordshire and Milton Keynes.

A strong theme in the conversations with patients and the public has been their wish to stay healthy and independent for longer and, to that end, to have more care provided closer to where they live, organised around their lives and available at times that suit them. In their discussions, clinicians describe how closer working between primary, community-based and hospital care can enable more care to be provided to patients without the need for hospital visits or inpatient stays.

These feedback have influenced the focus for the BCF Plan, identifying what services could be delivered within the community and ensuring care closer to home becomes a reality. Two further themes that emerged consistently were; more services offered out of hospital and GP practices, community services and social care providing one joined-up service, enhanced by greater networking across the NHS. Further information on feedback from service users are set out in Section 8.

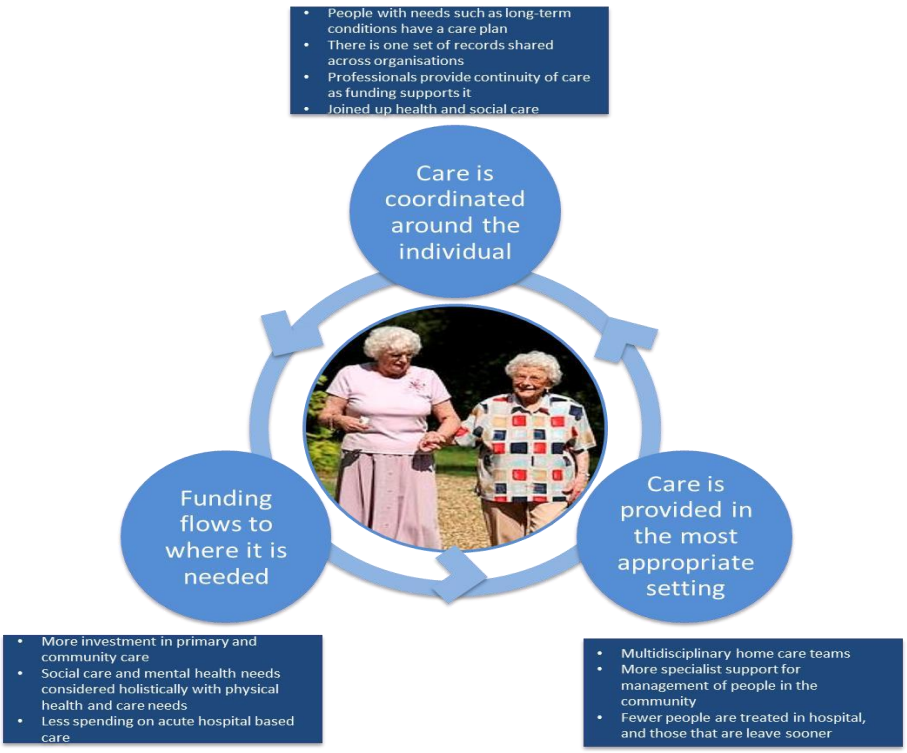
Vision for Health and Social Care Services

Our Better Care Plan is based on our overarching ambition to secure a fundamental shift in the ways in which care and support is provided to residents of Central Bedfordshire and sets out our shared vision and ambition for transformational change across health and social care rooted in a locality based delivery model. Our vision is for care to be coordinated around the full range of an individual's needs with prevention and support for maintaining and maximising independence remaining central.

We recognise the need to deliver these changes at some pace , underpinned by the following principles for integrated care with:

- Care coordinated around the individual;
- Care provided in the most appropriate setting; and
- Funding flowing to where it is needed.

These principles are reflected in the diagram below.



We wish to secure real transformational and step change to increase the quality and experience of care based on new care models through establishment of locality-based health and social care hubs offering improved outcomes and personalised support for individuals. This requires an integrated approach to deliver the right support in the right place at the right time. The challenges of our growing ageing population will increasingly put pressure on the health and

social care economy. Change will need to be delivered at pace and at scale to meet these emerging demands.

Responding to the needs of a growing and ageing population

Future Health and Care Model

Future health and care provision in Central Bedfordshire will be influenced, importantly, by the outcomes of the on-going strategic review of healthcare in Bedfordshire and Milton Keynes. The review was commissioned by Monitor and led by McKinsey in collaboration with Bedfordshire Clinical Commissioning Group, NHS England and the NHS Trust Development Authority (TDA). The system-wide review will consider the future shape of health and care services and provides a real opportunity for the Council, the Clinical Commissioning Group and other local partners, to establish high quality, sustainable care models that meet demographic pressures and local financial challenges. The review is expected to provide clear direction to move forward with plans to bring care closer to home, with a strong focus on preventative care to help people look after themselves better. The progress report, published on 29 October deals with many of the same challenges as described in the recently-published NHS 'Five Year Forward View'.

The progress report encourages local NHS organisations to bring more healthcare closer to people's homes. This will see health and social care across Central Bedfordshire, Bedford Borough and Milton Keynes come together in the community to deliver improvements in general practice, a broader range of services and more preventative care for the elderly and vulnerable.

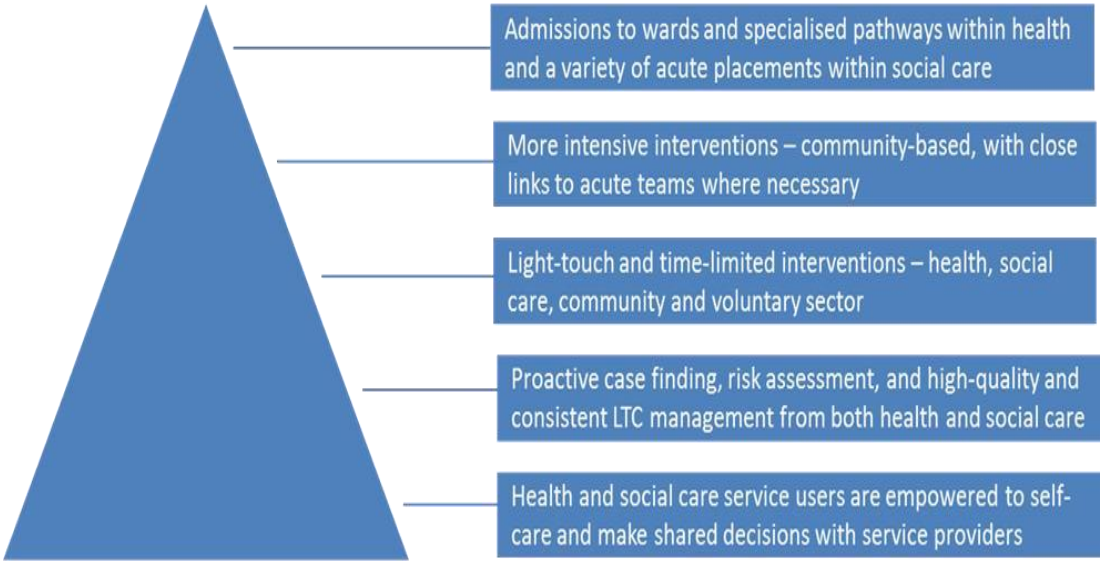
However, the scale of change implied by the review findings mean that further, more detailed work is needed to ensure proposed changes can deliver high quality, safe services that will be financially sustainable. Local health commissioners want to fully understand the impact of change on local residents and neighbouring hospitals. They will also need to ensure any changes link with centres for more specialised services that require high patient numbers to secure safe, high quality care, and therefore tend to be further away from local communities. The report recommends that NHS organisations carry out this work to shape proposals for change, to take to public consultation. It calls on them to continue working closely with Bedford and Milton Keynes hospitals, local authorities, clinicians and local residents.

The review is indicating a forward thinking, radical approach to localised integrated healthcare provision. The focus will be centred on the integration of health, social care, other council services and the community and voluntary sector to provide appropriate care and support at the right time and in the right place. This model is consistent with our local vision and ambition for the configuration and delivery of health and care services. It will provide locality based, early intervention and practical community and social care support that helps to reduce admissions and reliance on institutional forms of care. Our agreed model is population and risk focussed.

We developed the aims of our integrated care programme jointly in 2013. Engagement with our patients, users, carers, providers, and voluntary and community sector colleagues was a key part of this process. We recognise that in achieving our vision, the overall aims and objectives for our integrated care system (below) must also respond to demographic demands, increasing complexity of need, new requirements and changes in legislation such as the Care Act.

Consequently we aim to:

- Provide more proactive rather than reactive care;
- Develop care pathways focused on people rather than organisations;
- Apply local intelligence gathered from listening to the voice of our local communities;
- Co-produce the support for individuals and their families to remain independent;
- Work with individuals and communities to use public services effectively and thus manage their own independence and maintain their own health better;
- Improve outcomes by maximising independence and improving experience of health and care services ;
- Reduce the numbers of individuals admitted to hospital with urgent but sub-acute care needs, with a consequent reduction in capacity in acute services;
- Reduce the number of people in long-term residential care; and
- Improve the support provided to family carers.



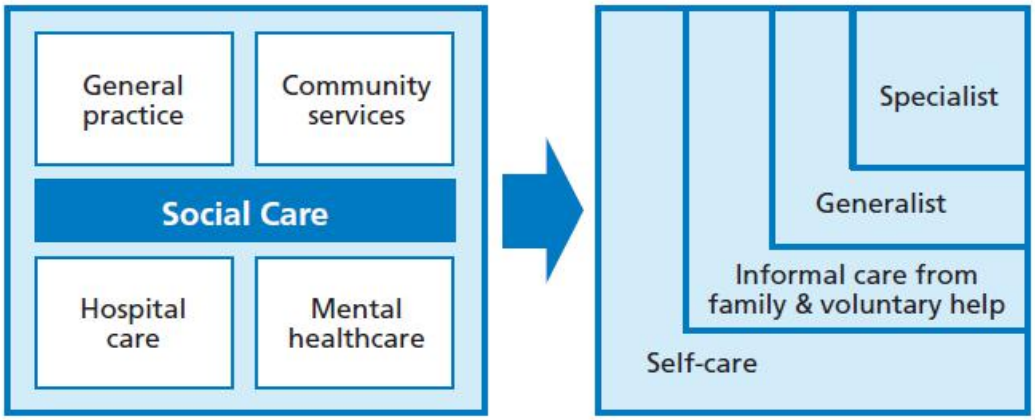
Delivering this vision for integrated care means overcoming barriers between primary and secondary care, physical and mental health, and health and social care. Our Better Care plan brings resources together to address immediate pressures on services and establish a foundation for a much more integrated system of health and care delivered at pace. Our agreed model of care is underpinned by a new delivery framework for joint working across partners and client groups to deliver the full continuum of health and social care support. This includes prevention and early intervention, self-management, reablement and independence. For mental health this will focus on closing the gap between access to physical and mental health services

b) What difference will this make to patient and service user outcomes?

Patient and Service User Outcomes

Our Better Care Plan will ensure that the discrete silos of current health and care provision are replaced with a 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. The focus of this would be to enable people to have healthier lifestyles and manage their long term conditions more effectively.

Unplanned emergency admissions would be avoided. Quality of life would be improved and people supported to live independently in their own homes for as long as possible. 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** delivered 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 primary, community and specialist teams and aligned to lifestyle Hubs
- Have access to 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.

Central Bedfordshire Council has signed up to **"Making it Real" Markers for change** and will be working across the health and care economy to secure the outcomes and values set out in the National Voices document. **Within the next five years, service will be coordinated and service users will 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"*

In advance of the national metric on patient experience, the GP Patient survey will be used to measure experience for "In last 6 months, patients had enough support from local services or organisations to help manage long-term health" and will form the reporting mechanism in Part 2. In addition and over the next five years as part of our sign up to "Making it Real; we will also use

the Adult Social Care Survey and the Carers Survey to measure patient and service user experience. The Schemes we have proposed for the Better Care Plan will deliver improved outcome and experience through a significant reduction in the number emergency admissions, an increase in the number of high risk patients being proactively managed in the community and early supported discharge for those needing to be in hospital.[1] These outcomes are central equally to the Bedfordshire Plan for Patients and the Five Year Plan.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contributes to this?

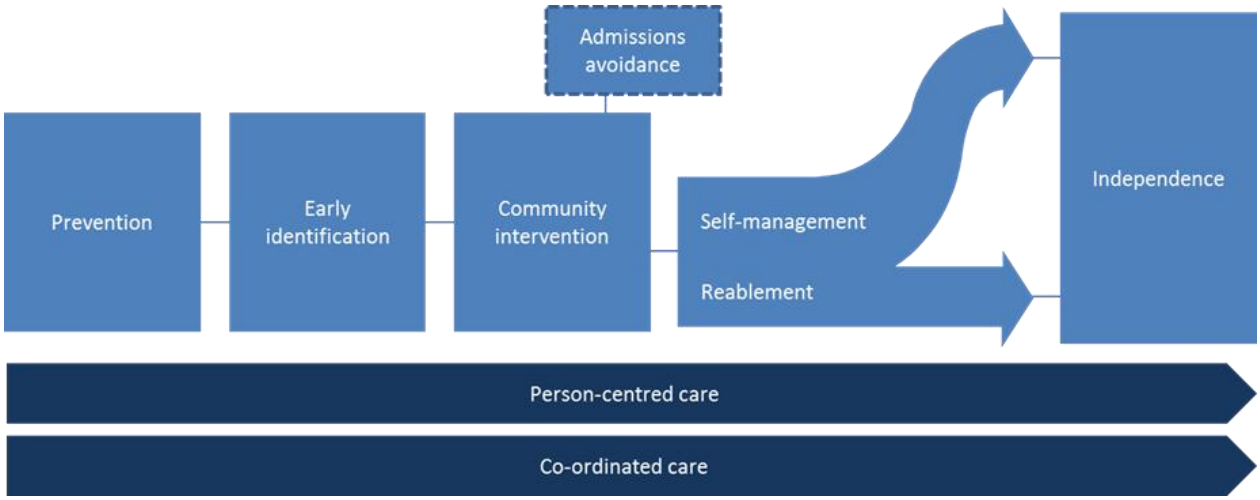
The Better Care Fund is a catalyst in our wider ambition for integration, which will help to reduce variations, improve the quality of care and the experience of our residents. Furthermore, this approach will ensure cost efficiency and that resources can be maximised across the local health and care economy. **Our whole system approach** will help to transform experience and deliver **care and support which is person-centred** with people being treated in the **correct care setting**, helping them to remain **independent for longer**. The focus will be for **care to be delivered close to home** which featured as a significant priority within the engagement we have undertaken in relation to the strategic review of healthcare services. A strong theme in the conversations with patients and the public has been their wish to stay healthy and independent for longer and, to that end, to have more care provided closer to where they live, organised around their lives and available at times that suit them.

Over the next year and by 2019, health and social care services will be promoting healthy lifestyle choices, self management and self-care approaches. There will be a new quality schedule and pricing structure in nursing and care homes which will monitor improved outcomes for reductions in falls and infections in residents. People with complex needs placed in community-beds will have care closer to home. Working collaboratively with our ambulance Services, paramedics will have access to patient care plans developed in primary care, and will initiate rapid response care from integrated community-based services.

We want to move to a population based approach that moves beyond the current performance measures. These are still important and will be tracked through the Better Care Plan implementation as well as partners' performance management systems. The current metrics across the health and social care system only tell part of the story. Our approach to measuring success will be one of co-production with our residents in determining what is important and what success looks and feels like. The Making it Real – Markers for Change initiative will provide the measures required to judge the impact that we are making in delivery care around the person. Our person-centred, locality based and integrated care model will be fully embedded over the next five years with the following delivery Framework.

[1] *This is the headline definition of what co-ordinated care is. It was derived from consultations with patient organisations and discussed and amended at the workshop on 24th September 2012.

Delivery Framework for Integrated Care



The growing demand for health and care services experienced in recent years, taken together with the current delivery model, has led to a programme of change and diversion of investment which this plan will support. The scale of change is significant. For example, residential care represents £29m or 34% of net spend on adult social care in Central Bedfordshire – a level that is unsustainable. This will be more acute given the changes heralded by the Care Act around the cap for people's contributions to their care costs. Shifting the balance of this care from institutional to personal support can be achieved through early intervention and prevention, the use of adaptations and technology, and better access to information and support for people to enable them to manage their own conditions and remain independent is the approach that has developed over the last 4 years. This provides a firm foundation to build on in the next 12 months as we continue to work to consolidate our information and advice offer, integrating our assessment processes so that people have access to timely and appropriate information about their care and support.

Joint programmes to improve the integration of services have already started. In the Dunstable and Houghton Regis locality, for example, CBC and BCCG have made significant progress in the development of sub-acute care pathways for the frail elderly working across hospital, community, social care, and GP services, investing in and delivering real changes in the pattern of services. The Better Care Fund is an important catalyst for enhancing our ambition for integrating health and social care services. The key focus of our Better Care Plan is older *people*, and especially older people experiencing frailty, and the changes we will deliver over the next five years are the types of changes we have started in the Dunstable and Houghton Regis locality.

Principal changes – 2014/15-2018/19

Together, these planned changes mean that over the next five years we will focus on the following priorities of change to deliver a whole systems response to health and care services in Central Bedfordshire::

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. This will ensure the most progressive, evidence-based prevention and early intervention programmes are available to our population.
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.` This will ensure robust and consistent arrangements are in place across Central Bedfordshire to both identify and organise effective support to those with long term conditions, particularly those with complex co-morbidities. This will include access to multi-disciplinary support and packages of care organised to maximise independence.

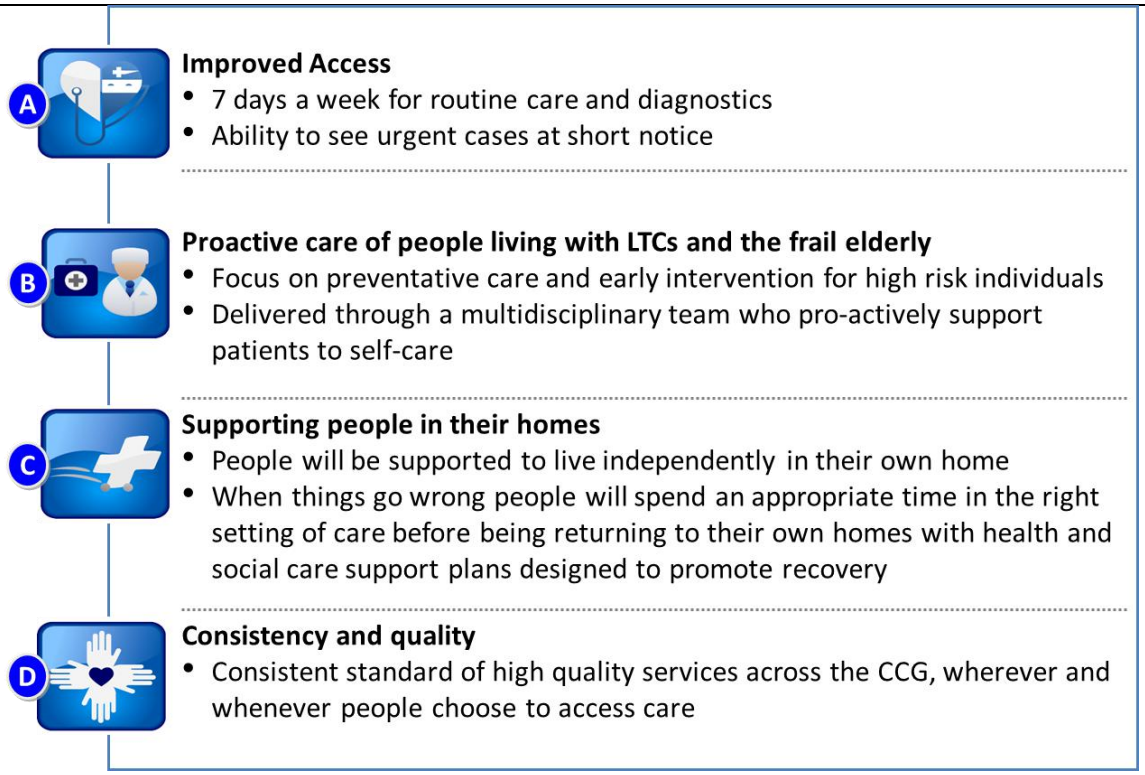
3. **Expanding the range of services that support older people with frailty and disabilities** – developing and integrating the range of housing and new technologies. This will ensure availability of services which wrap around older people with specific conditions to maintain their independence and remain in their own homes and in their communities for as long as it is safe for them to do so.
4. **Restructuring integrated care pathways for those with urgent care needs** – ensuring that these are seamless, clear and efficient to deliver the clinical shift required to move care away from acute settings, where appropriate.

Our priorities are based on delivering sustainable changes which will build our capacity for the longer term, including requirements of the Care Act. Overall, our approach will involve ensuring that those who would benefit most from person-centred and co-ordinated care do so and reduce traditional over-reliance on the acute sector to meet their needs. Joint Urgent Care programmes have commenced re-structuring of care pathways so that only patients who are acutely ill are treated in acute settings. This restructuring of sub-acute care pathways will enable a shift of resources to the community providing increased capacity, improving the experience of carers and users and the delivery of complex care including specialist services at the local level. The nature and scale of these changes is described in our Schemes.

Importantly, 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. There will be more effective management of long term conditions, including dementia. People will be supported with wrap around care in their own home or wherever they may be.

Building on a robust history of GP locality networking across Central Bedfordshire, we have established multi-agency locality partnerships. These partnerships will play a key role in the development of integrated services and will deliver multi-agency prevention programmes, and the delivery of proactive care services across health and social care. These partnerships will involve GP practices, community health and social care services, hospital outreach services, including consultant geriatricians, patient representatives, and the voluntary sector. They will have a vital role in profiling individuals who are at risk of hospital admission through risk stratification and case management, and working with community health and care services to reduce that risk through long-term condition management and home care support. Community health and social care teams will work together in an integrated way with single assessment processes and rapid responses to needs, focused on home care.

These changes which are set on our strategic goals for out of hospital care will deliver:



To deliver this vision, we will develop four integrated health and social care hubs which are integral to our priorities and will provide:

- A wider range of primary health services ;
- Accommodation for groups of practices who wish to co-locate under one roof;
- Improved access to GPs through extended hours, out of hours and walk-in services;
- A focus for management of more complex long term conditions including dementia care;
- clinically led Locality multi-disciplinary teams (MDTs)
- Access to mental health care services;
- Access to all out of hospital care services and hospital specialists;
- A single platform supporting information sharing across multiple organisations and providing access to integrated data sets for patients.

This will be underpinned with a shared record system and informatics platform. An integrated shared care record accessed through a flexible web based portal will provide timely access to information and enhance joint working between health and social care teams. We are participating in a whole systems bid for the Integrated Digital Care Technology Fund and have been successful to the next round. The Portal will offer a cross system interoperability benefits which will support key initiatives such as our Demonstrator Project.

Our Better Care Plan has a strong performance management framework and clear targeting of benefits. This will underpin decision making, effective use of resources, and how we make clear judgements about progress and realigning resources where necessary.

The principal measures of our programme will be the national BCF metrics, which will monitor:

- Admissions to residential and care homes;
- The effectiveness of reablement, i.e. the proportion of people (65 and over) still at home 91 days after discharge from hospital into reablement/rehabilitation services;
- Delayed transfers of care;
- reduction in non elective admissions;

- Patient/service user experience; and
- Local Metric - Injuries due to falls in people aged 65 and over

In addition, we will also use the following measures to assess our progress:

- Reductions in overall levels of urgent admissions of older people;
- Reductions in average length of stay, maximising stays of <48 hours;
- Reduction in excess bed days;
- Reductions in re-admissions to hospital within 30 days;
- Reductions in the rate of emergency admissions for the over-65s due to falls;
- Reduced hospital costs and increased investment in out-of-hospital care;
- Reduced proportion of budget spent on long-term residential and nursing care.

Our overall approach is consistent also with the emerging vision for out of hospital care from the ongoing strategic review of healthcare services in Milton Keynes and Bedfordshire. We submitted an Expression of Interest to the Transformation Challenge Award to pump prime the development of locality hubs incorporating complex care in our four localities and have been invited to submit a full bid for the Award. These Locality Hubs will be focal points for integrated care services to our population, to reduce variations and disparities in health and care experience. We know we have the support of two main acute providers, Luton & Dunstable Hospital and the Lister, who are already beginning to work differently with us.

Our Better Care Fund will enable us to deliver the vision of delivering care in the right setting, preventing avoidable hospital admissions and facilitating timely discharge. This pattern of care provision and changes will be influenced by the outcome of the Strategic Review of Health and Care Services in Bedfordshire and Milton Keynes and ensure delivery of a health and care offer that is consistent across Central Bedfordshire with oversight by locally based staff rather than the disjointed experience of limited coordination between hospital and the community. There will be reworking of hospital and out of hospital care that delivers integrated outcomes for local people and maximises the opportunities provided by community and voluntary organisation. The granular detail of delivery within the health and care hubs will be agreed once the outcome of the review has been ratified. Services will be able to focus more clearly on the quality of care and support that is delivered and experienced that could be tested by customer satisfaction measures.

The Better Care Fund remains a catalyst in securing our wider ambitions for health and social care in Central Bedfordshire.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Current issues in local services

Our Case for Change is built on a clear understanding of the challenges facing the Central Bedfordshire Health and Care Economy and the recognition that without change in the health and social care system there is significant risk that demand for care and support will not be met with consequential impact on quality of services and experience.

We have a growing and ageing population, with the number of people aged 65 and over seeing the most increase between 2010-31(87%). Life expectancy for both men and women is higher

than the England average, but with a gap in life expectancy for men of 7.4 years, and of 5.5 years for women, between the most and least deprived areas. The principle causes of differences in life expectancy between the most and least deprived are due to COPD, CHD and lung cancer – conditions closely linked to smoking. Over past 10 years, all death rates (including premature deaths) from cancer, heart disease and stroke have fallen. Our JSNA describes in more details the key issues impacting on health. It analyses a wide range of quantitative and qualitative data as well as reflecting the views of both professional and the community at large.

The Case for Change, importantly reflects feedback from our residents that their current experiences of services is that they are fragmented and confusing; they feel 'ping-ponged' between health and social care services and complicated financial systems. If we do nothing, the situation will worsen: we will have old-fashioned models of care that do not attract staff to work here, services that become increasingly overstretched and potentially unsafe, and growing financial pressures that cannot be addressed. This will all result in patient care suffering. People want services that are joined up between health and social care, are well signposted and with information that is widely accessible. The Case for Change document produced as part of the Strategic Review of healthcare services summarised the quality of care by each domain of the NHS Outcomes Framework. It looked in detail at a range of measures including premature deaths, support for people with long term conditions and unplanned readmissions to hospital. It also analysed patient satisfaction with a variety of services including maternity care and services to help people manage long term conditions. It showed that healthcare systems in Bedford Borough, Central Bedfordshire and Milton Keynes do not perform as well as those in similar local authorities. And it found issues with the quality of care both in hospital and closer to home. For example:

- Around one in three people across Bedfordshire and Milton Keynes with long term conditions such as heart disease or diabetes feel unsupported in managing their condition.
- 360 premature deaths could be avoided if health and social care systems in Bedfordshire and Milton Keynes were working as well as the best systems in equivalent councils.
- One in 10 people in Bedfordshire are readmitted to hospital within 30 days of being discharged, suggesting discharge from hospital can be poorly co-ordinated between the hospital, general practice and community services.

Care closer to home - Given that nine in 10 patients use primary care services as their first point of contact with healthcare, it makes sense to look at how healthcare in the community can be improved. Furthermore, changing care pathways based around hospitals needs to be developed in parallel with out-of-hospital care. Conversations with patients and the public have highlighted their wish to stay healthy and independent for longer and to receive more care closer to home. This is reflected in commissioners' strategies and their work with local authorities to bring health and social care together through the Better Care Fund. The Healthcare Review analysed the ways in which more robust care can be delivered closer to home which gives people:

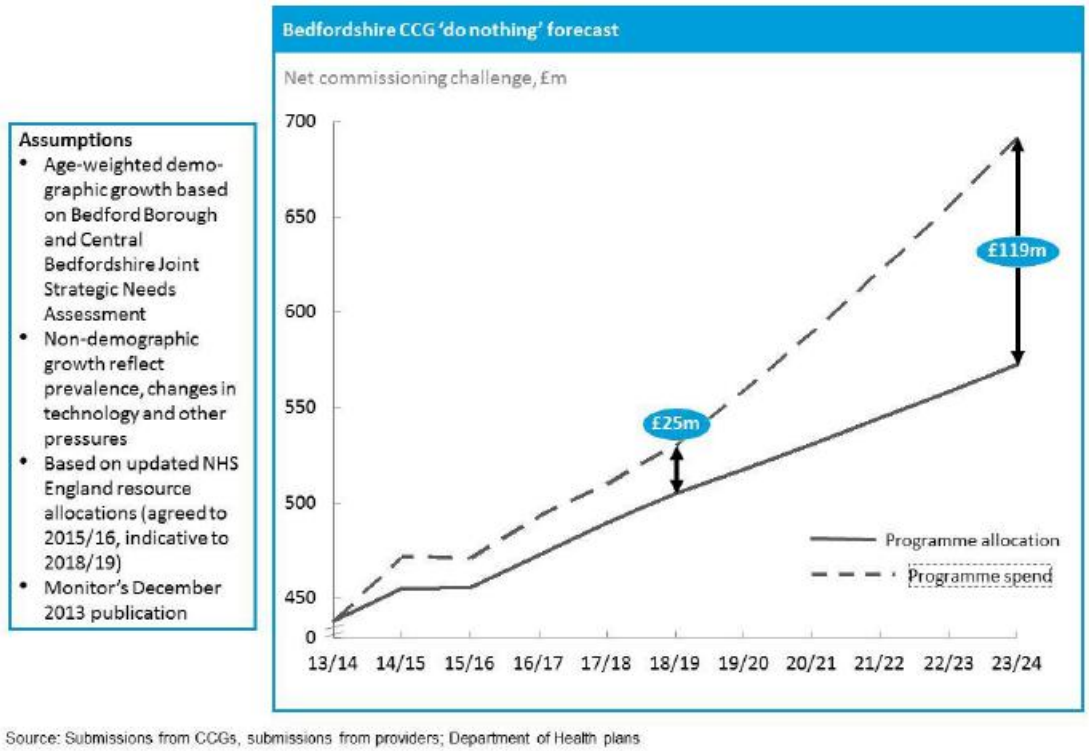
- Better access to primary care through longer hours and a wider range of services.
- Proactive care for frail older people, and those living with long term conditions
- Support for living in their own homes.
- Consistently high quality care.

Central to achieving this will be use of multi-disciplinary teams in the community, reliable patient and population data, extended hours in community and primary care, and improved hospital discharge processes.

Local evidence and initial risk stratification in primary care makes clear there is increasing demand for health and social care fuelled by a growing population with a changing age profile. Some of these challenges set out in the figure below are also reflected in the Clinical Commissioning Group's Two Year Operational Plan for Patients.

- By 2021, the population of people aged 65 and over will increase by 35% and those aged 85 and over by 53%.
- People are living longer with multiple and complex long term conditions.
- There are challenges for meeting this increasing demand within a context of diminishing resources whilst maintaining high quality, safe and effective care.
- There is a recognition that Health and care services would need to respond to changing expectations for person-centred seamless and integrated care pathways delivered at an appropriate time and in the right place.
- There is a strong need to increase efficiency and effectiveness of service provision through greater alignment and integration of care across agencies, developing new ways of working, avoiding duplication and ensuring skills are maximised to deliver improved health and care experience.
- There are also important challenges in ensuring we have the right workforce.

Health and social care systems are facing a significant funding pressure. The demographic increase together with complexity of need as people live longer as well as decreasing levels of public sector funding means that current models of care will not sustainable and a real shift in the way care is delivered is required. Bedfordshire CCG's financial allocation and NHS England's funding for primary care in 2013/14 total £500m. Almost half of available resources are spent on acute hospital care, 13% is spent on primary care and 10% on community services. The Strategic review found taking into account expected increases in CCG financial allocations and the financial impact of demographic and non-demographic growth, if nothing changes in how Bedfordshire CCG commissions for its patient population, by 2018/19 the CCG will have a net funding shortfall of £25m. If no significant commissioning changes are made by 2023/24, the net funding shortfall increases to £119m. The Figure below reflects the forecast gap between funding allocation and spend if nothing changes for Bedfordshire Clinical Commissioning Group.



Source: Submissions from CCGs, submissions from providers; Department of Health plans

Care provision from all services is meeting the most basic standards, with some examples of best practice, but it is not consistent. Quality of and access to GP services can vary significantly and there are noticeable gaps in the services being offered in the community and a risk that health and care resources are not being used efficiently and do not deliver the best health and care experience for individuals.

An assessment of the quality of local care against the five main domains identified in the NHS Outcomes Framework, as part of the on going review of healthcare services in Bedfordshire and Milton Keynes, suggests that, overall, our healthcare systems are not providing consistently joined up and effective care. People can find it difficult to make appointments with their GP when they want to and may either not seek help – missing an opportunity for healthcare to intervene early – or choose to use hospital-based emergency care instead. With delays in diagnosis of long term conditions and without adequate support to live with a long term condition, again, opportunities for early intervention when healthcare can be most effective are missed. The often unpredictable peaks in emergency activity overstretch hospital resources, with knock-on impacts on planned care, and create unnecessary patient safety risks at times of extreme pressure, times which are becoming increasingly common. Discharges home can be poorly co-ordinated between the hospital, general practice and community services, running the risk of deterioration in the patient's health and readmission to hospital.

It is therefore imperative that the emphasis of service provision needs to shift towards more local provision with a strengthening of intermediate and community based care. Primacy needs to be given to maintaining independence and choice for individuals supported by greater access to consistent information and advice. Developing capacity within the voluntary and community sector will be important.

Early Primary Care Risk Stratification

It is estimated that the population of elderly over the age of 75 in South Bedfordshire is

approximately 5,250. Previous programmes to risk stratify this group of patients in terms of higher risk of urgent admission using the PARR++ system has indicated that approximately 600 are at higher risk living at home and a further 600 are the residents of general residential care and nursing homes. Plans are being made to develop new risk stratification model based on health and social care systems (Health/Care Trak) and is being taken forward as part of our Data Sharing programme. This new approach will ensure a consistent approach to risk stratification and case management focused on support to GP practices working within locality clusters. GP, CHS and Social Care Services will be expected to organise patients at higher risk into Case Registers under a new Nationally Directed Enhanced Service (DES). Further analysis and key statistics on emergency activity is set out in appendix one.

Workforce and financial challenges

Our health services are also challenged by the workforce shortages that affect the whole Country. Local hospitals face important workforce shortages as well as significant financial challenges. The current financial position locally is already stretched. The Bedfordshire health economy will end the 2013/14 financial year in deficit by around £9 million. These factors will have an impact on the future provision of care and support. Keeping up with expected demographic changes, advances in care delivery, advances in technology and financial pressures will collectively make healthcare services more difficult to provide in their current form in future. Together, the strains in today's services and the challenges of tomorrow add up to an imperative need to update and reform the pattern of healthcare provision in Bedfordshire. Existing services can neither absorb the additional population requirements nor afford to implement the models of care that deliver the best quality of care and outcomes for patients.

A reshaping of how care is commissioned and delivered will be required. Community health services will be required to adopt a locality based approach working alongside other local health and social care services and collaborate with other partners such as voluntary services. With patients and clinicians working together to co-design integrated services the Better Care Fund provides a starting point for redirecting resources to where they can have they most impact. This will be underpinned by a joint commissioning framework led through the Commissioning Board. The Clinical Commissioning Group and the Council are working to establish the structure across both organisations to support this framework.

Our Better Care Fund will enable us to deliver the vision for delivering care in the right setting, preventing avoidable hospital admissions and facilitating timely discharge. We have developed some strategic goals for out of hospital care as follows:

All patients will have access to:

- Primary care services, 7 days a week, 24 hours a day
- Online booking for all appointments with the option of e-consultation, phone or teleconsultation, and electronic prescriptions
- Diagnostics through GP practice within 48 hours (e.g. blood test, ultrasound, ECG) with results delivered directly to the patient and GP within 24 hours of testing
- Consultations by GPs and other health professionals who have access to patient records, to ensure consistency and continuity
- Choice of GP to suit personal needs
- Online registration, electronic records and test results
- High quality information, including expertise in the interpretation of diagnostics test

Patients with complex needs, including those with long term conditions and the frail elderly will:

- Have access to a named GP with specialist knowledge of their condition and needs
- Have a named care coordinator, who will ensure the patient receives pro-active, timely care with appropriate follow up
- Be supported by a fully-integrated team of professionals, spanning primary care, mental health, social care and community care
- Be able to rely on a rapid response service staffed with multi-disciplinary professionals who are able to commission short term interventions, including carers, to support people in their own homes
- Have access to telecare to provide them with support and advice in their own homes
- Have access to short term intermediate care in the event of a crisis

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The Better Care Fund is a key strategic driver to delivering Central Bedfordshire's Caring Together approach particularly for frail older people, people with long term conditions and response to urgent care needs. The schemes and projects underpinning these will provide an integrated crisis response that ensures admission avoidance is aligned with integrated reablement services to improve discharge from hospital and improve outcomes for service users. We are working with our local hospitals, community services and social care services to determine how we can best support, particularly hospital services, at times of increased demand such as during winter. This has resulted in a System Capacity and Resilience Plan, which compliments the Better Care Fund Plan to identify additional initiatives such as administration of intravenous antibiotics at home, health coaching, 7 day working for pharmacy and therapies, clinical triage and navigation of patients attending A&E with minor illness and injury and improving discharge processes to provide additional support to hospital services. Developing a consolidated urgent care system which can be accessed via 111 is a key system-wide priority.

We have set out our high level priorities which reflect our ambition towards wider integration of health and social care in Central Bedfordshire. These remain our overarching plans and will be influenced by the output of the strategic review of healthcare in Bedfordshire and Milton Keynes. To meet the immediate challenges of the BCF we are focusing on 6 schemes to help deliver improvements, cost efficiency, more streamlined pathways of care and in particular secure the pay for performance element of the Plan for reduction in non-elective admissions. These are set out in Annex 1.

There are important opportunities to reshape services for older people in Central Bedfordshire, with a clear focus on those experiencing or likely to experience frailty. This requires a response to wider system issues, such as accommodation, adaptations, transport, and carers' support, which are important to making a step change in outcomes. The redesigned care system across Central Bedfordshire will utilise national evidence as well as local experience from the South Bedfordshire Sub-Acute Care locality partnership demonstrator site. Through engagement with clinicians and a robust approach to working in partnership, a sizeable reduction in acute activity has been achieved. This local evidence forms the basis for our modelling of benefits through this programme.

Four key priorities have been identified to deliver the overall plan. There are clear interdependencies between these priorities, which will need to be progressed in concert.

The four priorities are as follows:

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. This will ensure the most progressive, evidence-based prevention and early intervention programmes are available to our population.

This priority is focussed on preventing mental ill-health and the impact of disabilities. It will adopt an approach that moves away from assets and infrastructure to enhancing the skills and

abilities of the individual to be independent, thereby reducing reliance on care services through an integrated range of support in:

- Primary prevention – providing whole-population advice on healthy lifestyles and mental wellbeing;
- Secondary prevention – identifying people at risk of poor health or social care outcomes and helping them manage that risk as well as possible; and
- Tertiary prevention – providing active support to those with established conditions or complex social care needs to minimise disability and deterioration and maximise their independence, choice and control.

Planned changes and key success factors during 2014/2015:

- We will use locality partnership arrangements as a mechanism for assessing and facilitating effective delivery of prevention programmes in each locality by September 2014. This will include initiatives for reducing social isolation and promoting social capital.
- Review opportunities for lifestyle hubs, incorporating nutrition advice, exercise and mental health promotion, in support of each locality by March 2015.
- Integrate lifestyle modification and support programmes into joint care plans on a phased basis from 2015.
- Develop comprehensive primary care mental health services that promote wellbeing and ensure that people are assessed and treated at the earliest point in their illness. This will include the promotion of screening tools and access to self-help materials.

A key measure of success for this will be through the social care related quality of life, with people feeling supported to manage their long-term conditions.

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.

This will involve an integrated approach to the care and treatment of those with long-term conditions and frailty, including the development of practice case registers, effective multi-disciplinary team management of patients at high risk of admission, and effective coordination of care following discharge from hospital.

Planned changes and key success factors during 2014/2015:

- Establish locality partnerships to implement integrated multi-disciplinary developments in long-term conditions management by September 2014 – completed .
- Ensure that all patients over the age of 75 have a named GP by June 2014 - completed.
- Review opportunities for a clinical development programme for GP Practice leads in older people's care in collaboration with hospital specialists.
- Increase support to practices to aid early assessment and diagnosis of dementia.
- Ensure that the introduction of risk stratification is consistent and establish robust practice case management registers with a minimum of 2% of practice adult population (over the age of 18) being proactively managed with personal care plans.
- Establish robust arrangements to ensure vulnerable patients have same-day access to practices.
- Establish robust arrangements for practices to offer immediate access to other

professionals, including dedicated practice telephone lines.

- Review case registers on a monthly basis with particular focus to offer alternative management to those who have been admitted to acute care. Improving the quality of End of Life Care

Community Health and Social Care Support:

- Ensure lead professionals and locality care co-ordinators are in place.
- Integrate health and social care occupational therapy services to provide a single point of access.
- Deliver integrated intermediate rehabilitation and reablement support.
- Integrate personal health and personal care budgets within a single care package.
- Improve access to co-ordinated EOL care
- Enhance post diagnostic support services for people with dementia and their carers.

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.

This programme will:

- Meet the accommodation needs of older people through a range of housing types and the use of new technologies.
- Build on research evidence that extra care housing delivers improved health and well-being compared to residential care.
- Maximise the use of Mobility and Access to Transport.
- Reduce isolation and improve support to carers.

Planned changes and key success factors during 2014-2016:

- Ensure there is sufficient capacity in a range of accommodation to reduce significantly the need for placements in residential care.
- Take forward the CBC Meeting Accommodation Needs of Older People (MANOP) programme, focused on the expansion of extra care housing.
- Widen housing-related prevention programmes, such as 'Warm Homes, Healthy People' and falls prevention.
- Ensure the full use of new technologies within housing schemes, such as telecare.
- Establish an integrated non-urgent transport programme to maximise independence and meet specific transport needs, such as visits to GP practices and hospital, day activities, shopping, and other social events.
- Support village care schemes as a key access to support with transport needs.
- Improve access to psychological therapy services
- Ensure Primary Care identification of carers and their health and care supports assessed.

4. **Restructuring integrated care pathways for those with urgent care needs** – ensuring that these are seamless, clear and efficient to deliver the clinical shift required to move care away from acute settings, where appropriate.

As a key focus of activity and investment, this programme will produce an updated care model for the sub-acute care of older people based upon national best practice and the South Beds

Demonstrator site, ensuring person-centred care at all times. This programme will facilitate the deployment of this care model across Central Bedfordshire, at all times remaining sensitive to the needs of individual localities.

Planned changes and key success factors during 2014/2015:

- Jointly monitor individuals at risk and deliver rapid case management responses at times of crisis, thereby avoiding hospital or residential home admission.
- Implement robust 24-hour out-of-hospital care services for those with urgent but sub-acute care needs, including rapid intervention/hospital at home care services and access to intermediate beds (step-up/down) accessed through locality health and social care navigators.
- Provide new dedicated telephone access for professionals to link with general practice.
- Implement community-based geriatric specialist services.
- Implement rapid assessment through consultant-led older people's assessment and liaison services treatment and early effective discharge from the hospital sector.
- Implement a model of mental health provision within acute hospitals to provide seamless mental health support to patients. Establish a single point of contact for access to an integrated community-based health and social care service closely aligned with GP practices.
- Establish health and social care navigators on a locality basis with responsibility for delivering joint packages of care in support of practices.
- An integrated approach to the commissioning and use of intermediate care beds following the 2013 Community Bed Review.

Work within our Localities in 2015 - 2016

West Mid Bedfordshire Locality - West Mid Bedfordshire Locality is developing a multi-agency implementation plan and effective partnership arrangements at locality level. The locality has taken forward a successful domiciliary risk assessment and prevention service during 2014-15 and will continue to develop a proactive preventative model of care for higher risk and older patients into **2015-16**, with an increased focus on multi-disciplinary assessments and care provision in partnership with social care and community health services. The continued development of services offered by GP practices to local people will remain a key focus for the locality, with the aim of continuing to offer more high quality care closer to home and away from a hospital setting.

Ivel Valley Locality – The Ivel Valley Partnership is implementing a joint project for targeted prevention to reduce hospital and care home admissions. Patients at high risk of an unplanned admission will be identified and reviewed jointly between health and social care. The project will pilot in one practice and if successful be rolled out across all nine practices. Through partnership work the locality will improve outcomes for the frail elderly by developing a model for community based care of the elderly services, based around a community care of the elderly consultant. Development of primary care geriatric assessments for the over 75s will ensure that the frail elderly residents of Ivel Valley receive the right care in the right place at the right time and remain in their own homes for as long as possible. Ivel Valley will implement its Primary Care Strategy to support the organisational development of its practices to enable them to operate at scale and undertake a full role in the implementation of the Better Care Fund plans in **2015-16**.

Leighton Buzzard Locality Leighton Buzzard locality is developing its five year primary care strategy which will encompass the Better Care Fund plans, delivering commissioned services over and above traditional general practice services, supporting care homes, extending hours and sharing more clinical expertise. The locality will play a key role in the **'Demonstrator' project** for improving care for the frail and elderly population by robust care planning, case management and risk stratification of vulnerable people who are at risk of hospitalisation. Work will continue on ensuring that the number of patients on the palliative care list will be higher than the national average and flu vaccination rates will be above the national target of 75%.

Chiltern Vale Locality - As the pilot site for the integrated care 'demonstrator' project Chiltern Vale will continue to work in partnership with the Luton and Dunstable hospital, social services and community colleagues to strengthen the urgent care provision for their population and focus on care for the frail elderly. Clinicians will work together to provide integrated services and reduce emergency admissions for those patients with chronic ambulatory care sensitive conditions. Robust advanced care planning and increasing the number of people receiving coordinated care from the PEPs service will support at least 50% of people to die in their usual place of residence by 2015-16.

The delivery framework, through which we will translate the priorities into practical implementation, has been developed through a series of joint sessions between the Council and the CCG, and have looked at

- The implementation plan, with clear next steps;
- Development of Locality Delivery Partnerships;
- Dependencies and issues across the components of the BCF scheme;
- Further prioritisation for delivering the plans at scale and pace;
- Communication and engagement plans for the programme implementation; and Further development of the programme structure, including governance and communications.

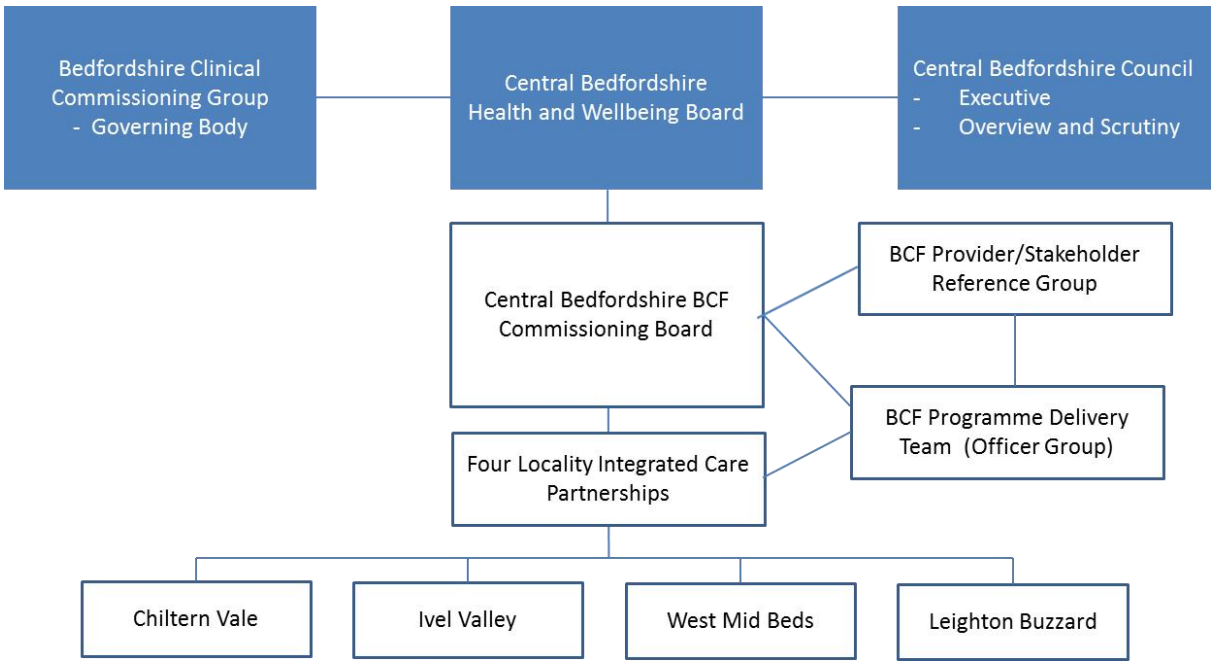
A high level programme plan setting out our Schemes is attached – Appendix Two

b) Please articulate the overarching governance arrangements for integrated care locally

The BCF plan and overall integration programme for Central Bedfordshire will be overseen by the **Health and Wellbeing Board**. A Chief Officer Group, comprising Director of Strategy and Service Redesign, Director of Contracts, Chairs of the Locality Groups for Ivel Valley, Chiltern Vale, West Mid Beds, and Leighton Buzzard; Director of Social Care Health and Housing and Directors of Finance, will commission for integrated care (the **BCF Commissioning Board**). The Commissioning Board which has now had its first meeting will provide joint accountability and oversight of the strategic direction of the Better Care Fund Plan, the pooled budgets and the wider transformation agenda, including output from the Strategic Review of healthcare services in the context of Central Bedfordshire. A **Delivery Programme Group** comprising locality leads has been set up and will work closely with the four locality Integrated Delivery Partnerships.

The HWB membership includes the executive member for Health, Social Care and Housing and the Chief Officers of the CCG and Council. The BCF Commissioning Board will have oversight of finance and performance and will report to the Health and Wellbeing Board. The performance framework has been developed and aligns equally to the Council and CCG performance monitoring processes. Monthly monitoring reports will also be circulated to the Council's Corporate Management Team, Political Leadership and the CCG's Governing Body. A programme

management approach is being adopted. **Local integrated partnerships** have been established across Central Bedfordshire's four localities.



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. The BCF governance arrangements will link into an **Integrated Care Partnership**, which will take forward the strategic approach to securing wider integration and transformation across our health and social care economy.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The Health and Wellbeing Board has overall responsibility for both operational and financial delivery of the Better Care Fund and will maintain oversight of the outcomes. In addition the CCG and the Council through existing and robust governance mechanisms will ensure there is appropriate oversight and decision making. The Health and Wellbeing Board has given mandate for a Joint Commissioning Board for our BCF. This Board will be responsible for overseeing the operational performance of the delivery of the BCF Schemes and will report to the Health and Wellbeing Board. The Health and Wellbeing Board will approve the Scheme of delegation for the Pooled Budget and Section 75 agreements.

From 2015-16 BCF funding will be underpinned by a Section 75 pooled budget arrangement which will be jointly governed by the LA and CCG under an existing overarching arrangement.

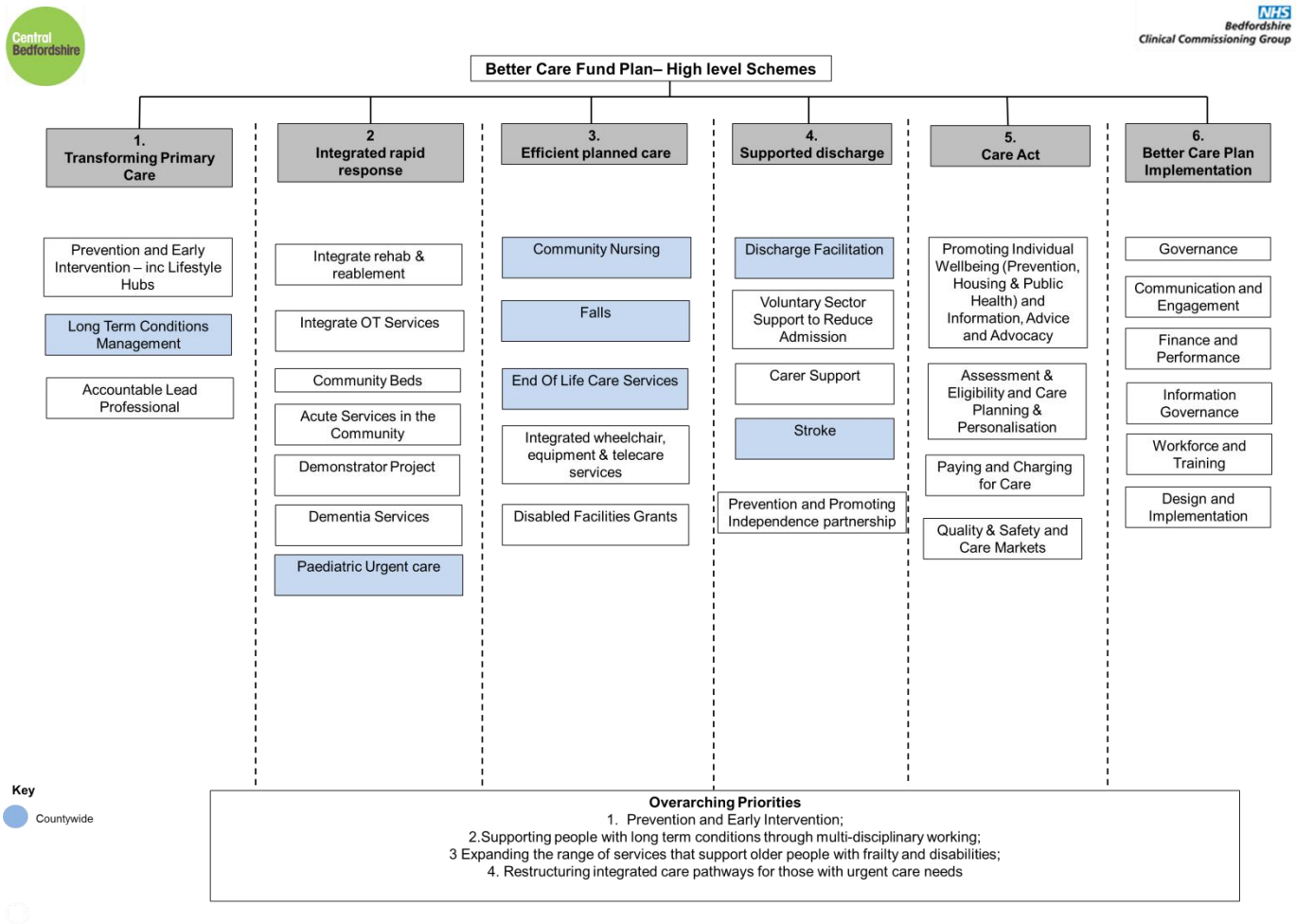
A Provider Alliance for integration will be established with a clear mandate for developing a shared approach and common methodology for performance and evaluation. This Alliance will include all key Acute Providers. As part of the focus on integration between health and social care, a joint CBC/CCG operational management group, which includes the local authority Chief Executive and Chief Officers of the CCG, has been established. This leadership group will also continue to have oversight on the vision and programmes and performance which will influence the outcomes from the BCF.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Transforming Primary Care
2	Integrated Rapid Response for People with long term conditions and the frail elderly
3	Efficient Planned Care – predictable, reliable and close to home.
4	Coordinated and supported discharge from hospital with ongoing community care
5	Implementing the Care Act
6	Implementing the Better Care Plan

The figure below shows the links between our priorities, the related high level schemes and constituent projects. A programme plan is attached as Appendix Two



5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

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 And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Finance. Due to underperformance of the schemes or delays in realising benefits, there is a risk that identified savings (£2.1m) are not realised and therefore restrict the ability to fund new models of care.	4	4	16	1. All key providers signed up to their proportion of 3.5% reduction. 2. All schemes will have business cases detailing benefits in terms of finance and activity. 3. Robust performance framework to ensure monitoring of performance and prompt action to mitigate under performance including discontinuing those not realising expected benefits. 4. Risk and gain share has been agreed between CCG and CBC for management of pooled budget.

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* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Due to the implementation of the Care Act and the increase in the number of assessments from April 2015 and an increase in the cost of care provision from April 2016 there is a risk that the full impact of this cannot be fully quantified at present	4	Financial impact from April 2016 when new charging regime starts could be significant and will have an impact on the resources of the Council.		Working with National Programme Board and Regional Networks on modelling the cost impact.
Performance There is a risk that when the pay for performance non elective admissions activity reduction is recalculated based on actual Q1-3 14/15 instead of plan, the required reduction is higher than the 757 admissions included in the current plan.	4	3	12	Monitoring of non elective activity as actuals become available. Identification of additional schemes to deliver reductions in non elective activity.
Capacity There is a risk that demand for crisis services (residential/ hospital services) will not reduce because of insufficient capacity of Community &	4	4	16	Early and broad engagement with community and primary care providers on the CCG and Council quality agenda.

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 And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
primary services.				
There is a risk that due to lack of supply of Care Services especially in the north of Central Bedfordshire, the model as described cannot be implemented.	4	3	12	Early and broad engagement with all providers linked to the Central Bedfordshire health and care economy. Working with existing and potential new suppliers to maximise supply.
HR/workforce There is a risk that staff within organisations do not receive sufficient support to manage the change with resultant impact on morale and service delivery.	3	3	9	Workforce strategies across partners need to take into account change requirements. High level strategic intentions need to translate into practical system, practice and process change support for staff delivering the change. Service and team plans reflect high level priorities.

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* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Reputational Risk Reputational risk to all partner organisations in the event of failure to meet statutory duties occurs.	3	4	12	Appropriate governance structures Provision of regular, timely and accurate information to support monitoring of services. The BCF Plan has been involved all our key providers, including PVI sector who have signed up to the plan.
Implementation There is a risk that due to transition between existing and new model of services there are risks related to quality and safety.	3	4	12	The development of the BCF and strategic plan has been used as a key means to forward plan in detail. Accountability to H&WB board as well as internal governance boards. A robust performance and quality outcomes framework is being developed to monitor outputs and quality of outcomes. The BCF Commissioning Board will take remedial action on any scheme that is underperforming.

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 And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
There is a risk that the BCF does not implement a 'whole system' approach resulting in negative financial and patient outcome consequences.	3	4	12	Work on jointly developed commissioning priorities and value based commissioning supports this. Accountability to H&WB board as well as internal governance boards. A performance framework which captures a more holistic view of people's journey through the care and support systems. A programme of culture shift to support education and change in practice across all partners.
As a result of a number of schemes being at scoping stage and limited project management capacity there is a risk that implementation will not proceed at the required pace.	4	4	16	Direct and senior Programme management capacity will be secured through non recurrent underspend in 14/15.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The Council and the Bedfordshire Clinical Commissioning Group have signed up to a risk sharing agreement. There will be a shared risk to the pool around the core element previously funded through historical S256 agreements. Any further financial risks to service budgets included in the pool but outside of this core will be managed by the host organisation.

The financial impact of non delivery of the reduction of 3.5% (757) on non elective admissions valued at £1,128.000. This represents the value of the pooled fund at risk in relation to the Pay for Performance element of the BCF. Further details on is set out in Part two.

Additional evidence of analytics and modelling on the Pay for Performance metric is set out in Appendix Three

The BCF Project team have commenced reviews linked to these service integration efficiencies as this is part of the integration priorities for the local system. Once the preferred approach has been agreed the BCF will work with providers over an agreed period (probably 6 months) to deliver this change. Contingency funding is therefore likely to be available from Q2 15/16 onwards. This provides a half year overlap of delivery, providing sufficient time for any further remedial action required to be initiated.

The part 2 financial plan, expenditure, investments and planned savings were taken to HWBB on 15th September.

Further contingency is planned as phasing of schemes means not all have yet been fully scoped and mobilised meaning further significant savings are expected to be identified from later financial modelling analysis. As a result, any other risk associated with not meeting the target for reduction in unplanned emergency admissions are expected to be limited and fully mitigated by the later phased projects planned to come on line once the phase 1 projects are in delivery. Programme risks are fully articulated with mitigation plans in the risk register.

The CCG and CBC have agreed that a risk and gain share would be appropriate for the management of the pooled budget. This would include sharing of risk across both organisations and sharing gains across organisations and the pool itself. The planning of this risk/gain share has been discussed at the BCF Finance Group and the Contracting and Finance teams have agreed to develop the detailed proposals that will manage the pool.

We have set up a performance framework that would ensure monitoring of performance and prompt action to mitigate any under- performance. The Health and Wellbeing Board is mindful of this risk and discussions on managing this system wide risk is commencing and a risk sharing mechanism will be developed.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Our Better Care Plan is strongly aligned to the Bedfordshire Plan for Patients and the Five Year Strategic Plan of the Clinical Commissioning Group. The Council has a strategic vision for shifting the balance of care from institutional to personal solutions. There is a programme for Meeting the Accommodation Needs of Older People which is part of the Council Medium Term plan. Although this sits outside the Better Care Fund programme, there is close alignment in governance both in the Health and Wellbeing Board and whole systems leadership. There is close alignment with Five year strategic plans our key Providers. A Shared System Leadership Group exists to ensure alignment of plans and ambitions across the health and care system. The Five Year Plan for the CCG references the on going strategic review of healthcare services in Bedfordshire and Milton Keynes. This remains a key influence in our Better Care Plan and wider ambitions for integrating health and social care. There are common ambitions to develop locality based approaches; establish GP Federation – which remains a key part of our Scheme One – Transforming Primary Care; our expansion programme for extra care housing provision and the development of more geographically specific step up/step down provision to facilitate timely discharge from hospital as well as reduce reliance on hospital care. This is also consistent with the Health and Wellbeing Strategy with a particular focus on improving outcomes for frail older people. All the foregoing activities will support our ambition of reducing reliance on residential care.

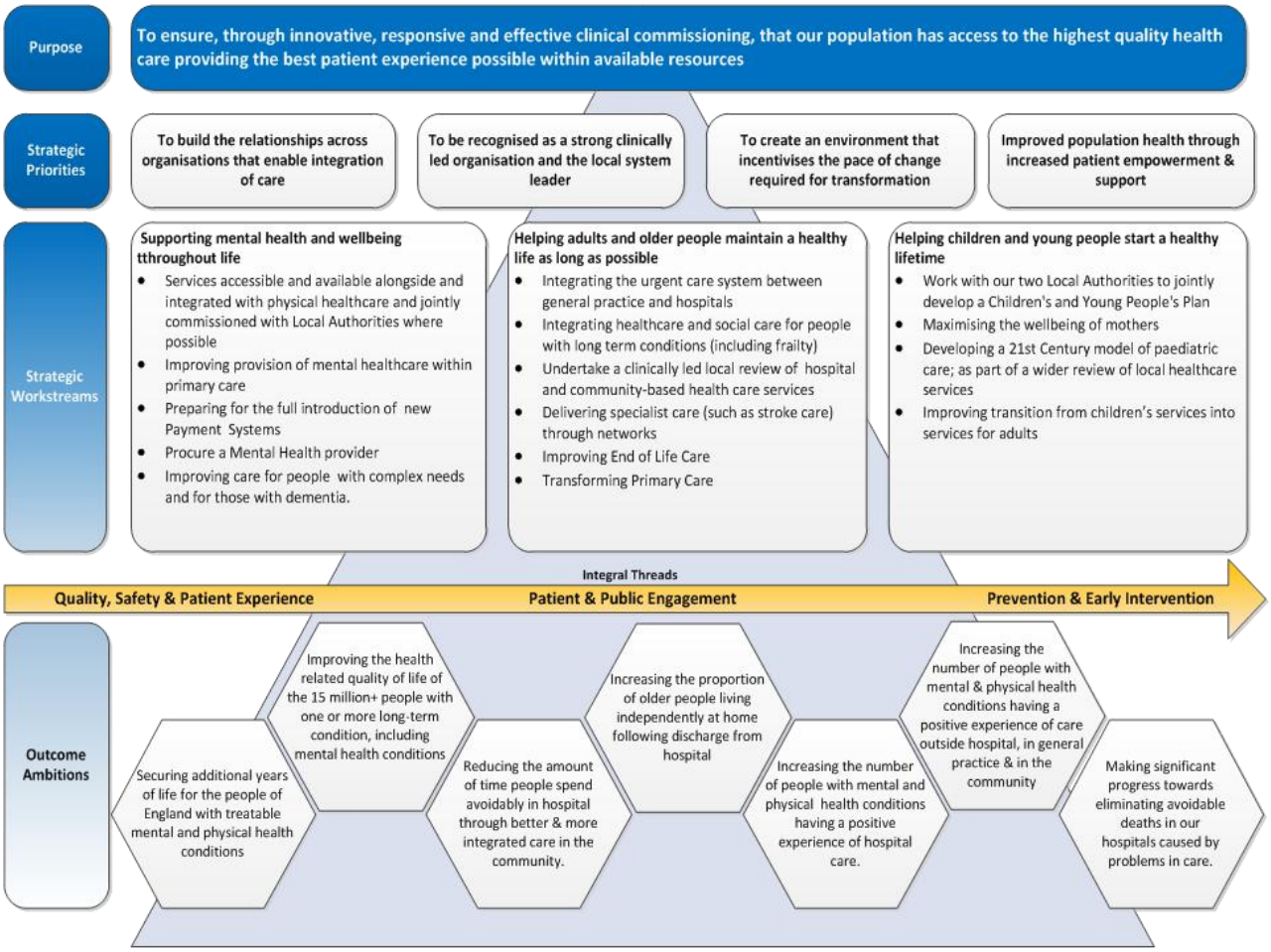
We have been invited to submit a full bid following a successful expression of interest to the Transformation Challenge Award. The project proposes real transformational and step change to increase the quality and experience of care based on new care models through establishment of locality-based health and social care hubs offering improved outcomes and personalised support for individuals. The Hubs will deliver coordinated health and social care accommodating a wide range of clinicians and allied practitioners offering core general practitioner, community health and out-patient services. Our expression of interest builds on our Better Care Plan which sets out our shared vision and ambition for transformational change across health and social care rooted in a locality based delivery model.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Central Bedfordshire's Health and Wellbeing Strategy sets the overall direction vision for health and care provision. Development of the Better Care Fund Plan, Schemes and plan of action reflects the key strategic plans for Central Bedfordshire. Bedfordshire Plan for Patients **2014-2016,** the Five Year Strategic Plan, the Council's Medium Term Plan focus on bringing together resources across health and social care to commission integrated services to support improvement of the lives of vulnerable people, ensuring a person centred approach and giving people greater control over their own care and support. The Better Care Fund Plan schemes are closely aligned with Bedfordshire CCG's two year operating plan – Bedfordshire Plan for patients priorities which are focused on:

- Integrating the urgent care system between general practice and hospitals
- Integrating healthcare and social care for people with long term conditions (including frailty)
- Transforming Primary Care
- Delivering specialist care (such as stroke care) through networks
- Improving End of Life Care

The 2014-2019 Five year strategic plan for the CCG identifies the priorities for adults and older people and is aligned to the Better Care Fund Plan schemes. The figure below sets this out.



The Better Care Fund provides an opportunity to bring resources together to address immediate pressures on services and lay foundations for a much more integrated system of health and care delivered at scale and pace. Our Better Care Plan is based on accelerating our progress to deliver the priorities and outcomes agreed by the Health and Wellbeing Board. The Better Care Plan is closely aligned to **the Care Act** and the delivery framework which underpins it. Key elements within the Act include:

- Prevention and early intervention – including requirement to provide information, advice and advocacy;
- Assessment and care planning – with a requirement for joint care planning, integration of services and use of personal budgets,
- Market shaping and commissioning

The Clinical Commissioning Group is working closely with the Local Authority on implementing

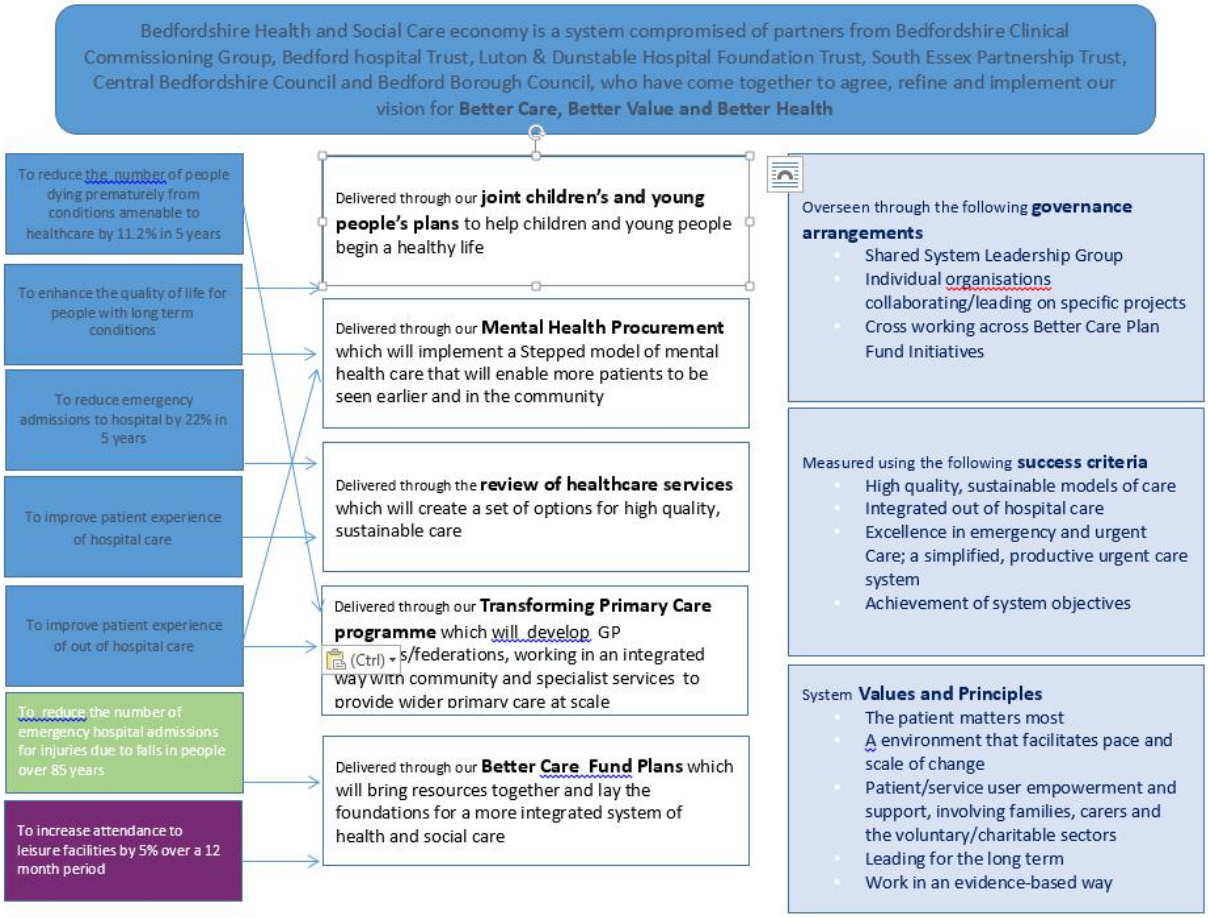
key elements of the Care Act. The general duty for prevention and promotion of wellbeing is central the Better Care Plan for Central Bedfordshire. This principle underlines joint working approaches in primary care and community health services though case management, risk stratification and targeted prevention delivered by multidisciplinary teams in the community. This will help to identify those who are most vulnerable for early intervention and prevention work and reduce need for emergency admissions or acute care.

The Act proposes significant investment and support for carers. There are already joint working initiatives to support carers and more timely identification and support for cares will be developed with links into MDTs. The role of the "expert carer" is being considered. This enhanced support for cares with provision of information and advice will be significant in reducing demand for emergency services and need for urgent care.

Central Bedfordshire Council's eligibility criteria is set at moderate. This offers timely care and support to more people and is consistent with our local health and care economy's joint approaches to prevention and early intervention. Access to free and universal Reablement services is consistent with the Care Act regulations which requires intermediate care and Reablement to be provided for up to six weeks with access to aids and adaptations to promote independence and help sustain people at home.

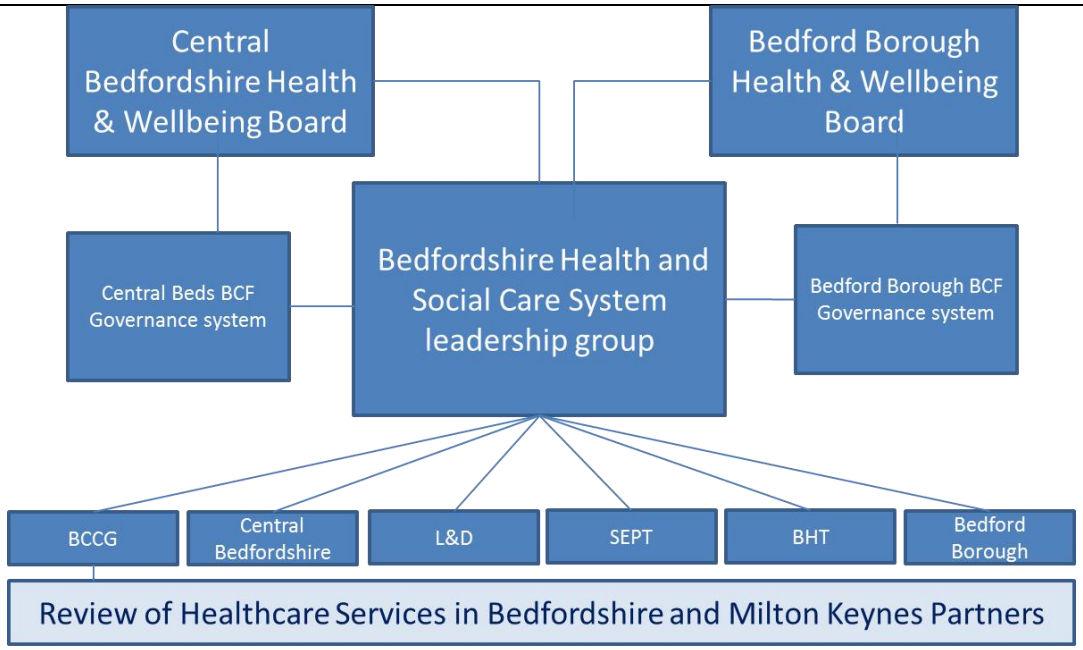
The Care Act sets out a duty for partnership working and integration of services. Arrangements are on going through integrated working to provide support to frail older people with access to services such as "home from hospital support" and step up step down. The ongoing work to develop integrated assessments, joint planning systems and a single care and support plan will enhance approaches to developing sustainable health and care systems. These are also key components of the Better Care Fund Plan for Central Bedfordshire.

The figure below provides a high level view of the alignment of the Better Care Plan with the 2 year operating and five year strategic plans.



The Bedfordshire Health and Care System leaders acknowledge that we collectively manage a complex system of care encompassing two Local Authorities, two main hospital providers (with patient pathways to multiple hospitals outside of the system). Alongside the governance framework for our Better Care Fund Plan, we have also mapped a leadership and management framework which demonstrates how we will collaborate together to monitor the support the implementation of sustainable models of care across the range of improvement initiatives identified in the Health and Care System strategic plans. This includes

- Shared System Leadership Group
- Individual Organisations collaborating/leading on specific projects e.g. demonstration project
- Cross working across Better Care Plan Fund Initiatives



We are also extending our group membership to welcome the Local Medical Council, HealthWatch, voluntary/charitable sector representatives and Primary care representatives to advise and input into system planning.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Following the completion of the Call to Action consultation it is anticipated that NHS England will develop a new National Framework for Primary Care which will set out the overall vision for Primary Care and required improvements in patient outcomes. It is anticipated that the National Framework will encourage and support general practice to play an even stronger role at the heart of more integrated out-of-hospital services that deliver better health outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources. NHS England has a responsibility for the core contracts for Medical Services (GMS and PMS) with CCGs having a clear statutory duty to improve the quality of Primary care services. Bedfordshire CCG will work with NHS England to deliver the national strategic framework.

Our commissioning intent for Primary Care Services is to establish an environment that enables General Practice to undertake a pivotal role as part of a more integrated system of out-of-hospital care. This programme will include

- Preventing ill-health, ensuring more timely diagnosis of ill-health, and supporting wider action to improve community health and wellbeing.
- Proactive co-ordination of care, particularly for people with long term conditions and more complex health and care problems.
- Developing holistic care, addressing people's physical health needs, mental health needs and social care.
- Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances.
- Ensuring consistently high quality of care: effectiveness, safety and patient experience. Involving patients and carers more fully in managing their own health and care.

Scheme One of the Better Care Plan is focused on transforming primary care with plans for developing GP Provider Networks and how these will align with other services and deliver improvements to outcomes and care experience. A central plank of our ambitions for the future configuration of health and social care sets out a plan for locality based health and social care hubs. This approach is strongly aligned with the direction of the Strategic Review of healthcare services in Bedfordshire and Milton Keynes the integrated out of hospital care models and is consistent with Central Bedfordshire Council's position statement on its vision for the local health and care economy.

We see Co-commissioning as an enabler to our ambitions and critical for the future development of our local health economy and central to delivering the following outcomes:

Access

- 7 days a week for routine care and diagnostics
- Ability to see urgent cases at short notice

Pro-active care of people living with long term conditions and the frail elderly

- Focus on preventative care and early intervention for high risk individuals
- Delivered through a multidisciplinary team who pro-actively support patients to self-care whilst offering continuity of care
- People feeling supported to manage their long term condition/s

Supporting people in their homes

- People will be supported to live independently in their own home
- When things go wrong, people will spend an appropriate time in the right setting of care before being discharged to their own homes, with access to coordinated health and social care support

Consistency and quality

- Consistent standard of high quality services across Bedfordshire CCG, no matter where and when people need it

Patient experience out of hospital

- Increasing the number of people having a positive experience of out of hospital care, in general practice and in the community

The CCG will take forward the following development programme for General Practice in 2014/15**.**

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Central Bedfordshire Council and the Bedfordshire Clinical Commissioning Group recognise the interdependence of health and social care in avoiding unnecessary hospital admissions, facilitating earlier discharges from hospital, 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

The Council recognises the need to maintain current arrangements of providing social care support to adults and older people assessed as having moderate, critical, or substantial needs, particularly in light of our increasing and ageing population. Maintaining our moderate eligibility criteria is critical to preventing reliance on acute/institutional care. This will continue through reablement, additional funding for 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 is set at moderate. This offers timely care and support to more people and is consistent with our local health and care economy's joint approaches to prevention and early intervention. This will continue to enable us support some people before they reach a crisis and thus avoid unnecessary hospital admissions. Access to free and universal reablement services is consistent with the Care Act regulations which requires intermediate care and reablement to be provided for up to six weeks with access to aids and adaptations to promote independence and help sustain people at home.

The requirements of the Care Act are identified and the implementation of key changes will be integral to the programme plan, covering the national eligibility criteria, portable assessments along with the requirement to provide universal assessments for all those in need of care and for carers. Key emphasis will be on the provision of enhanced information and advice, including signposting, and promotion of wellbeing and independence. Particular focus would be in identifying and supporting carers.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

In the context of the reductions to local government funding, the Council's Medium Term Financial Plan assumes (to date) for adult social care pressures of £2.9m for 2014/15 and £3.8m for 2015/16 with efficiencies of £ 6.8m and £3.8m respectively. Currently, social care services have been protected through a succession of efficiency programmes, however these are now proving much more challenging and there is a real risk of not achieving planned targets. The increasing demographic pressures and legislative changes place new and additional burdens on a local system facing unprecedented challenges. Our plans for protecting social care services focus on the following key areas:

- Funding for personal budgets/care packages, recognising unavoidable demand and demographic growth;
- Funding increased capacity to meet growing demand for reablement, telecare, and associated interventions to reduce increasing demand and costs;
- Funding increases in capacity/infrastructure to ensure more integrated case management and, crucially, to protect the supply of locally available services; and
- Building community capacity to enable support for people in their communities, for example through expansion of Village Care Schemes and Community Navigator type roles, as well as development of micro-enterprises.

Our local schemes will assist in protecting services through initiatives designed to:

1. Transform Primary Care
2. Integrated rapid response care for people with long term conditions and the frail elderly
3. Deliver efficient planned care which is more predictable, reliable and close to patient's homes
4. Coordinate and support discharge from hospital with ongoing community care

Key elements of these will include:

- Developing Integrated Care Teams with a single management structure to improve cost effectiveness and health and care outcomes.
- Supporting improvements in quality and efficiency of existing services through the development of integrated initiatives such as lead professional, data sharing, increased hours of operation.
- Developing preventative services to help avoid pressure on acute services.
- Developing integrated 7 day services which offer timely responses and make better use of existing resources.

The Better Care Fund will be deployed to fund the agreed on-going investment in 2014/15 and meet the unavoidable demographic/demand growth in 2015/16, providing additional capacity to develop/double run services. Present financial projections based on the Local Government Spending Settlement has and will continue to have significant impacts on Integrated Health and Social Care Services which help to improve health and wellbeing. Without the utilisation of the Better Care Fund to offset the impact of some of the proposed reductions, the Council would be unable to provide social care services to the extent of services and the number of people currently supported. The Plan will therefore be utilised to ensure that a range of Integrated Health and Adult Social Care Services continue to be maintained and developed.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

An amount of £3.372m in 2014/15 and £5.556m in 2015/16 has been allocated for the protection of adult social care services. This covers the costs of a range of services, including step up/step down provision, equipment, telecare, hospital social work teams and care packages where residential care admissions are directly from hospital or respite. An amount for demand from demographic increases has also been included.

Clearly, implementation of the Care Act, particularly in meeting duties for self funders and supporting carers will create additional cost pressures to an already challenging Council budget. A sum of £0.100m in 2014/15 and £0.554m in 2015/16 has been allocated to support implementation of the Care Act as well as meet the impact of demographic change. Through greater integration we aim to maximise the use of our resources and improve care and support for local residents.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

A sum of £0.554m has been allocated to support implementation of the Care Act as well as meet the impact of demographic change. A Programme Board has been established to oversee the implementation of the Care Act with a governance structure to manage the key workstreams that are required. Work to scope and develop workstream plans have commenced. A clause by clause analysis is being used to complete a gap analysis which will form the basis for the workplan for each of the workstreams. The focus currently is on planning for change.

Although there are important new challenges and duties from the Care Act, the Council has made considerable progress in key areas of the Act and will continue to expand this provision to meet the new and additional duties. Significant progress has been made in developing an approach for prevention and early intervention. The Council is very focused on promoting independence and wellbeing. This is reflected in the Council's eligibility criteria which is set at moderate to provide universal access to prevention and early intervention initiatives such as Reablement support. Personalisation is central to the care management and support planning processes. We are expanding provision of community support services such as Village Care Schemes. The established worksteams below will drive the implementation of the Care Act to meet the duties which will commence from April 2015.

- **Workstream 1 - Promoting Individual Wellbeing (Prevention, Housing & Public Health) and Information, Advice and Advocacy.** This workstream will review the general principles of the Act against what is currently being offered and to ensure that the general 'offer' is based on integrated, preventative services that improves people's wellbeing and care outcomes. It will also ensure access to information, advice and advocacy to enable people to make informed choices about care options and financial implications.

- **Workstream 2 - Assessment & Eligibility and Care Planning & Personalisation.** This workstream will review and develop systems to meet the care and support duties of the

council, assessing needs to address unmet needs. This includes support to self funders. It will review and develop mechanism to ensure young people, adults and cares receive timely, consistent integrated services which are person-centred and deliver value for money, whilst keeping them independent and safe.

- **Workstream 3 - Paying and Charging for Care** – This workstream will review and develop the mechanism for making financial assessments and delivering financial advice and support. It will assess the implications of the funding cap and administer the process for deferred payments and care accounts.

- **Workstream 4 - Quality & Safety and Care Markets.** This workstream will ensure there is an appropriate regime in place to provide oversight of the quality of the care system, working in partnership and sharing data to ensure safeguarding. It will develop and support the Care Market to deliver a wide range of care and support services which are person centred and promotes independence and wellbeing.

The immediate priority is to understand the total implementation costs of the Care Act. We are working with the National Programme Board and Eastern Region ADASS Network to undertake cost modelling. There is some concern about the variance in the new proposals on allocations to local authorities and how the final allocations will be made.

v) Please specify the level of resource that will be dedicated to carer-specific support

There is an excellent track record of supporting Carers in Central Bedfordshire. Support for Carers is jointly commissioned through Carers in Bedfordshire. The spectrum of services provided is set out below.

Spend on Adult Carers Services in 2013/14	
Service Type:	**CBC Adult Spend 13/14 £'000:**
Direct Provision – dedicated Carers Support Officers (including on-costs at 24%*)	109
Externally commissioned - Carers in Bedfordshire (main service provider)** - CBC Contribution	170
Externally commissioned - Carers in Bedfordshire (main service provider)** - BCCG Contribution	312
Direct payments	727
Carers Vouchers	86
Residential respite***	1,086
Residential respite*** – Older People Care Homes managed by the Council	277
TOTAL £:	**2,767**

Only the elements of the externally commissioned services, totalling £482k, across Central Bedfordshire Council and the Clinical Commissioning Group is included in the BCF pool.

Work is on going to reach more carers. The Care Act places carers on the same footing as the cared for and sets out Carers rights assessment and an entitlement to services. Initial estimates

on the number of Carers in Central Bedfordshire based on the 2011 Census is 25,000. It is not yet possible to determine the number of Carers who will present themselves for assessment and support however financial modelling of the costs is underway. The Care Act sets out a positive duty of information, advice and guidance. This is likely to influence the number of carers presenting for support. A sum of £0.482m in 2015/16 has been allocated for carer specific services. Modelling undertaken using the Lincolnshire model for the national stocktake identifies a requirement of additional 4000 carer's assessments in 2015/16.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There have been no changes made to the local authority's budget as a result of the resubmission process. The additional amount of £3.417m included in the pool from the Council's revenue and capital budgets, from the initial submission remains. This is intended to support the investment required in the system to deliver the changes required as per our vision. There is, therefore, no direct affect on the Council's budget unless the necessary benefits are not accrued.

7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Our plan is to further develop 24/7 services that are comprehensive across the four localities but recognise the need to flex the response based on differing needs. Currently there is a varied picture dependent upon the requirements of the seven Acute Hospitals outside of Central Bedfordshire. The Seven Days a Week standards were developed by NHS England and consist of ten clinical standards to ensure patients receive the best possible care and treatment every day of the week. The standards include: appropriately involving patients, their families and carers, in decisions about treatment; all emergency admissions should be seen by an appropriate consultant within 14 hours of admission; and, patients must have seven-day a week access to diagnostic tests such as x-ray and endoscopy (with varying time-related targets according to the need of the patient). This is essential to offer a much more patient focussed service, offers the opportunity to improve clinical outcomes and the patient experience.

We will work with our providers to secure a commitment to improving seven day services within our systems leadership framework. We recognise that a key factor in the successful delivery of our Better Care Plan is the workforce and have begun discussions with Acute Providers and social care operational staff to secure our vision for safe and good quality seven day services.

The Luton and Dunstable Hospital has defined a project to deliver the "seven day service offering" that supports both the Trust's 5 year business development vision and the overarching aspiration for the future new hospital.

Bedford Hospital has set out key areas of improvement planned for 2014/15 and will implement the following measures in order to meet the targets for reducing readmissions:

- Implementation of standards for effective ward rounds seven days a week in acute medicine
- Review and plan for clinical support service to facilitate seven day working

- Complete a review against the Seven Days a Week7 standards and develop a robust plan for implementation

Currently, consultant delivered care is available with resident consultants between 9am and 9.30pm, seven days a week. There has also been an increase in the establishment of medical and nursing staff. Hospital at Home is provided seven day a week. The hospital at home model provides an opportunity to deliver acute level care in the community, in people's homes, managed by a team of acute nurses and under the care of acute consultants. This initiative builds on the innovative model that has been developed at the Luton and Dunstable Hospital. The Clinical Navigation Team offers 7 days extended hours. A scheme is currently underway to allow flexibility where needed to extend to midnight.

Bedford Hospital Social Work Team operates seven day services to provide assessment and care management. This service also extends to families and carers and all patients in need of support are referred for an assessment to assist timely discharge from hospital. The Hospital team contribute to the development of joint policies within the hospital e.g. the choice directive and assist in times of crisis such Winter Pressures, ensuring that patient experience an integrated health and social care approach to discharge planning.

The East and north Hertfordshire Trust, which also serves Central Bedfordshire population, Service Delivery and Improvement Plan (SDIP) for 2014/2015 aims to deliver an action plan with trajectories for the 10 recommendations for 7 day working. Milestones include a self-assessment and action plan for presentation to the July 2014. Currently the Trust provides seven day services across emergency services, pathology and radiology, as well as weekend pharmacy services. Seven day services operate within the Community Hospitals. There is a seven day service until 22.00pm provided by the community Integrated teams. A seven day Navigator role at E&NHT A&E to facilitate the care of patients within the community where appropriate rather than in the hospital as well as integral members of the HomeFirst model.

Hertfordshire Health and Community Services are providing seven day a week social work services from both the Lister and QEII sites. At present this services assesses an average of four new patients at weekends and expedites discharges for people already in the system through access to the countywide enablement homecare contract, which is also seven days per week.

Our key focus is to deliver the right care, at the right time and right place for our residents. Our locality based approaches for multidisciplinary teams will ensure robust, timely and appropriate response to identified needs. The availability of robust intermediate services to prevent unnecessary admissions and to support early effective discharges in partnership with GPs and hospital consultants is fundamental to changing patterns of care. This has been described in a range of strategic documents and form part of the System Capacity and Resilience Plan.

In addition to the foregoing, the existing rapid intervention services for health and social care operating in Central Bedfordshire are well placed to form the core of an enhanced service available to people in their own homes or care homes. This includes our Urgent Falls and Home Response Service and Reablement services. To enable the offer to achieve its full potential there needs to be:

- Consultant-level leadership ensuring that comprehensive geriatric assessment is provided to patients in all urgent care situations, i.e. in the home setting or within hospital A&E and assessment units;
- An integration of the existing community-based nursing and personal care services with Hospital at Home specialist nursing outreach from the hospital sector;

- Sufficient capacity and skills to enable the most progressive treatments to be available in out-of-hospital care settings on a 24/7 basis;
- Progressive working arrangements between hospital consultants and GPs to enable overall clinical responsibility for discharged patients to be passed at an appropriate stage of a patient's recovery;
- Access to an appropriate range of intermediate care/rehab beds which will be part of a joined up service;
- Align the 7 day service provision implementation plan with our providers wherever possible e.g. to ensure services are deployed in the community for acute discharge out of core hours.

It is likely that services need to be accessed through locality health and social care co-ordinators with direct links to practice named GPs, hospital physicians and consultant community geriatricians. This is being developed as part of our Proactive Service approach which is described in Section C – below.

As part of our System Capacity and Resilience Plan and the Better Care Fund Plan specific work streams have already been identified and commenced their work to increase the provision of 7 day a week services

Health and social care commissioners will produce a new specification for such services. Partnership working between primary, hospital, community, and social care providers, as evident in the Demonstrator project, should enable the required service to be put in place readily. In particular, we will work with providers on staffing patterns and care quality standards to enable them respond to care requirements, especially at weekends.

Equally, our Primary Care services Locality Development Plans set out the framework for the transition being made by general practice towards seven day working, especially how this might initially be delivered to support our older population. Localities are exploring early options that include creating seven day hub practices and integrating seven day care with their existing out of hours providers.

We are working in Partnership with Health Education England and the Bedfordshire and Hertfordshire Workforce Partnership Group to develop a comprehensive cross-sector workforce strategy, modelling the impact of service changes on the system-wide workforce and addressing the cultural shift required to deliver new ways of working and maintain standards of clinical care. An options and issues paper which will inform the response to seven day working has been produced.

As we implement our Better Care Fund Plan and specifically our integrated service models, we will ensure that where it will deliver better outcomes for patients and provide value for money, services will be available 7 days a week. We will continue to work in partnership with providers on staffing patterns and care quality standards to enable them respond to care requirements, especially at weekends. We will use commissioning and contractual mechanisms to ensure that this is built into service models and service specifications.

b) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

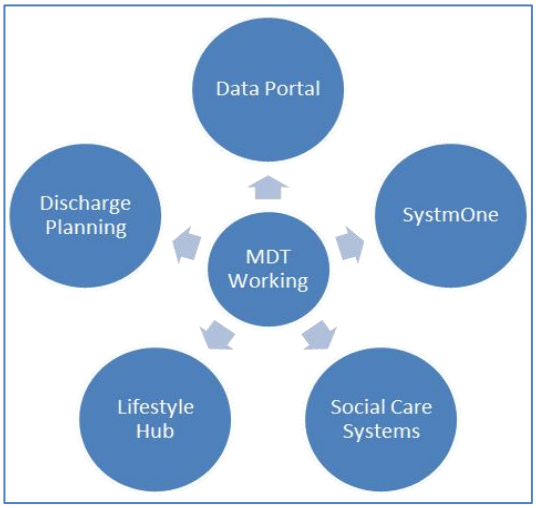
BCCG use the NHS number through using SystmOne. CBC has reinforced the collection of NHS numbers as part of the implementation of the Zero Based Review from April 2014. NHS numbers will be routinely collected as part of the assessment framework and will be recorded within the adult social care system (SWIFT). We are committed to using the NHS Number as the primary identifier for correspondence. We will also be reviewing options for developing common and shared systems across health and social care to facilitate data sharing.

A Bedfordshire wide steering group has been established to drive this work forward and is linked into the national pilot led by McKinsey and Monitor to ensure we benefit from best practice and national guidance. A programme plan has been agreed with three key priorities:

- Programme 1 – Performance & Outcomes
- Programme 2 – Joint Risk Stratification
- Programme 3 – IT to Support MDT Working

<table>
<tr><th>Current</th><th>Future</th></tr>
<tr><td colspan="2">Programme 1 – Performance & Outcomes
Financial Modelling & Tracking
• Project 1 : Financial Modelling Tool
– Health and Care Trak
– Mede Analytics
• Project 2 : Cross-organisational File Sharing
• Project 3 : NHS Number as Primary Identifier</td></tr>
<tr><td>Data Flows
Sharing and exchange of data</td><td>IT Information Portal</td></tr>
<tr><td colspan="2">Programme 2 – Joint Risk Stratification
Joint Risk Stratification
• Project 1 : Risk Stratification
– Unplanned Admissions DES
– Mede Analytics
– Health & Care Trak</td></tr>
<tr><td>Different tools being used across Primary Care
Health and Care Trak</td><td>Unsure of direction</td></tr>
<tr><td colspan="2">Programme 3 – IT to Support MDT Working
IT to Support MDT Working
• Project 1 : Data Portal (Shared Patient Record)
• Project 2 : SystmOne in Care Homes
• Project 3 : Lifestyle Hub and SystmOne
• Project 4 : Discharge Information Exchange</td></tr>
<tr><td>SystmOne - Data Sharing Portal</td><td>SystmOne</td></tr>
</table>

As a result of implementation, the system will operate with Multi-Disciplinary Teams with shared data and joint care planning.



Ensuring all health and social care systems use the NHS Number as the primary identifier is a key project within the IM&T programme. A number of other IM&T projects are dependent on the success of this project, therefore it is paramount timescales are followed.
The plan below is taken from the IM&T programme plan and shows the key milestones in delivering this project:

	Start Date	Finish Date	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
IT Data Sharing																	
Social Care - existing records populated with NHS Number	01/02/2014	30/01/2015															
Social Care - protocols in place to capture NHS number as primary identifier	01/02/2014	01/04/2014															

There are two phases to ensuring NHS Number is the primary identifier. The first phase is to populate existing social care data with the NHS Number; the second phase is to ensure the NHS Number is recorded at the point of care.

The process for phase 1 involves the use of the Migration Analysis Cleansing Service (MACS). MACS is a service offered by the Health and Social Care Information Centre (HSCIC) to NHS organisations to aid them in tracing NHS numbers for their patients in preparation for PDS compliance and to Local Authorities in the provision of social care services. All social care data will need to be uploaded to MACS to populate the NHS Number. Any discrepancies following the MACS trace will be need to be addressed manually, using a process of cleaning the data to ensure all fields are correct.

Phase 2 has been driven by requirements of the Zero Based Review of adult social care collections which requires the use of NHS numbers as the Primary Identifier. This came into effect from April 2014 and will ensure the NHS Number is collected as part of the input forms within the social care 'Swift' system.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The CCG is committed to the prescribed standards and the Council will work towards adopting the standards. Open Standards and are compliant with Health & Social Care Information Centre (HSCIC) Information Governance Statement of Compliance (IGSoC) and Interoperability Toolkit (ITK). The proposed integrated Multi-Disciplinary Team (MDT) approach to patient care will feature two systems, TPP SystmOne and Northgate Public Services SWIFT.

Primary Care and Community Care services use TPP SystmOne; SystmOne is a centralised clinical system that provides healthcare professionals with a complete management system. SystmOne complies with IGSoC and ITK2.0. allows interoperability with other clinical systems via APIs.

Social Care Management system uses Northgate Public Services SWIFT; SWIFT is a complete management system for adult social care, and complies with ITK2.0, as well as the data protection act 1998. It also can communicate with other systems via APIs.

Other systems that commissioners are using for financial modelling, such as Mede Analytics, are also IGSoC compliant. The vision set by the Better Care Fund will need to be supported by robust IM&T; in addition to all systems currently being compliant with IGSoC and ITK2.0, any systems implemented under the BCF going forward, will meet the same levels of compliant as the current systems.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

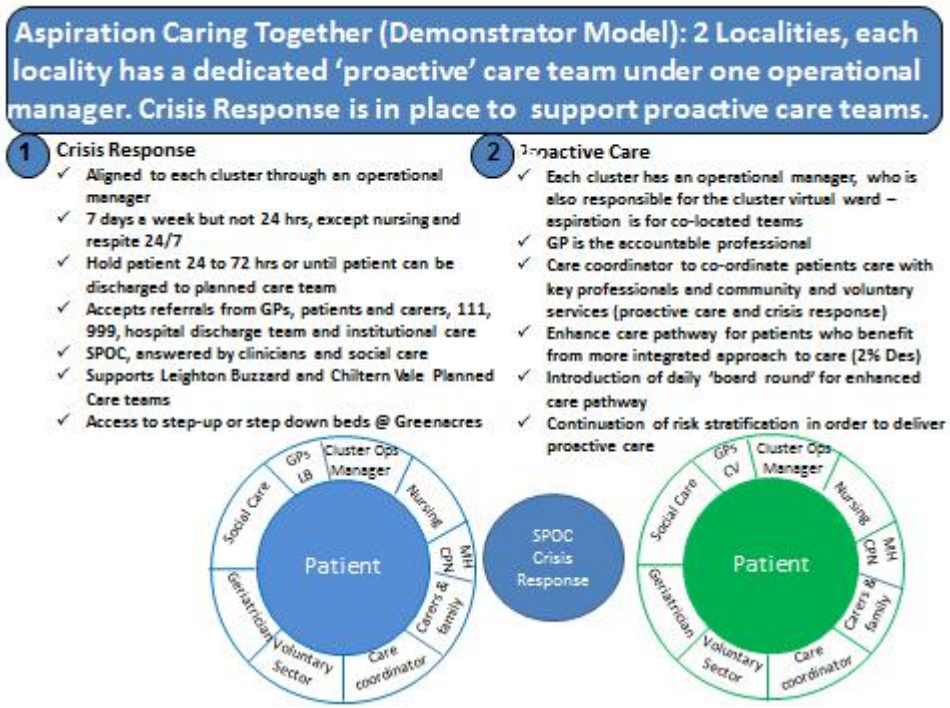
BCCG has completed the Information Governance toolkit and is compliant. It has also attained Stage 1 accredited Safe Haven status. All staff undertake annual IG training along with confidentiality clauses written into their contracts. Central Bedfordshire Council has completed a self assessment against the standards and is working actively to achieve the required standards

by March 2015. Both organisations have designated Caldecott Guardians. Information sharing agreements are in place and the Council is working towards compliance with Caldecott 2 standards.

c) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Approximately 4,209 Central Bedfordshire residents registered with a GP have been identified as at high risk of hospital admission. This represents 2% of the overall adult population in Central Bedfordshire. Three main tools have been made available to all GPs, a MedeAnalytics risk stratification tool, and two methodologies developed by local GP. The planned approach for management of high risk patients based on a proactive case management will be rolled out across Central Bedfordshire. The Demonstrator project in Chiltern Vale and Leighton Buzzard is setting the pace for this work. Figure bellows sets out the approach.



ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

A joint process to assess for risk stratification and case management through a lead professional is in place and is supported by Case Management Directed Enhanced Service. This currently profiles the 2% of those most at risk of emergency hospital admission. This approach is being expanded and remains a key mechanism for delivering our Better Care Plan. Supporting people with long term conditions in our four localities has commenced with the initial identification of those patients at high risk of admission and effective multidisciplinary team management of those patients.

A toolkit based on DES was developed in order to help GPs approach the identification of their 2% patient population, and the methodology applied to patients 75+ is outlined in figures 1 and 2 below:

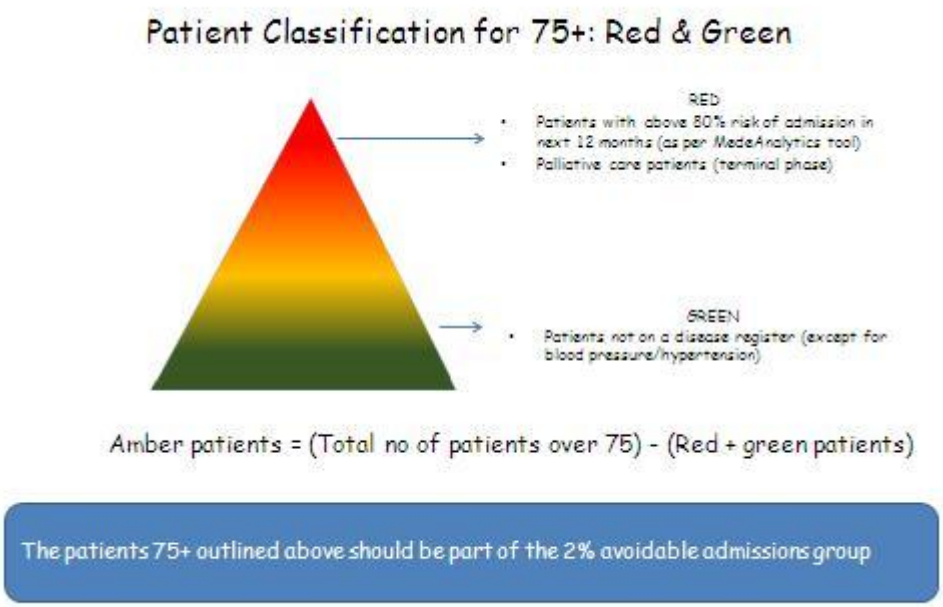


Figure1: Identify patients that are 'Red = very high risk' and 'Green = healthy'

The intention of the project team to focus their care on the amber patients as those patients who are 'red' are probably end of life and very little can be done to reduce the risk for these patients through further intervention.

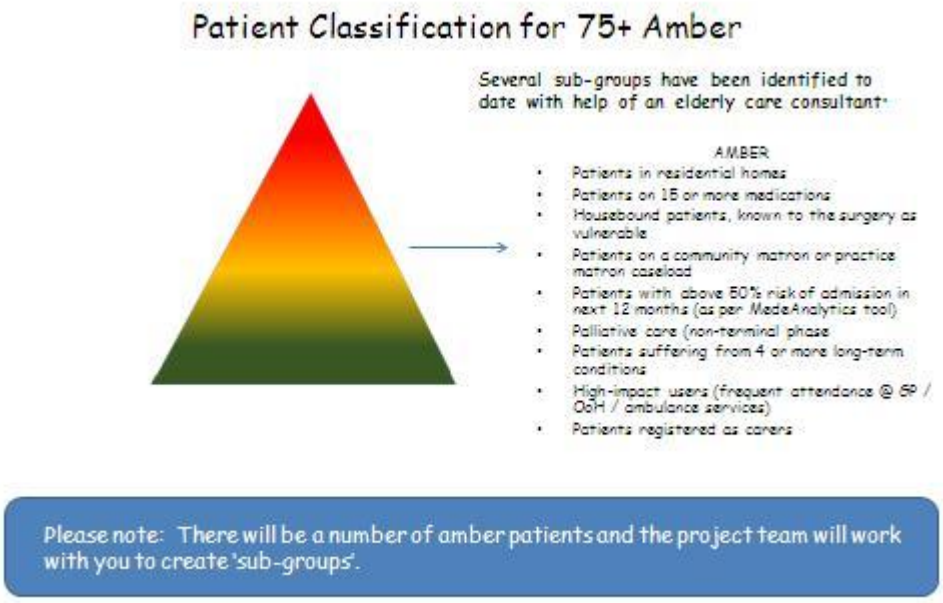


Figure 2: Standardised approach to identifying patient subgroups.

Patients identified as part of the above risk stratification process will:

1. Be screened to ensure that they are receiving the correct health and/or social care intervention
2. Where gaps in care are identified, these patients will be referred appropriately, in a more co-ordinated way
3. Each patient will have their care plan appropriately updated; this will further inform the crisis response teams should this patient ever be referred to this team.

This approach is being used in our Demonstrator Project and Proactive Care Service. Our intention is to expand the tool, based on Health and Care Trak to include social care, mental health data and other relevant information to provide a more holistic picture of individual's risk. This is set out in our programme for joint risk stratification in the Data sharing section above.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

It is a requirement of the avoiding unplanned admissions DES that 2% of high risk population have named GP and care plan in place by end of September 2014, all CBC practices are signed up to this. Therefore the 2% we talked about will be covered. The plan is holistic and takes into account health and social care needs (see extract below).

In addition to this, practices within the Chiltern Vale Demonstrator Project have been asked to consent to share their records with social care. All patients over 75 within the 2% high risk group this is 894 patients and to date 194 patients have agreed to this.

Work is underway as part of the MDT initiatives to create joint care plans for those patients identified to be at high risk of admission and as part of our approach to supporting patients with long term conditions. This is a key part of Scheme one – Transforming Primary Care.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Across Central Bedfordshire, partnerships are central to how we ensure that our plans for commissioning health and social care are shaped by the views, ideas, and experiences of patients, service users, and local communities. Our main means of engagement has been through the development of the JSNA, JHWS, and the strategic planning processes for both Bedfordshire CCG and Central Bedfordshire Council. The outcomes of these events have directly shaped both the Bedfordshire Plan for Patients and this Better Care Fund submission.

Developing our plans in partnership - deliberative events held in June 2013: In June 2013, we held deliberative events with patients, carers and the general public to listen and understand the views of our local communities and organisations in key areas, including the vision for healthcare

services, what needs to happen immediately, and the key priorities to consider when developing health and social care services. The outcomes of these events have helped to shape the Bedfordshire Plan for Patients and are helping to shape the emerging Better Care Plan for Central Bedfordshire. A report on these deliberative events can be accessed from this webpage: https://www.bedfordshireccg.nhs.uk/page/downloadFile.php?id=12381

We have used our Healthier Communities and Older People Partnership Board to engage service users, carers, and user-led organisations on plans for how care and support should be provided for older people (and particularly the frail elderly). We have adopted a principle of co-production with all key stakeholders in redesigning and commissioning care and support.

The Better Care Plan reflects the output and findings from the various engagement activities, all of which are helping to influence and shape the priorities for health and care.

We have continued to share and discuss plans with service users through existing forums and specific events. We held an event in one of our localities in Ivel Valley on 1 May 2014. 'Caring Together' brought a wide group of stakeholders together to explore ways that frail older people in the area can be supported. The aim was to harness expertise from the local community, including voluntary and social groups and health and social care professionals, and recognised the potential of coming together collectively to think about things differently. There were over 60 attendees at the event. Representation included GPs, social workers, Healthwatch, voluntary sectors, carers, patients and senior managers and leaders from the Local Authority as well as the wider health and social care economy. Discussions took place around the following areas:

- Admission avoidance (hospital and social care)
- Imagine there is no hospital- radical thinking
- How we move forward on multidisciplinary teams
- 7 day working across the Health Service
- Combatting loneliness, keeping people happy, and encouraging exercise and communication
- What do older people think, how do we communicate and contact people and use information we already have
- Exploring labels that make older people feel less good about themselves like geriatric wards
- Values and Beliefs in workforce in hospitals and care homes

Detailed discussions from the Ivel Valley event have been reviewed and these are being reflected in our Better Care Plan approaches and Schemes. A number of 'What ifs' emerged from the session and in response we have ensured that the principles of these aspirations ("you said, we did") are reflected in the Better Care Fund Plan. A snapshot of the 'What ifs' included:

'WHAT IFs':

1.Keeping Older People Safe, Happy and Healthy:

- "Everybody made an agreement to call on five neighbours. (Joining Residents Association). Awareness of people who many need support from health and social care services (statutory and voluntary)"

We are expanding our Village Care Scheme and increasing our emphasis on developing a strong volunteer base for our local communities.

2. Making sure older people have support when and where it is needed

- There are community hubs – different for different communities: What if someone discharged from hospital receives co-ordinated welfare visits from someone to check they are ok-holistic assessment.

Our Plan sets out a clear commitment to developing locality-based health and social care hubs offering improved outcomes and personalised support for individuals. The Hubs will deliver coordinated health and social care accommodating a wide range of clinicians and allied practitioners offering core general practitioner, community health and out-patient services.

3. Keeping older people out of hospital

- We can all operate as one team - multi-disciplinary teams that regularly meet/have processes for improving co-ordination of care. ? : Everyone involved in your care has access to your information in a way that allows them to support you appropriately.

Our Plan sets out an approach for centred on multidisciplinary teams with early intervention and practical community and social care support which helps to reduce admissions and reliance on institutional forms of care.

At a recent Public Engagement Forum in Leighton Buzzard facilitated by Healthwatch Central Bedfordshire, the majority of members of the Forum were pleased to see initiatives such as the Demonstrator Project supporting the frail elderly. In general the majority of people thought it was a valuable concept (bringing health and social care closer to home) but were not entirely sure how this would be achieved.

Similar events are planned across the remaining localities in Central Bedfordshire. An engagement event is planned for 4 November for patients, service users and other key stakeholders for the Leighton Buzzard Locality.

A robust communication and engagement plan is being produced for our wider integration agenda. It is influencing our engagement activity for the Demonstrator Project which is a flagship of our Better Care Fund Plan.

We will continue to have on-going meaningful engagement with service users and will work with Healthwatch Central Bedfordshire to undertake more broad-based engagement on specific projects of the Better Care Fund.

BCCG has established systematic ways to routinely and methodically capture the views and experiences of patients/service users, carers and the public. They include a Public Engagement Forum which quality assures the engagement activity and acts as a critical friend by regularly assessing that engagement plans are effective and meaningful.
https://www.bedfordshireccg.nhs.uk/page/downloadFile.php?id=11994

The review of healthcare services across Bedfordshire and Milton Keynes has undertaken in-depth and comprehensive engagement activities with local people, clinicians, organisations, communities and a range of sectors. This extensive engagement activity means that we have heard the views of local people, including various seldom heard groups, in a variety of ways all of which are detailed on the dedicated website http://www.yourhealthinbedfordshire.co.uk/
What we have heard has helped to shape and inform our Better Care Fund plan. A cross section of what people told us is set out below:

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

There is no district general hospital located within the boundaries of the Council consequently our residents are served by up to nine hospitals in surrounding areas. These are

- Luton & Dunstable University Hospital
- Bedford Hospital Trust
- Cambridge University Hospital
- Buckinghamshire Healthcare Trust (Stoke Mandeville)
- Milton Keynes Hospital Trust

- Hinchingbrooke Health Care NHS Trust
- East and North Hertfordshire NHS Trust

Community Health and Mental Health services are provided by South Essex Partnership Foundation Trust.

All our key providers were engaged with for the earlier submission of the Better Care Fund Plan. Implications for our key acute care providers is set out in section 8C and reflects further engagement which took place to meet the requirements for this resubmission.

In principle, our Better Care Plan reflects the broad understanding of the key issues, vision, and ambitions for the population, developed with our providers and has been influenced by detailed pieces of work focused on specific issues. These include the recent review of community beds provision in January 2013, the Central Bedfordshire Pioneer Bid for integrated care submitted in June 2013, the Ageing Well programme, the Joint Commissioning Strategy for Improving Outcomes for Frail Older People (2012-15), and our Voluntary, Community and Social Enterprise Commissioning Pilot in 2013.

There are well established mechanisms for provider engagement. Regular meetings and forums take place across the Council and NHS and increasingly these are joint and part of integrated governance arrangements. Open days bring together providers to discuss emerging trends, strategic and financial issues, and commissioning intentions.

These large events bring together providers across the area. We recognise the challenge of working with different acute hospital providers to ensure equity of access to care and support services for vulnerable older people.

These forums and meetings have been fundamental to the development of the current Joint Strategic Needs Assessment (JSNA), the Joint Health and Wellbeing Strategy (JHWS), Central Bedfordshire's Adult Social Care Market Position Statement (MPS), Bedfordshire CCG's Plan for Patients, and other strategic planning documents. Forums are followed up with other regular communication; including newsletters, further information, and consultation. Open communication is maintained throughout as a key part of the commissioning role. One-to-one leadership meetings with the acute providers and other key providers also take place.

Specifically on the Better Care Fund Plan, we have shared our plan with key providers and stakeholders with specific workshops on developing integrated services with the Luton and Dunstable NHS Hospital Foundation Trust on 30 January. This is in addition to the wider contract negotiations led by Bedfordshire CCG and the review of sustainable health services taking place across Bedfordshire and Milton Keynes. The Director of Social Care, Health and Housing (CBC) and Director of Strategy and System Redesign (BCCG) held meetings with our key acute care providers to discuss our Better Care Plan and to understand any consequential impact. Already we have identified key points from acute providers such as the need for detailed modelling to take place to understand patient flows and different models of care for increasing complexity of need. A separate engagement meeting was also held with the community health services provider (SEPT), who will play a key role in delivering more integrated locality based services. We recognise that the shift required will have implications for the workforce and will work with key providers to determine the impact and address these changes as we implement new ways of working.

We have also undertaken specific and targeted engagement with community-based health and social care providers. This includes engagement on elements of the plan with our locality GP networks in January 2014 and our Older People's Delivery Partnership in February 2014.

Providers remain integral to all of these established governance groups and consultative forums.

In March, April and May 2014, System Leaders which includes the main providers for health and social care met to understand the collective impact of operational plans on the local health and social care economy and start to set the scene for the creation of 5 Year Bedfordshire Health and Social Care System Strategic Plan.

In the context of the large number of acute hospitals providing urgent care services to our population, a process has been put in place to ensure that there is good knowledge of the Better Care Fund change programme being led by the host health and social care commissioners of those hospitals. Given the national requirements for the Better Care Fund it is anticipated that neighbouring systems will be taking forward very similar programmes but co-ordination will be very important. A framework for locality partnerships, which will play a lead role in liaising with their catchment area hospitals, is being established.

A group of stakeholders were brought together on 24 March to discuss opportunities, issues, risks and challenges of the Better Care Fund Plan. The event was well received with over 70 stakeholders attending from a wide variety of organisations, including acute care providers, care providers, the voluntary and community sector and Healthwatch.

A copy of the presentation event held on 25th March 2014 for Providers is attached.
http://www.centralbedfordshire.gov.uk/health-and-social-care/adult-care/better-care-fund/better-care-fund.aspx#

We will continue to engage with our providers across health and social care services as we implement our Better Care Plan and monitor the risks and consequential impact of the changes proposed in our plan. Further meetings between our Health and Wellbeing Board and Boards of our Acute Providers are planned. This will ensure that all key stakeholders are engaged on the Plan, remain aware of the consequential impact and shared risk and that the Plan has broad ownership and is deliverable. Successful implementation of our plan will require on-going engagement and forms part of the overall communication and engagement strategy for our Better Care Fund Plan. We will continue also to use existing forums and meetings to share and discuss the plans with the wider workforce and other key stakeholders.

As part of the resubmission process, we have engaged with all our key providers. A meeting with discuss our Better Care Fund Plan and the wider implications for delivery of the plan. The meeting was held on 9 September. Those providers who were not able to attend were invited to comment on the draft plan and implications for the 3.5% reduction in non-elective admissions. We will continue to engage with our providers as part of monitoring delivery of the Better Care Plan and developing more integrated approaches to health and care services in Central Bedfordshire.

ii) primary care providers

Both the Council and the Clinical Commissioning Group use existing locality structures to engage with general practices and other primary care providers. In addition, it has identified three GP clinical directors that represent and engage with other stakeholders. One clinical director works with each unitary authority, sitting on its Health & Wellbeing Board, as well as having their own specialist interests, such as quality of care at Bedford Hospital Trust and the care of older people

in general (for the northern clinical director), and mental health and respiratory care (for the southern clinical director). The third clinical director focuses on Luton & Dunstable University Hospital Foundation Trust, building clinical networks and establishing a route for dialogue between Bedfordshire GPs and the L&D's consultants, as well as being prescribing lead for BCCG. Primary care leads have been central to the development of the Better Care Fund Plan and constituent schemes.

The Better Care Plan is shaped by the views of GPs, practice staff and locality staff about the health needs of the local population and the services required to meet these needs. These early planning outcomes have been captured during planning workshops with our Localities in May 2013 and built upon during engagement and deliberation with a wide range of stakeholders from the local community (see Deliberative Events engagement attachment). A further engagement event is planned for 4 November in Leighton Buzzard to help shape the integrated locality based approaches for delivering health and social care.

As plans have developed engagement through locality forums and Locality Commissioning Group leads have contributed and influenced the Plan. (Please see governance structure).

iii) social care and providers from the voluntary and community sector

Central Bedfordshire Council is the social care commissioner and also provides some in-house services, including reablement. Social Care and community based support is provided by a wide range of private, voluntary and independent sector providers. There is a robust and productive partnership working with a wide range of community and voluntary sector organisations, with Provider Forums take place across commissioners and client groups

In adult social care, quarterly provider forums take place with domiciliary and care home providers, and engagement on the Better Care Fund has been a key part of the Forums held in recent months. Specifically, we engaged with Residential/Nursing Care Home, Domiciliary Care and Learning Disability Care providers on Wednesday 2nd April 2014 at the Care Provider Forum on the Better Care Plan for Central Bedfordshire. Our Care Providers share the vision for health and social care and the approaches set out in the Better Care Fund Plan. Further discussion will take place to discuss key elements of the plan and in particular implications and support for 7 day working.

More specific engagement activity is linked to clearly signposted commissioning changes and takes place focused on client groups (such as older people), services (such as home care) and sectors (including targeted voluntary sector engagement). These forums and meetings have been fundamental to the development of the current Joint Strategic Needs Assessment (JSNA), the Joint Health and Wellbeing Strategy (JHWS), Central Bedfordshire's Adult Social Care Market Position Statement (MPS), which have also helped to shape our Better Care Plan.

In addition to this, we are engaging on the implications of the Care Act which will impact on the delivery of the Better Care Fund Plan. Key elements of this includes promoting a person centred approach and the requirement to ensure promotion of independence and wellbeing in all our commissioned services. Social Care Providers and our Voluntary sector recognise the significant changes required to deliver the vision for the Better Care Plan and the Care Act. We worked with Age Uk and the Red Cross to develop a scheme to support early discharge from hospital and

reduce readmissions.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The developments described in this Better Care plan will strengthen primary and community health and social care services to enable more patients with urgent care needs to be managed at home or close to home. Investment in these services will mean reduced reliance on the hospital sector for emergency care and an opportunity to re-invest a very significant element of the current hospital spend associated with the current level of admissions. Development of our Better Care Plan has been through a co-production with our key providers and other stakeholders. There is a shared and common understanding of the challenges, vision and agreement on the schemes which underpin the Better Care Plan for our health and care economy. Some of these joint initiatives have commenced.

Cost of urgent care and savings targets

This scale of change is described in paragraph 18 of the NHSE Planning Guidance Everyone Counts: Planning for Patients 2014/15 to 2018/19: "The funding and implementation of the Better Care Fund has the potential to improve sustainability and raise quality including by reducing hospital admissions. Hospital emergency activity will need to reduce by 15% and CCGs will need to make significant progress towards this in 2014/15."This clearly has important implications for the general hospitals serving the population of Central Bedfordshire.
The situation in the Central Bedfordshire health and care system is particularly complicated, with significant urgent admissions to seven general hospitals plus regular but modest flows to a number of others.

In Central Bedfordshire in 2012/13 the overall number of emergency admissions (spells) was 20,342 at a gross value of £42.268m. Within this total, there were 6,211 admissions of patients over the age of 75 with a gross value of £17.413m (source: MedeAnalytics). To respond to NHSE guidance, the health and care system will need to re-structure care pathways in a way that enables 15% of £42.268m i.e. £6.340m, to be released from hospital spending. It is anticipated that the focus of changed patterns of care will be upon the sub-acute care of patients over 75. To release the bulk of the £6.340m from the current spend of £17.413m on this age group will require a reduction both in the number of patients admitted and lengths of stay.

In response to this, the Clinical Commissioning Group and local authority adult social care leads have successfully engaged with clinicians across all sectors in the co-design and delivery of new ways of treating patients. In 2012 almost £4m of NHS transformation funds and Adult Social Care reablement funds was deployed on a programme of community-based sub-acute care in South Bedfordshire to reduce hospital admissions and shorten lengths of stay. This project culminated in successful benefits and positive outcomes for patients, an increased proportion of who were able to return to live independently in their homes. Senior hospital and community clinicians are

encouraging the continuation of this programme into a second phase of development. This is described as a Demonstrator Project in this plan.

The current service configuration within Central Bedfordshire often results in the frail and elderly population not receiving the 'right care' in the 'right place'. The acute hospital is deemed to be the only viable option when a frail and elderly patient becomes 'unwell' and an unnecessary admission to hospital occurs, often exacerbating the patient's frailty. Key stakeholders within the Central Bedfordshire health economy (Luton & Dunstable Hospital, the local authority, CCG, Primary Care, SEPT and the voluntary sector) have recognised this issue and are now in the process of designing and implementing a new model of integrated care for the elderly. Initially this integrated model of care will be rolled out in two of the four localities within Central Bedfordshire - Chiltern Vale and Leighton Buzzard, however the other two localities will adopt this new model of care soon after the initial implementation is proven. The model outlines a co-located health and social care team working together to deliver care, supported by a geriatrician and the voluntary sector. The team would be clustered around a group of GP practices and there will be one single point of contact for patients and professionals.

This project in the south of Central Bedfordshire has already seen a 50% increase in the numbers treated on a short-stay basis at the Luton and Dunstable Hospital, moving from 20% of total in the base year (2011/12) to 32% in 2013/14. Senior hospital clinicians have indicated that 50% short stays could be targeted with comprehensive geriatric assessment on arrival at hospital and early, effective discharge from A&E and assessment units to enhanced intermediate services. This scale of shift in hospital bed days, associated with higher levels of short stays of less than 48 hours and shorter stays for those staying over 48 hours, would cover the bulk of the cost of alternative community management.

Ivel Valley Locality

A proposal for integrated working for improved outcomes for frail older people is being developed in Ivel Valley as part of a wider system leadership programme. This will bring together a targeted prevention approach with social workers and community matrons around practices to enable proactive case management of older people. Ivel Valley residents look to two acute hospitals principally for their acute care needs – Bedford Hospital and The Lister, part of East and North Herts NHS Foundation Trust. Early engagement with these hospitals has identified good alignment of strategic ambition and highlighted key priorities that the BCF delivery plan in Central Bedfordshire will seek to address, from an acute perspective. This incudes

- Intermediate services which align acute services such as clinical navigation team operating hours with the rapid response team and the responsiveness, simplicity and flexibility of these services
- Discharge to assess – support within Central Bedfordshire for the move to discharge to assess models of care for patients requiring a CHC DST
- Case management – in line with the evidence base that this should be at the correct scale and with effective risk stratification to ensure that intensive proactive support is targeted effectively and does impact on acute admissions
- 7 day working – that plans to move to 7 day working across acute and community should mirror one-another in implementation timetable and capability
- Role of geriatricians – that further work will be undertaken to explore the opportunities for geriatrician roles within Ivel Valley, the key areas where this will add value to the

patient experience and how this might be provisioned

- EOL and Care Homes – to develop common approaches across counties to the management of patients as they approach the end of their lives to ensure more are supported to die in their usual place of residence
- Public engagement – to provide strong assurance to the public during the implementation of the BCF transformation and especially to consider social marketing techniques that address risk perception and the shift to community care as the gold standard for older people and those at EOL, rather than a historic association to acute care
- Workforce – that there are early opportunities to realign workforce as well as challenges such as dual running during transition periods and that these should be addressed as part of a whole system workforce plan
- Carers – to recognise the signs of carer fatigue and how alternatives to acute care can be made available to support them proactively
- Local BCF alignment – to co-ordinate the Central Bedfordshire BCF with those of neighbouring counties, who host acute providers, to enable the impact on acute providers of changes to community patterns of provision to be managed.

The locality integrated partnership approach and Programme Partners Meeting are seen as strong tools in continuing this active acute sector engagement and co-ordination of the BCF plan going forwards.

Role of Locality Partnerships

The Demonstrator Project in the south of Central Bedfordshire will continue during the course of the Better Care Fund plan and expanded through a partnership programmes rapidly rolled-out across Central Bedfordshire. These partnerships will focus both on localities and across hospital catchment areas. Commissioning managers from health and social care will liaise with neighbouring commissioners and acute services regarding similar programmes in the seven hospitals based outside Central Bedfordshire but for which Central Bedfordshire forms part of their catchment population.

All health and care systems have a similar agenda driven by the national Better Care Fund programme. So although many of the hospitals serving Central Bedfordshire are outside of the Bedfordshire system, we expect commissioners in Hertfordshire, Cambridgeshire, Milton Keynes, and Buckinghamshire to be taking forward aligned programmes. It is anticipated that the NHSE Local Area Team will support co-ordination of programmes across a wider area.

Locality partnerships in the four Central Bedfordshire localities will be key to organising alternative community management. As described in other sections of this plan, the patterns of care cannot be changed unless there is improved infrastructure and improved ways of working. Locality partnerships will be central to delivering the changes that will necessarily reflect individual locality's circumstances and needs.

Although the focus is very much on releasing funds from the hospital sector, improved ways of working should also achieve greater productivity in primary and community care services. Locality responses to the Better Care Fund plan are emerging.

For example:

- **Taking forward integrated, multi-disciplinary care for older people and higher risk patients**

West Mid Beds practices have already embarked on a programme to provide proactive, personalised care to people with complex health and social care needs and who may be at higher risk of being admitted to hospital and desire to proceed with an integration of rapid response health and social care services which will potentially include elements of out of hours medical care, nursing care and social care.

- **Developing a future proof general practice business model for the locality**

The practices will develop a business plan for collaborative working to advance as providers of care, to give them an appropriate platform and infrastructure for delivery over and above traditional GMS core services and to more effectively play a role in the integration of health and social care services. Practices are committed to retaining their current 'clinical delivery units' and patient registers, but recognise that collaborative working offers opportunities around:

- premises management and development
- sharing clinical expertise and delivering services more efficiently (e.g. locality clinics)
- extending working hours
- delivering rapid response services (e.g. home visits) supporting care homes.

- **Ensuring a future commissioning model which encourages and incentivises integration between services**

Following the completion of the review of healthcare services in Bedfordshire and Milton Keynes and the subsequent re-commissioning of community services and out-of-hours services, the locality will work with other teams aligned to the BCF to develop commissioning models and service specifications which span care pathways, incentivise joint working between organisations and professionals, and are focused on improving health and social care outcomes for local people.

- **Programme Budgets, Provider Partnerships and Risks**

Where plans are delivered on schedule and savings are realised, service delivery and quality will be improved and sustained. Where plans are not delivered on schedule and savings are not realised this may cause destabilisation to both providers, the CCG and the Council. In addition, this is likely to impact negatively on key performance indicators, including those in the NHS Constitution such as referral to treatment times and A&E waiting times.

To reduce the risk of financial pressures associated with pump-priming new services whilst reducing reliance on current patterns of care and costs, commissioners will seek to establish provider partnerships with agreed programme budgets supported by a manageable risk share agreements. These provider partnerships will include at a minimum the hospital sector, GP locality networks, community health, and adult social care. They will be charged with changing patterns of care in line with the Better Care Fund programme, perhaps utilising 'Alliance Specifications and Contracts' that set out the programme of change required. This will ensure a clear financial envelope is agreed within which the change programme can be taken forward. At the same time as the Demonstrator Project and other partnership projects gather pace, a review of sustainable services is being undertaken by Bedfordshire and Milton Keynes CCGs alongside Monitor, NHS England, and the NHS Trust Development Authority. The review will help to understand what high quality, sustainable services will need to look like to support care needs into the future.

The table below sets out the anticipated impact of our Better Care Plan Scheme on activity to secure the required minimum 3.5% reduction in emergency activity (757 emergency spells), to the value of £1,127,930. The majority impact is on 4 acute hospitals. All hospitals have been informed of the indicative impact of the schemes on their individual Trust and given an opportunity for discussion and to provide feedback on these changes.

Split by Hospital	**Split of CBC acute activity by provider**	**Reduction in acute activity (hospital spells) based on Plan**	**BCCG Contract performance ytd against plan as at month 4**
L&D	46.2%	350	192 over plan 7%
Bedford	21.6%	164	160 below plan 3%
East & North Herts	14.8%	112	224 over plan 21%
Milton Keynes	8.5%	64	23 under plan 12% - month 2
Cambridge	2.5%	19	activity month 1-3=434, awaiting plan
Buckinghamshire	2.2%	17	4 over plan, 2% month 2
Other Acute Trusts	4.2%	32	
Total	**100.0%**	**758**	237

In securing these outcomes we are equally mindful of the requirement to mitigate any adverse impact on the quality of mental health services. Bedfordshire Clinical Commissioning Group is currently re-procuring mental health services based on current levels of investments. Securing improvements in dementia crisis care and psychiatric liaison services are part of the procurement and improvements in these will lead to fewer A&E attendances. The bidders currently involved in the procurement process are all keen to understand and be involved in BCF Plans. The focus of our programme on prevention and early intervention will also ensure a continued focus on securing additional investments in mental health services which we expect will help to reduce pressure on Acute Trusts.

ANNEX 1 – Detailed Scheme Description

Ref no.	Scheme
1	Transforming Primary Care
2	Integrated Rapid Response for People with long term conditions and the frail elderly
3	Efficient Planned Care – predictable, reliable and close to home.
4	Coordinated and supported discharge from hospital with ongoing community care
5	Implementing the Care Act
6	Implementing the Better Care Plan

ANNEX 1 – Detailed Scheme Description

Scheme 1 – Transforming Primary Care

Scheme ref no.
1
Scheme name
Transforming Primary Care Transforming primary care is a key component of delivering person centred, locality based integrated health and social care with a focus on prevention and self-care. It is fundamental to responding to a rapidly growing and ageing population. This BCF scheme includes three key projects: • Prevention and Early Intervention • Long-term conditions management in primary care • Accountable Lead Professional/GP Federations
What is the strategic objective of this scheme?
Prevention To ensure that a range of services are in place that: • Prevent or delay the deterioration of wellbeing resulting for ageing, illness or disability • Promote independence • Delay the need for more costly and intensive services **Long-term conditions management in primary care** To ensure that a range of services are in place that: • Prevent or delay the deterioration of wellbeing resulting for ageing, illness or disability • Promote independence • Delay the need for more costly and intensive services **Accountable Lead Professional/GP Federations** • Provide person-centred, coordinated health and social care tailored to the needs and preferences of the individual, their carer and family
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Prevention There are a number of strands to this scheme: • The development of **lifestyle hubs** which will allow patients to access the support of a lifestyle advisor who delivers motivational interviewing to determine the

most appropriate referral route and support, as well as agreeing an action plan. This is a joint venture between public health, BCCG and Adult Social Care.

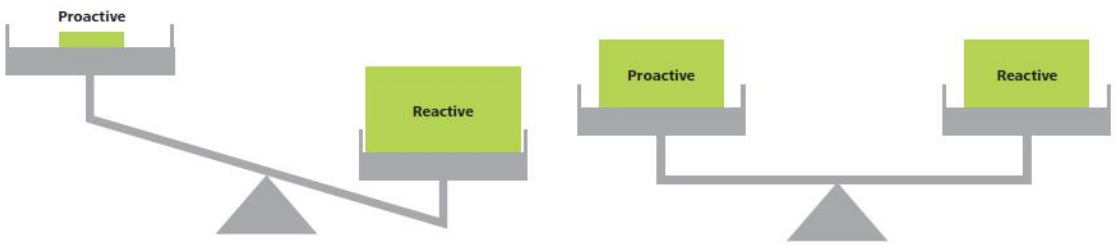
- Increasing **Making Every Contact Count** further across the health, social care and voluntary sector workforce to ensure that people are given brief intervention and signposted to further advice on healthy lifestyles and good mental health. This is delivered by Public Health.
- Exploring the costs and benefits of an **Older Persons Healthcheck** (over 75s) by expanding on the current NHS Healthchecks model and introducing a more holistic assessment of risk and need. This will be led by public health but in very close collaboration with BCCG and Adult Social Care
- Providing increased **early identification of harmful drinking** through the use of validated tools, a new web based resource and MECC. To then provide brief advice from Community Alcohol Liaison Workers and treatment from a specialist provider, including an intensive outreach worker for those who attend A&E regularly as a result of their alcohol consumption. The level of alcohol related admissions is increasing in Central Bedfordshire due to the long term impacts of harmful drinking, so the initial target is to halt the rise and then reduce it. The work is led by Public Health.
- **Reducing Social Isolation and Loneliness** through the delivery of schemes such as sliver line, village care schemes and befriending. This work is led by Adult Social Care.
- Increase the uptake of **flu vaccinations** in all target groups to reduce the number of emergency admissions related to flu. This work is led by the Local Area Team

Long-term conditions management in primary care

The aim is to implement a proactive and integrated Long Term Condition care model in primary care across BCCG that will deliver a step change in the management of LTC patients' health, from early identification through to treatment and supported self-management. It aims to improve care planning and case management processes within practices, ultimately with the aim of reducing emergency admissions to hospital.

The proposed model of care moves away from the traditional model of see, treat and discharge in a reactive way towards a proactive integrated system where GP, Practice Nurse, Community Matron, Community Psychiatric Nurse, Health Visitor, Social Care worker, Administrator and patient (self-care) work together as a team.

Current Model **Future Model**



The way forward will ensure that within BCCG care for patients with long term conditions is no longer patchy and inconsistent. Currently there is variation in care; it is recognised that some practices manage their patients with LTCs very well and are

following national guidelines and completing basic QoF templates. However, this cannot be said for all practices across BCCG. There is also a need for much better data to prove that quality LTC care is being delivered. Currently this is difficult to access and share.

The model of care will change from

- Limited proactive and patchy care
- Multiple access points
- A level of inappropriate admissions & delayed transfer of care
- System difficult to navigate between health and social care
- Care only provided in response to crisis or cry for help
- Poor access to information and data

To

- Prevention and early identification of those at risk
- Single access point, care co-ordinator (named GP)
- Standardised high quality care, consistent across all practices
- Priority access, rapid assessment and early diagnosis
- Supported discharge, self-management, follow-up and support
- Access to single patient record

By implementing the new approach patients will experience the same standard of high quality LTC management care which will be consistent, effective and safe across all practices and will ensure that all patients are included, e.g. housebound patients, in the delivery of care.

The proposed model is underpinned by the following three primary drivers which have been identified as critical features of all best practice long term conditions care programmes nationally and internationally:

- Systematic risk profiling of the population (Avoiding Unplanned Admissions DES)
- Integrated locality care teams
- Maximizing the number of patients who can self-manage through systematic transfer of knowledge and care planning

General Practices will identify patients as part of the Unplanned Admissions DES who are at high risk of hospitalisation to ensure that they are proactively managed in line with their personalised care plan. They will be managed by a multi-disciplinary team within primary care whose members are currently involved in the care but not as a functionally integrated holistic team at a locality level. Going forward each care team will provide a single main point of contact for patients and carers and will embrace specialist services when necessary, but treats a patient holistically, regardless of their condition(s).

The care model has a common spine for all long term conditions that recognizes that the greatest increase will be the number of people with co-morbidities.
This is not to say that in the integrated teams that look holistically at patients' needs, there won't be a specialist nurse; rather a specialist nurse will be embedded in a team that possess multiple skills best suited to managing what will be a majority of their

patients: people with multiple conditions. These specialist skills will be retained as will be their connections and mentoring from secondary care. However, they will work with others collectively to meet the assessed patient needs. This will ensure that the multi-disciplinary team in primary care can offer the right care, in the right place at the right time, as opposed to separately, in discrete specialist teams which patients report as disjointed and confusing.

Self-management is a key factor in the management of long term conditions and self-management support is a responsibility and an integral part of the delivery system. Care is delivered by a prepared proactive workforce enabling patients to move away from being passive recipients to becoming informed and activated to self-manage and willing to co-manage their condition(s).

It has been recognized that this transformation will happen over a period of time and further changes will be made as new opportunities arise.

To achieve this shift in care a number of work streams have been identified; work in some work streams is already well on the way:

- Up-skilling of GPs and nurses – work to identify the gaps in knowledge and skills in dealing with patients with LTCs has already commenced with the aim to provide all practices with educational support.
- Development and implementation of standardized templates for long term conditions – this work has also started and templates are ready to be uploaded to SystmOne. These will support GPs and nurses in the consultation with a patient suffering from LTCs ensuring a holistic approach is being considered and all aspects are included in the care plan.
  The templates will allow the production of reports which will demonstrate how well patients are being managed, that medication is sensibly prescribed and how practices are managing patients with LTCs across the localities. The latter will contribute to the GP variation agenda.
- A Long Term Conditions Management Conference is currently being organized for the 30 September 2014 to raise awareness and launch the work already on the way.
- Self-management is a key factor in the management of long term conditions. A number of schemes/programmes have been identified and for example work with Diabetes UK regarding the participation in a national pilot re 'peer to peer support' and intensive nurse led Health Coaching has already commenced.
- Review of disease pathways and relevant management guidelines and policies – work has commenced with establishing the feasibility of a Community Heart Failure nurse service. A Task and Finish Group has been set up. A visit to the Community Cardiovascular Service in Milton Keynes took place on the 14 August 14. The other conditions still require scoping.
- Other work streams which still need to commence include establishing links with the Admissions avoidance work outlined in the Resilience Plan to ensure cross over points are being managed and a communication plan which supports the activities within and across the work streams.

Accountable Lead Professional/GP Federations
General Practices in Bedfordshire are planning to federate or join together in localities to provide enhanced primary care to local people. So far all practices are committed to the Named GP for the over 75 year age group (part of national GP contract changes in 2014/15) and have allocated each patient in this group to an individual GP. One of the aims of federation is to work more closely with other local services to target a specific cohort of people who do not fully engage with health and social care ordinarily. These people, at risk of "falling through" gaps in service provision would greatly benefit from additional primary care.

West Mid Beds Locality
Within West Mid Bedfordshire locality the federation is planning on redesigning the traditional Health care assistant role and expanding this to a community worker who will conduct certain clinical activities such as flu immunisations, dressings, blood tests in the home. In addition this new community worker will target "frequent attenders" of GP practices to provide signposting, health and wellbeing advice and some informal "befriending" to practice patients who would otherwise visit the GP for advice or reassurance. The role is expected to contribute to reducing social isolation and improve patient's ability to self-manage their conditions and would encompass elements of care coordination.

Additionally WMB locality is piloting a new facilitated discharge service, hosted by the Luton & Dunstable hospital. The service provides assistance, signposting and support of hospital staff and pulls together other local services for patients attending Bedford, Milton Keynes and the Luton & Dunstable Hospital who have complex health & or social care needs. The role is responsible for acute and primary care liaison and provides care coordination for patients at risk of delayed discharge from the three hospitals.

Leighton Buzzard locality
The federation in Leighton Buzzard is planning to align practices to the residential care and nursing homes in the locality in support of care planning and urgent care needs ensuring full co-ordination with Community Nursing and Adult social Care. Additionally there are plans to prioritise the development of GP led complex care services for those with Heart Failure and COPD and are considering the development of GP led Specialist Services and an Eye Clinic which will reduce reliance on Hospital services. The Federation will also seek to roll-out a GP led hospital step-down/rehab service following surgery led by one practice across all practices in the locality.

Chiltern Vale Locality
The locality plans to build upon the national avoiding unplanned admissions DES to develop risk stratification, case management and care co-ordination. It is anticipated that there will be an expansion of the Practice Matron project locally, supported by a review of District Nurse support (especially in the area of wound care). GP led multidisciplinary Complex Care Services/development of a community geriatrician support role, Intermediate Services and a Clinical Hub will be developed as plans for the Dunstable Health project are developed during 2014.

Ivel Valley Locality
The Federation is prioritising the development of intermediate care services, including establishing Community Geriatrician services alongside GP led Complex Care services via integrated working with M-Doc (a GP Out of Hours Collaborative) to support a reduction in urgent admissions and facilitate early effective discharge.
The Federation will seek to establish community diagnostics, phlebotomy and telehealth services in support of practices. The locality also plans to re-establish GP led Practice based Primary Health care teams consisting of Practice and Community clinicians and Practitioners able to offer a highly responsive service with the minimum of bureaucracy

The Demonstrator project (Chiltern Vale & Leighton Buzzard localities)
The current service configuration within Central Bedfordshire can result in poor outcomes for our elderly population as they do not always receive 'right care' in the 'right place'.

Often the hospital is deemed to be the only viable option when an elderly patient becomes compromised. An inappropriate hospital admission often exacerbates the patient's fragility and undermines their independence.
This project aims to co-locate health (including geriatricians and mental health), social care and voluntary sector into community 'care co-ordination teams'. Care co-ordination teams will be aligned to GP practice clusters, and aim to:

- Co-ordinate care around our patients, delivering care in the most appropriate setting
- Keep patients in their place of residence for as long as possible helping them to remain and maintain their independence
- Scale up and build on current initiatives
- Improve current links for the patient and carer with health and social care teams
- Integrate care pathways across organisational boundaries
- Join up health and social care teams by changing current behaviour: teams deliver care acting as 'one team' from 'one organisation'.
- Navigate the patient to appropriate care quickly with seamless hand-offs
- Initiate early intervention with potential 'high' risk patients through risk stratification

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- Prevention and Early Intervention

Lifestyle Hubs – in final stages of scoping, procurement to commence in the autumn
MECC – delivered by Public Health
Older Persons Healthcheck – costs and benefits being explored as well as optimum model of delivery
Reducing Harmful Drinking – commissioned by Public Health from CAN
Reducing Social Isolation and Loneliness – commissioned by Adult Social Care, health

and Housing
Flu Vaccination – commissioned by Local Area Team from Primary Care

- Long-term conditions management in primary care

The proposed service will be delivered in primary care by federated/networked organisations. In the short/medium term services will be complemented by local community services that are currently being provided by SEPT. There is a strong link to the implementation of the Community Health Services Care Function Approach under scheme 3 – Efficient Planned Care. For the longer term future it is envisaged that the group of practices or partnerships will be providing community nursing services and GPs with extended roles.

- Accountable Lead Professional/GP Federations

Commissioners- NHS England (for primary care)
Central Bedfordshire Council & BCCG (Demonstrator)
Providers- GP practices across Bedfordshire
Luton & Dunstable hospital teaching trust

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

- Prevention and Early Intervention

The evidence base for prevention is less well developed than for other areas of care partly because it is a broad and complex area where the impact of interventions can take years to become apparent.

However there is a good evidence base to support:

The impact of healthy lifestyle choices on healthy life expectancy – thereby delaying the requirement for high cost interventions
Interventions to reduce harmful drinking (NICE clinical Guidance 115)
Managing overweight and obesity (NICE guidance PH 47& 53)
Behaviour Change: individual approaches (NICE guidance PH 49)

The evidence base is less strong for the impact of flu vaccination on emergency admissions.

In areas where there is a lack of evidence of impact (rather than evidence of a lack of effectiveness) e.g. reducing social isolation, lifestyle hubs, older persons Healthcheck, then services will be evaluated as to their effectiveness in meeting the strategic objectives.

- Long-term conditions management in primary care

The design of the model of care was influenced by a number of sources of evidence such

as Avoiding hospital admissions – What does the research evidence say? The King's Fund, December 2010; Better care for frail older people - Working differently to improve care, Deloitte for Health Solutions 2014, A Guide to the Implementation of the Long Term Conditions Model of Care, Long Term Conditions QIPP Working Team and the Avoiding Unplanned Admissions Enhanced Service: Proactive Case Finding, Care Review For Vulnerable People, NHS England, April 2014, Long Term Conditions Compendium of Information, Third Edition, DoH 2012 and Milton Keynes and Bedfordshire Healthcare Review – Long term conditions Clinical Working Group, Working draft, February 2014.

- Accountable Lead Professional/GP Federations

The impact of multi-morbidity and frailty is profound and multi-faceted. Patients with several long-term conditions have poorer quality of life, poorer clinical outcomes, longer hospital stays and more post-operative complications, and are more costly to health services. Evidence suggests that a patient-centred approach that addresses a person's various needs in an integrated way leads to better quality care There is a particularly strong case for case management for people with multiple long-term conditions, to provide the relational continuity and coordination of care that the evidence suggests is highly important to this group.

The implementation the accountable professional role supports the government's agenda of managing people with long term conditions more effectively (Raising the profile of Long Term Condition Care, 2008) and the NHS Outcomes Framework domain 'Enhancing quality of life for people with long-term conditions.

It supports the case for change for general practice as outlined in the document 'Improving General Practice – A Call To Action. General practice has a key role in dealing with patients with long term conditions, especially with frail older people with complex needs.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3 of the HWB Expenditure Plan

The investment in Transforming Primary Care in the main comes from existing Primary Care and Public Health resources although an additional amount of £0.034m in 2014/15 and £0.090m in 2015/16 will be made available to support the creation of the Lifestyle Hubs.

Impact of scheme 14/15
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.
Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

The resulting anticipated benefits from this scheme are a reduction in 225 non-elective admissions, a financial saving of £0.335m in 2015/16.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to

understand what is and is not working in terms of integrated care in your area?
Key performance indicators (KPI) and outcomes will be developed for each of the schemes and sub schemes. For lifestyle hubs this will include the number of people accessing the service, and improvements in key lifestyle indicators including increases in: physical activity, uptake of weight loss programmes, uptake of smoking cessation programmes. Improved clinical outcomes e.g. BMI, reduced blood pressure. All scheme KPIs will be reported through the BCF project delivery group.
What are the key success factors for implementation of this scheme?
Key success factors include: • Establishment of integrated health and social care locality teams • Roll out and adoption of LTC SystmOne templates across all practices. • Determining the model for the lifestyle hub • Capacity within primary and community care services • Establishing robust KPIs for each scheme to effectively measure impact

ANNEX 1 – Detailed Scheme Description
Scheme 2 Integrated Rapid Response for people with long term conditions and the frail elderly

Scheme ref no.
2
Scheme name
Integrated Rapid Response for people with long term conditions and the frail elderly This includes the following areas: • Demonstrator project • Community Beds • Acute services in the community – Hospital at Home, Specialist Nurses (neurology) • Paediatric Urgent care • Integration of OT Services • Integration of rehab and reablement • Prevention and Promoting Independence partnership
What is the strategic objective of this scheme?
The overall aims of the schemes are to reshape the way in which care is provided and delivered in order to: 1. Place the patient at the centre of their care 2. Deliver safe care in the right setting, at the right time 3. Support independence and self-care 4. Reduce avoidable hospital admissions 5. Reduce hospital and institutional length of stay 6. Reduce the number of patients discharged into permanent institutional care settings
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Demonstrator project, Community Beds, Acute services in the community To develop locality based models that provide an integrated rapid response to urgent health and/ or social needs as an integrated team, implementing an integrated/ co-ordinated care plan. Stakeholders have been engaged through formal design workshops to better understand how the current service setup should be reshaped in order to improve patient experience and outcomes. A number of contributing factors that compound care in the wrong setting were identified: 1. Disjointed working between health and social care teams – teams work in

isolation due to how services have been commissioned and setup
2. Multiple hand-offs between health and social care – often delays to care result from the current referral processes
3. Lack of patient centred care and shared decision-making
4. Patients have to navigate themselves through a complex, fragmented health and social care system, some patients find the very overwhelming
5. Carers are not part of or do not have access to an integrated solution for planning, support and feedback
6. Duplication of effort across health and social care teams

The design teams strongly supported that health and social care professionals need to work in a more integrated co-ordinated way. Building on this as one of the key design principals the following 'crisis' response model for integrated, rapid responds to urgent care has been proposed:

1. Create one central crisis co-ordination team by co-locating current crisis response teams in health (hospital at home, rapid response, and nurse navigation), social care (urgent falls and Urgent Home and Falls Response Service Emergency Duty Teams) voluntary sector.
2. Implement a Single Point of Contact (SPOC) with an open access referrals system (referrals received from 999, 111, specialist nursing (respiratory and diabetes), community services and social care teams, patient and carers).
3. Implement a GP cluster model (group a number of GP practices together)
4. Align:
    a. The crisis care co-ordination team to the GP practice clusters
    b. A hospital geriatrician to a GP cluster (elderly patients receive continuity of care)
    c. Step-up beds for patients who need intensive support for a short period of time
    d. Step-down beds

The new model therefore proposes to integrate and co-locate current crisis response teams into clusters. The team will be contactable by a SPOC, (one number for crisis response) and aligned to a group of GP practices and each cluster will have a named elderly care consultants (for the 75+ patient cohort). The care of the elderly consultant and hospital at home team will provide additional expertise and support primary care to care for complex elderly patients in their homes or through rapid access clinics.

The crisis co-ordination team will respond to an urgent health and/ or social need as an integrated team, implementing an integrated/ co-ordinated care plan. The crisis co-ordination team will be responsible for the clinical delivery on the virtual ward, inclusive of step up and step down beds. Progress to date has identified the team required to support the Chiltern Vale cluster which includes a 100 bed virtual ward. Work is in progress to develop the model of care within each locality.

The crisis co-ordination team will as part of their virtual ward bed base, support early supported discharge where patients are medically fit but require intensive nursing input for a period of time.

Patients will be held for a period of 24-48hrs (or until stable) before being discharge back to the community services and social care 'maintenance' teams. This team will also be able to provide short-term respite care where necessary.

In order to prevent avoidable admissions, where a patient self-transports to the hospital, a nurse navigation team will be on site to identify those patients who need to be turned round. This will be further supported by having access to the patients care plan through the 'portal' solution (outlined below).

There are four key enablers to support this new model of care. Firstly patients need to provide consent for their care information to be shared across health and social care.

Work is already underway within South Bedfordshire to obtain explicit patient consent for their information to be shared for the purposes of direct care by the care co-ordination team. An information sharing agreement has been signed by all providers of care within South Bedfordshire.

Secondly a functional specification is in the process of being written which will facilitate better integrated working through creation of an integrated care record. The intention would be to create a 'portal' web based solution which pulls patient information from core IT systems across health and social care in order to provide key crisis response services (999, 111, GP OOH, and Care co-ordination team) with a common view of the patients care plan so that the patient can be appropriately directed.

Thirdly the GP clusters within Chiltern Vale and Leighton Buzzard have commenced (supported by the current 2% avoidable admission Des) to complete care plans for this patient cohort. A standard approach has been followed so as to ensure that a clear and detailed process is outlined to ensure care is delivered in the right setting and what the steps are to avoid a hospital admission.

Finally the team needs to be setup to be available to respond 24/7.

Initially (the first three months starting in October 14) patients who are 75+ will be directed through the new SPOC to the care co-ordination team. It is envisaged that the service will be opened to all patients with LTC and who are younger than 75 from January 15.

Paediatric Urgent Care

The aim of this project is to reduce A&E attendances and admissions for children and young people with lower respiratory tract infection. This will be achieved through a targeted approach to groups of the community i.e. parents and carers of children and young people and, if identified, those GP's with higher rates of the A&E attendances.

As a result of the project, children, young people and their families or carers will:

- be more empowered and informed
- be aware of range of options within the locality / neighbourhood that they can use as an alternative to A&E – when appropriate
- be more confident about making the decision whether to attend A&E or seek an alternative
- be assured that the A&E option is still available to them if that is their decision

Integrated Rehabilitation and Re-ablement
The strategic objective of this scheme is to establish in the 4 primary care localities in Central Bedfordshire a co-located health and social care team to facilitate an integrated rehabilitation & reablement service.

Integrated Occupational Therapy
Currently across Central Bedfordshire Occupational Therapy Services are directly provided by Central Bedfordshire Council and by Commissioned arrangements by the South Essex Partnership University NHS Foundation Trust (SEPT).
When fully implemented the Integrated Occupational Therapy Service will provide Central Bedfordshire residents with:-

- A seamless integrated service delivering high quality, person centered services.
- A single point of contact/access.
- An early triage process ensuring residents receive the right services at the right time and from the most appropriate resources.

Prevention and Promoting Independence partnership
The objectives of this group are to:

- Work holistically to promote Health and Well Being and positive lifestyle choices at every opportunity, making every contact count.
- Encourage individuals to be independent and manage their own health and care, take responsibility for decisions and plan for the future.
- Develop accessible information and advice to support individuals and carers to make informed choice.
- Provide targeted support and information at key life stages and events at the appropriate time to prevent or delay the need for care and support or further deterioration.
- Use resources across the whole system more effectively and efficiently to maximise investment in prevention and early intervention.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Demonstrator project, Community Beds, Acute services in the community
Within Chiltern Vale and Leighton Buzzard a weekly project group has been meeting for the last 5 months to help design and inform this new model of care.

Representation on this group includes:

- GP Patient Representatives
- Current Community services & mental health provider
- The Acute Trust
- Central Bedfordshire Council
- Primary Care
- Bedfordshire CCG
- Ambulance Trust (when required)

Current crisis response services are commissioned and provided as follows:

Commissioner	Provider	Service
Bedfordshire CCG	SEPT	Rapid response, Nurse navigation, step-down units – Biggleswade and SSMU
Bedfordshire CCG	SEPT	Mental Health
Bedfordshire CCG	Luton and Dunstable Hospital	Hospital at Home, Elderly Care Consultant
Bedfordshire CCG	Care UK	GP OOH
Bedfordshire CCG		Ambulance Trust/ 999
NHS England	GP Practices	Primary Care
Central Bedfordshire Council	Local Authority	Urgent Home Falls Response Service and Emergency Duty Team, Rehab and reablement step-down: Greenacres and Wingfield Court
	Joint	Integrated Discharge Team
Bedfordshire CCG		111

Relevant acute and community providers will be included on each of the locality partnership groups, these will include Bedford Hospital, Lister Hospital, Milton Keynes Hospital, Luton and Dunstable Hospital, Addenbrooke's Hospital, Buckinghamshire Hospital.

Paediatric Urgent Care
Providers: All acute Trusts delivering care to CBC residents: main acute providers are Bedford Hospital, Luton & Dunstable Hospital, Lister Hospital. South Essex Partnership Trust (SEPT) – Community health services, Cambridge Community Health Services.
Commissioners: BCCG, Local Area Team

Integrated Rehabilitation and Re-ablement
Providers: SEPT Rehabilitation & Enablement services, SEPT Rapid Intervention Team, Central Bedfordshire Community Reablement

Commissioners: CBC, BCCG

Integrated Occupational Therapy
Providers: Central Bedfordshire Council, South Essex Partnership University NHS

Foundation Trust (SEPT).
Commissioners: CBC, BCCG

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Demonstrator project, Community Beds, Acute services in the community

The most recent external audit, the Oak Group Study, undertaken at the Luton and Dunstable Hospital, showed that of the 648 bed days analysed, 460 or 70% were considered to be in the wrong care setting.

Central to the project and planning has been a patient story of a patient who unnecessarily spent four of their last five months in hospital because services were not correctly configured in the community to prevent hospital admission.

Central Bedfordshire Joint Strategic Assessment (JSNA)
Integrated Care: Key Factors for Success, Kings Fund Conference London, 18 September 2012

Paediatric Urgent Care

NHS England Outcomes Benchmarking Support tool and 'Zero Length of Stay Report' from Public Health)
The Kings Fund (April 2013) briefing, *Can we keep up with the demand for urgent and emergency care.*
The Royal College of Paediatrics and Child Health (RCPCH) has recently published *Standards for Children and Young People in Emergency Care Setting* (2012)

Integrated Rehabilitation and Re-ablement

Best Practice Discharge – Hertfordshire and South Midlands Area Team 2014
Innovative Practice from Bristol, North Somerset and South Gloucestershire – Health Futures, Rehabilitation, Enablement and Reablement Review
Model of Care South Tyne and Wear
Improving rehabilitation service in England – NHS Improving Quality (June 2014)
Avoiding Hospital Admissions – A review of innovative practice across the UK – Kings Fund

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The investment in Integrated rapid Response is £0.853m in 2014/15 and £7.144m in 2015/16. This includes activity through Reablement, Rapid Intervention, Community Capacity and Home from Hospital services.

Impact of scheme 14/15

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Demonstrator project, Community Beds, Acute services in the community

Improved care co-ordination should:

1. Reduce the number of patients referred to intuitional care following a hospital discharge
2. Improve patient choice
3. Enhance patient experience
4. Decrease in hospital length of stay
5. Increase training and education, especially for carers
6. Provide better care without unnecessary delays

The resulting anticipated benefits from this scheme are a reduction in 307 non-elective admissions, a financial saving of £0.457m in 2015/16. In addition savings of £0.249m are proposed from Rapid Intervention and Reablement as we combine service delivery as well as £0.421m from reducing capacity in Community Beds. In total and to correlate with Part 2 – this scheme equates to £1.127m.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Individual projects will be managed through project boards and progress will be reported to the BCF delivery group. All projects will have an agreed set of KPIs.

Demonstrator project, Community Beds, Acute services in the community

Key performance indicators are being developed to monitor the impact of the demonstrator project

Reduction in Number of A&E Attendances	Weighted per 1000 pts and Actual number of patients	By the 14 practices for Chiltern Vale and Leighton Buzzard Data to be presented by month starting April 2013
Reduction in Number of A&E Admissions	Weighted per 1000 pts and Actual number of patients	By the 14 practices for Chiltern Vale and Leighton Buzzard Data to be presented by month starting April 2013
Reduction in Number of Avoidable Emergency Admissions	Weighted per 1000 pts and Actual number of patients	By the 14 practices for Chiltern Vale and Leighton Buzzard Data to be presented by month starting April 2013
Reduction in Average LOS	Weighted per 1000 pts and Actual number of patients	By the 14 practices for Chiltern Vale and Leighton Buzzard Data to be presented by month starting April 2013
Reduction Excess Bed Days	Weighted per 1000 pts and Actual number of patients	By the 14 practices for Chiltern Vale and Leighton Buzzard

		Data to be presented by month starting April 2013
Number of Emergency Readmissions within 30 days	Weighted per 1000 pts and Actual number of patients	By the 14 practices for Chiltern Vale and Leighton Buzzard Data to be presented by month starting April 2013
Deaths in preferred place of residence	Actual number of patients	By GP Practice
Number of patients – step up hospital at home, community beds	Actual number of patients	By GP practice
Number of patients – step down hospital at home, community beds	Actual number of patients	By GP practice

Paediatric Urgent Care
KPI will be reduction in admissions for children with lower respiratory tract infection.

What are the key success factors for implementation of this scheme?

Demonstrator project, Community Beds, Acute services in the community

- Patient consent to share information
- Development of integrated care record
- Establishing integrated 24/7 crisis response
- Use of standardised careplan.

Paediatric Urgent Care

- Project management capacity
- Development of LRTI advice sheet with traffic light system
- Engagement with healthcare providers, parents and carers, to build confidence to lead to change in behaviour.

Integrated Rehabilitation and Re-ablement and Integrated Occupational Therapy

- Collaboration between Local Authority and Community provider of existing services.

ANNEX 1 – Detailed Scheme Description

Scheme 3 Efficient planned care which is more predictable, reliable and close to patient's homes

Scheme ref no.
3
Scheme name
Efficient planned care which is more predictable, reliable and close to patients homes
What is the strategic objective of this scheme?
To reshape the way in which planned care is provided and delivered to: 7. Improving the quality of care 8. Provide planned care in an more integrated way (GPs, Social Workers, Community and Mental Health Services, Voluntary Sector) 9. Support independence and self-care 10. Use risk stratification to facilitate 'earlier' intervention and identify current 'gaps' in care 11. Reduce hospital and institutional length of stay and admissions This shift in planned care will be delivered through the following high-level schemes: • Implementation of the redeveloped community nursing specification • End of Life (EoL) services • Integrated falls, osteoporosis, and fracture prevention services • Mental health services including dementia services • Integrated wheelchair, equipment and telecare services • Transforming Planned Care into an Integrated 'Maintenance' Team
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
1) Implementation of the redeveloped community nursing specification The implementation of the redeveloped Community Nursing Specification will be delivered to all central Bedfordshire residents registered with a Bedfordshire GP. The new service specification is intended to move away from the traditional medical model where care is delivered by teams dedicated to a specific operational or disease pathway. Instead the intention is for community services to work as part of a multi-disciplinary team and for this team to deliver a person's care needs. A key design principle of this MDT will be that care will be delivered holistically wherever possible, by any member of any team that has the capacity and capability. This care function approach moves away from what we professionals believe is needed by our population to what the patient/service user needs are and groups these needs or activities into 'Care Functions'.

This Care Functions approach has been used in a number of CCGs and local authorities to ensure an integrated better care approach to improve system.

The Care Function Approach includes seven Care Functions:

1. Access and Coordination
2. Rapid Response
3. Facilitated and Supported Discharge
4. Maximising Independence
5. Complex Case Management
6. Scheduled and On-going Care
7. Specialist Input

2) End of Life (EoL) services

The objectives of this scheme are to systematically review all the services that support End Of Life Care pathway.

The focus will be:

- improving quality and responsiveness of services for patients, carers and families
- reducing variation in services available to patients across Bedfordshire
- improving integration of services across health and social care
- bringing care closer to people's homes
- improving choice in level and place of treatment
- enable more people to die in their preferred place
- and improving the patient experience at end of life

This will enable us to:

- Allow patients the freedom to make their preferences and choices for their preferred place of care.
- Enable patients to achieve, where possible, their preferred place of care and support carers and families in carrying out the patient's wishes as much as possible and in particular through the dying phase of the patient.
- Provide the patient, carer and families' access to high quality care and support timely to their needs.
- Improve the quality of the lives and experience for patients, and their carers and families, in their final year of life.

Ensure patients are treated at all times with dignity and respect

The scheme cohort of patients that will be identified for **EoL services** will be those adults on an end of life pathway, usually:

- With any advanced, progressive, incurable illness, life threatening acute conditions caused by sudden catastrophic events. General fragility and co-existing conditions that mean death within 12 months.
- Care given in all settings (e.g. home ,acute hospital, residential/care home,

nursing home hospice, community hospital and other institution)
- Care given in the last year of life (people approaching the end of life within 12 months)
- Patients, carers and family members (including care given after bereavement)

3) Integrated falls, osteoporosis, and fracture prevention services

The model of care being proposed for the integrated falls, osteoporosis and fracture prevention services redesign is based on the DoH's four stage approach to falls and fracture prevention published in 2009: Falls and fractures – effective interventions in health and social care. Aligning to this systematic approach this high-level scheme will involve the developed of four sub-projects beneath it, which are:

1. A Fracture Liaison Service
2. Community Falls Prevention Coordinators
3. Community Strength and Balance Exercise Classes
4. A Central Bedfordshire Physiotherapy Falls Service

4) Mental health services including dementia services

The planned care mental health services, or post-diagnostic support for people with dementia and their carers will include:

- Locality based support
- Ongoing proactive support and communication from the service
- Person centred support
- Financial, emotional and behavioural support,
- Identifying stress, anxiety and depression
- Identify and treat UTIs
- Families will be able to contact services in between of visits/contact so that persons with dementia and carers can address issues as and when they arise.

There will also be improvements in Dementia Crisis Care and Psychiatric Liaison Services.

5) Integrated wheelchair, equipment and telecare services

Through the early joint working relationship between the BCCG and CBC it has been identified that there may be duplication of spend and service provision for wheelchair and equipment services. It is believed that streamlining and integrating these services into a co-commissioned arrangement to sit within the BCF pooled budget will ensure that the services patients receive is efficient and reliable by releasing resources to others services to enable them to be commissioned in the same way.

6) Transforming Planned Care into an Integrated 'Maintenance' Team

A number of contributing factors fragment the delivery of 'maintenance' care:

7. Maintenance teams (planned care teams) work in a fragmented way
8. Very little risk stratification takes place and the health and social care

economy is reactive rather than proactive, patients should be identified before they go into 'crisis'

9. Multiple hand-offs between health and social care
10. Lack of patient centred care and shared decision-making
11. Duplication of effort across health and social care teams

The design teams strongly supported that 'maintenance' health and social care professionals need to work in a more integrated co-ordinated way. Building on this as one of the key design principals the following ''maintenance' care delivery model for the delivery of health and social care is proposed:

5. Implement a GP cluster model (group a number of GP practices together)
6. The GPs are the accountable professional
7. Create and assign 'maintenance' care co-ordination teams (community and mental health nursing, GP practice matrons, voluntary sector, social care, reablement and social workers) to each GP cluster
8. The vision is to co-locate each care co-ordination team in the same location however initially some joint-working will be achieved through the introduction of multi-disciplinary team meetings (MDT's).
9. For patients who are 75+ each GP cluster will have an assigned elderly care consultant
10. Later development of this model would include building further links with ambulatory care pathways, respiratory, diabetes services, etc

Each cluster care co-ordination team will carry a caseload. The caseload is made up of:

1. Patients who are currently being cared for by community matrons, district nursing, practice matrons, community reablement and OT, mental health and social care.
2. Patients will come onto the caseload either through a GP referral, or as within the case current social care practice, a self-referral.

In order to facilitate a more proactive approach to case management risk stratification will be introduced. Work is already underway with regards to this due to the GP 2% DES. GP's are currently identifying the 2% of their adult patients who have a high risk of a hospital admission. MediAnalytics has been used to facilitate this within Central Bedfordshire.

In addition to this guidance has been sort from an elderly care consultant to better inform how the 2% of patients are selected. A toolkit was developed in order to help GPs approach the identification of their 2% patient population, and the methodology applied to patients 75+ is outlined in figures 1 and 2 below:

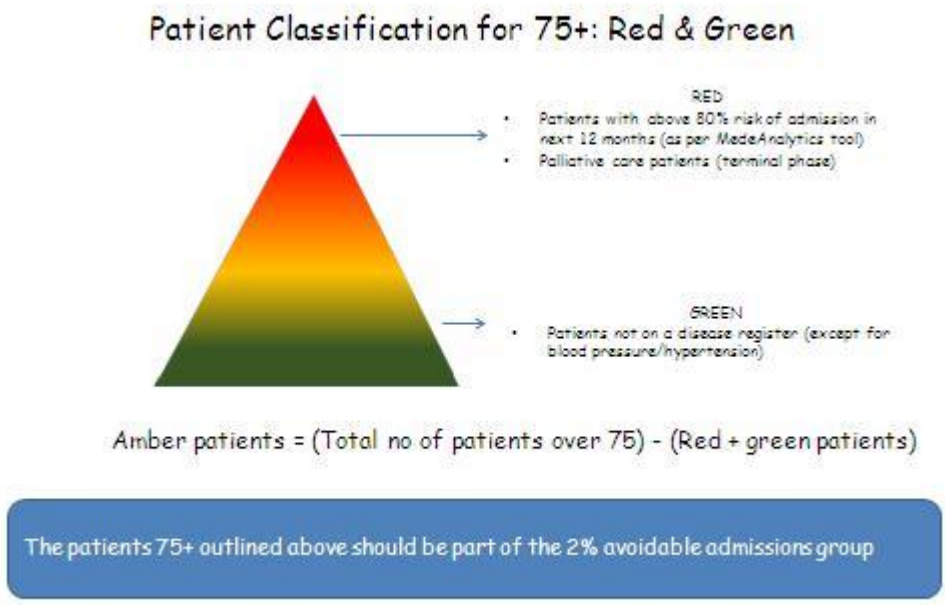


Figure1: Identify patients that are 'Red = very high risk' and 'Green = healthy'

Please note that it is the intention of the project team to focus their care on the amber patients as those patients who are 'red' are probably end of life patients. .
Palliative and End of Life patients will follow a different pathway and should be on the Gold Standards Framework and registered to Bedfordshire Partnership for Excellence in Palliative Support (PEPS). Being registered to Peps will reduce the risk for this cohort.

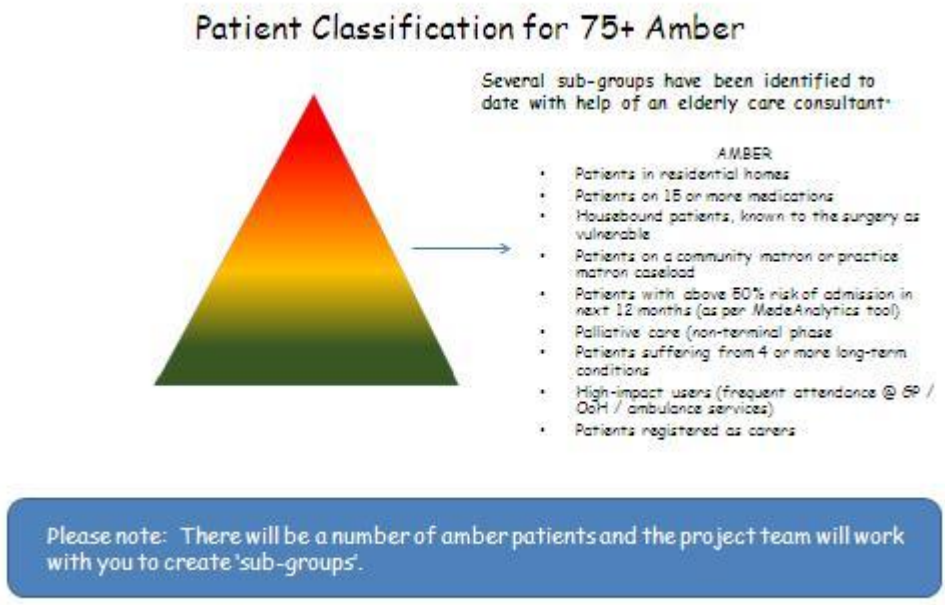


Figure 2: Standardised approach to identifying patient subgroups.

Patients identified as part of the above risk stratification process will:

4. Be screened to ensure that they are receiving the correct health and/or social care intervention
5. Where gaps in care are identified, these patients will be referred appropriately, in a more co-ordinated way
6. Each patient will have their care plan appropriately updated, this will further inform 'the crisis' response teams should this patient ever be referred to this team.

In order to prevent avoidable admissions, where a patient self-transports to the hospital, a nurse navigation team (who work as part of the crisis care team) will be on site to identify those patients who need to be turned round. This will be further supported by having access to the patients care plan through the 'portal' solution (outlined below)

There are four key enablers to support this new model of care. Firstly patients need to provide consent for their care information to be shared across health and social care and for it to be discussed as part of an MDT.

Work is already underway within South Bedfordshire to obtain explicit patient consent for their information to be shared for the purposes of direct care by the care co-ordination team. An information sharing agreement has been signed by all providers of care within South Bedfordshire.

Secondly a functional specification is in the process of being written which will facilitate better integrated working through creation of an integrated care record. The intention would be to create a 'portal' web based solution which pulls patient information from core IT systems across health and social care in order to provide key crisis response services (999, 111, GP OOH, and Care co-ordination team) with a common view of the patients care plan so that the patient can be appropriately directed.

Thirdly the GP clusters within Chiltern Vale and Leighton Buzzard have commenced (supported by the current 2% avoidable admission Des) to complete care plans for this patient cohort. A standard approach has been followed so as to ensure that a clear and detailed process is outlined to ensure care is delivered in the right setting. Risk stratification of patients' needs to become an ongoing process within the maintenance teams in order to support early intervention.

The MDT needs to be setup and run

Initially (the first three months starting in October 2014) patients who are 75+ and fall into the 'amber' category will be reviewed by this new MDT care co-ordination team. Initial focus on the 75+ population is due to:

1. The GPs are currently incentivised through the 2% DES to undertake this piece of work

2. Analysis on hospital admissions has shown that especially for Chiltern Vale a significant number of hospital spells can be attributed to this age group.

Plans are being made to develop new risk stratification model based on health and social care systems (Health/Care Trak) and will be implemented as part of the data sharing programmes – programme 2. .

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

A weekly project group has been meeting for the last 5 months to help design and inform this new model of care. Representation on this group includes:

- GP Patient Representatives
- Current Community services & mental health provider
- The Acute Trust
- Central Bedfordshire Council
- Primary Care
- Bedfordshire CCG
- Ambulance Trust (when required)

Current planned care services are commissioned and provided as follows:

- **Community Nursing Specification –** BCCG is the commissioner of this service and negotiations commenced in July 2014 with the current community provider SEPT.
- **EoL Services –** delivery of this project will be centred around seven main themes that address the whole of the pathway:
    - Integration Specialist Services
    - Support for Primary Care
    - Review of Hospice Care
    - EoL Training
    - Coordination of Care
    - Voluntary Sector Services
    - Information and Communication

  The EoL programme delivery is supported by a countywide, multi-agency local implementation (LIG) with membership from a wide range of stakeholders.
- **Falls, Osteoporosis & Fracture Prevention –** The commissioners of these services are BCCG, Luton CCG, CBC and L&D Hospital with the providers including Bedford Hospital, CBC, L&D Hospital and others.
- **Mental Health Services –** BCCG is the provider with SEPT the commissioner. These services are currently going through procurement and the new provider will be in place April 2015.
- **Wheelchair, Equipment & Telecare Services –** The commissioners of wheelchair and equipment services are split between the CCG and CBC. However, the commissioners of telecare services is CBC only. Providers include SEPT, Millbrook and telecare services is provided by Aragon Housing in

CBC.

- **Planned Care Integrated 'Maintenance' Team –** The commissioners covering the breadth of this new model of care are BCCG, NHS England (GPs) and CBC and provides include SEPT, GPs, the Ambulance Trust and again CBC itself.

The evidence base

Please reference the evidence base which you have drawn on

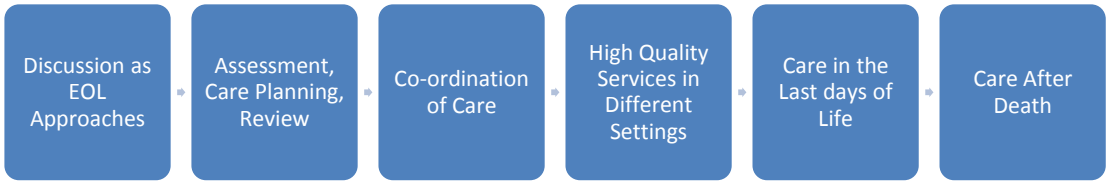
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

1) The redeveloped **community nursing specification** is based on best practice from other CCGs and Local Authorities with input from local clinicians from the five BCCG locality areas, the two local authorities and a review of current community services.

2) **EoL Services** the following data underpins the implementation of the redesigns:

- 1969 deaths occurred in Central Bedfordshire in 2012. 23% were deaths from cancer, with similar proportions from cardiovascular and respiratory disease. Most recent data indicates 90% of patients on EOL registers are cancer patients.
- Most recent data suggests 45% of deaths occurred in usual place of residence. Patient surveys nationally suggests that for 63% the preferred place of death is at home. Increasing the proportion of patients being enabled to die at home would meet patient's preferences as well as being cost effective.

The model of care is based on the national End of Life Care Pathway approach:



The model will also encompass support services for carers and families, information for patients and carers, spiritual care services and other non-health led EOL services.

3) The local picture supporting the **integration and expansion of falls and falls related services** is shown below in tables 1 and 2. In 2014, approximately 11,876 people aged 65 and over are predicted to have a fall in Central Bedfordshire, and this is expected to increase by 14,008 by 2020. The predicted number of falls related hospital admissions for people aged 65 and over during the same period is likely to increase from 901 to 1,095 (table 2).

Table 1: *Predicted number of falls for the BCCG (broken down by LA) area for people aged 65 and over (POPPI Data, 2012).*

	Year				
Local Authority Area	**2012**	**2014**	**2016**	**2018**	**2020**
Bedford Borough	6,974	7,423	7,807	8,138	8,538
Central Bedfordshire	10,982	11,876	12,569	13,284	14,008

Totals	**17,956**	**19,299**	**20,376**	**21,422**	**22,546**

Table 2: *Predicted number of hospital admission related to falls for people aged 65 and above (POPPI Data, 2012).*

	Year				
Local Authority Area	**2012**	**2014**	**2016**	**2018**	**2020**
Bedford Borough	554	583	608	540	679
Central Bedfordshire	846	901	952	1,021	1,095
Totals	**1,400**	**1,484**	**1,560**	**1,561**	**1,774**

Furthermore, key publications providing evidence to support the development of this scheme include:

- DOH (2009) Fracture prevention: an economic evaluation. Gateway ref 13081
- DOH (2009a) Falls and Fractures: effective interventions in health and social care. Gateway ref 11998
- National Institute for Clinical Excellence (NICE), (2004) Falls: The assessment and prevention of falls in older people London: NICE
- National Institute for Clinical Excellence (NICE – CG 161), (2013) Falls: assessment and prevention of falls in older people London: NICE

4) Mental Health Services

The model being procured is based on the BCCG Mental Health Strategic objectives, national best practice and local stakeholder engagement. The service specifications are outcome based using the NHS outcomes framework.

5) Integrated wheelchair, equipment and telecare services

Through the early joint working relationship between the BCCG and CBC it has been identified that there may be duplication of spend and service provision for wheelchair and equipment services.

6) Evidence for Planned Care Integrated 'Maintenance' Team

The King's Fund, "Integrated Care; Key Factors for Success", conference London, September 2012.

Investment requirements

Please fill in details below required to complete Part 2, Tab 3 of the HWB Expenditure Plan

The investment in Efficient Planned Care is £0.876m in 2014/15 and £7.755m in 2015/16. This includes activity through Community Nursing & Matrons, Equipment, Telecare, Wheelchair, End of Life and additional Falls services.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The resulting anticipated benefits from this scheme are a reduction in 225 non-elective admissions, a financial saving of £0.335m in 2015/16. In addition savings of £0.064m are proposed from the Telecare, Equipment and Wheelchair services as we combine service delivery. Contractual savings of £0.100m will be sought from both End of Life Services and Community Nursing. In total and to correlate with Part 2 – this scheme equates to £0.595m.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Evaluating and assessing the impact of all of the high-level schemes is integral to ensure that the approach is delivering a more reliable and efficient planned care services. Below is a brief summary to how this will be achieved with every scheme:

1) Community Nursing Specification – whilst determining the key performance measures the BCF metrics were taken into account and have been included in the metrics. It is planned that a dashboard will be developed that will be discussed at the performance monitoring contractual meetings with the current provider.

2) EOL - KPIs will be developed for each of the seven key areas. Programme delivery is supported by a county wide, multi-agency Local Implementation Group (LIG) with membership from all stakeholder organisations, reporting to the BCF delivery group.

3) Falls, Osteoporosis & Fracture Prevention – each service development within the scheme will have a specific set of KPIs against which it will be monitored. These will include service activity, patient experience, patient outcomes, impact on and trend of Public Health falls indicators. The services will be monitored on a monthly basis through the Bedfordshire and Luton Falls and Fracture Prevention Strategy Group, reporting to the BCF delivery group.

4) Mental Health

Improvements in services will be monitored through contract management of the outcome based KPIs detailed in the new service specification.

5) Integration of Wheelchair, Equipment and Telecare Services – currently the wheelchair and equipment services are monitored by both the CCG and CBC. Through the integration of these services a more joined up reporting arrangement will be developed to support the integration of these services. They can then be monitored through newly arranged contractual meetings from both the CCG and CBC for integrated effectiveness.

6) Planned care - proposed outcomes to monitor the impact of the planned care maintenance team:

Reduction in Number of A&E Attendances	Weighted per 1000 pts and Actual number of	Age 75+ By the 14 practices for Chiltern Vale and

	patients	Leighton Buzzard Data to be presented by month starting April 2013
Number of Avoidable Emergency Admissions	Weighted per 1000 pts and Actual number of patients	Age 75+ By the 14 practices for Chiltern Vale and Leighton Buzzard Data to be presented by month starting April 2013
Reduction in Average LOS	Weighted per 1000 pts and Actual number of patients	Age 75+ By the 14 practices for Chiltern Vale and Leighton Buzzard Data to be presented by month starting April 2013
Reduction in Excess Bed Days	Weighted per 1000 pts and Actual number of patients	Age 75+ By the 14 practices for Chiltern Vale and Leighton Buzzard Data to be presented by month starting April 2013
Reduction Number of Emergency Readmissions within 30 days	Weighted per 1000 pts and Actual number of patients	Age 75+ By the 14 practices for Chiltern Vale and Leighton Buzzard Data to be presented by month starting April 2013

Improved care co-ordination should:

7. Reduction in 'unplanned' admissions into hospital or institutional care for patients 75+ initially
8. Early intervention in care, improving patient outcomes
9. Enhance patient experience and improve independence
10. Decrease in hospital length of stay
11. Increase training and education, especially for carers
12. Provide better care without unnecessary delays

What are the key success factors for implementation of this scheme?

1) A key success factor for the revised community nursing specification is that the current provider agrees within the negotiation process to implement the new service specification. The commissioners (BCCG) appreciate that this change has to be implemented in stages as there are training and education issues that need to be addressed. An implementation Plan is being developed and BCCG has been transparent with the current provider that if during the negotiation stage no agreement can be achieved, the service specification will

be taken to the market. A further factor that is important is that patients experience a more joined up service, which underpins the entire scheme.

2) EOL
   Key success factor include:
   - GP Engagement and use of new SystmOne template based on the Gold Standards Framework, including anticipatory prescribing.
   - Capacity of community nursing teams, Macmillan, Palliative Support Workers, Marie Curie, etc. to support the patient in their usual place of residence if that is their wish.
   - Continuing marketing until new pathways are embedded.

3) One of the key success factors for the implementation of the falls, osteoporosis and fracture prevention services is the funding to enable recruitment to the posts to begin as soon as possible, successful recruitment within a relatively short period time and finally, engagement with and buy in from the previously identified providers.

4) Mental Health
   Completion of procurement process, contract award and implementation.

5) Integration of Wheelchair, Equipment and Telecare Services
   Collaboration between Local Authority and Community Services provider.

6) Planned care maintenance team: Key success factors include:
   - Patient consent to share information
   - Development of integrated care record
   - Use of standardised careplan.

Annex 1 Detailed Scheme Description

Scheme 4
Co-ordinated and supported discharge from hospital with ongoing community care

Scheme ref no.
4
Scheme name
Co-ordinated and supported discharge from hospital with ongoing community care. This scheme includes: 1. Communication links between Discharge Planning, GP's and Community Teams, to incorporate any Social Care element when known. 2. Restarts (Permanent Residential), Nursing or Care Home 3. Section 2 Initial Assessment form for Local Authorities (Social Care Referrals) 4. Section 5 Delayed Transfer of Care Form 5. Locality Discharge Coordinator (informed by West Mid Beds pilot) 6. Voluntary Sector – meet and greet
What is the strategic objective of this scheme?
1. To deliver fully integrated, IT generated communication links for all patient discharges from acute hospitals to GP's and Community Nursing Teams on a daily basis, initial starting with Luton & Dunstable Hospital. This will enable both GP's and Community Teams to continue the care of the patient as soon as possible following discharge, with the key aim of preventing re-admissions. For BCCG patients, there were a total of 3,328 Multiple Emergency Admissions to Luton & Dunstable Hospital during 2013/14. This amounts to in excess of £15m spend on multiple emergency admissions via A&E alone, with further spend identified in other areas. 2. To develop an enhanced and streamlined way of working between provider services surrounding Permanent Residential accommodation enabling patients to return back to their usual place of residence as soon as possible once confirmed Medically Fit. 3. Section 2 form (Initial Assessment form Social Care Referrals). Incorporate social care needs earlier within the discharge process. 4. Section 5 form - Delayed Transfer of Care (DTOC) by either health or social care. Section 5 form can only be raised following a multi-disciplinary decision (MDT) that the patient is both "safe to transfer" and "medically stable". The objective of both Section 2 and Section 5 forms is to have enhanced and streamlined processes working between provider services in the lead up to

patient discharge reducing any unnecessary excess bed days or resultant delayed transfer of care.

5. Locality Discharge Coordinator (informed by West Mid Beds pilot).
   To provide a dedicated Discharge Coordinator who is aligned to a specific locality to improve patient discharges (pull). This role will identify locality patients in the acute hospital setting and help to facilitate discharges for complex patients from admission.
   - To reduce the length of stay by facilitating prompt discharge at the point the patient is medically fit.
   - To reduce avoidable hospital re-admissions

6. Voluntary Sector. To include the voluntary sector to support patient discharges.

- To provide practical help and support following a discharge from hospital.
- To promote a safe, well and warm check to ensure patient is settled back into their own home.
- Help prevent readmissions to hospital.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

1. **Communication links between Discharge Planning, GP's and Community Teams.**

To develop a daily IT driven data flow between acute hospitals initially providing discharge information but scope to also include admissions and estimated discharge date (EDD) to GP's and Community Teams. Further scoping would then be required in order to ensure from this that relevant Community Teams are made aware of the patient actual discharge. This will need Information Governance support in all areas. The aim is to provide

- A daily report from Hospital to GP Surgeries for all patient discharges, all ages, all diagnosis, elective and NON-elective.
  - This currently does not happen due to data restrictions on Patient Identifiable Information (PID).
- Requires further scoping to put something in place for the future based on what we now need and to also include Social Care element/requirements when known.

To be replicated at Bedford Hospital NHS Trust once completed.

2. **Restarts (Permanent Residential), Nursing or Care Home**

Patient Cohort

- This scheme affects all patients, all ages, although predominantly elderly this is not restricted to this cohort.
- Includes elective and emergency admissions.

Brief Introduction and outline of the background to project

The Ward at L&D Hospital contact Care Home by phone, to arrange for Care Home staff to carry out an assessment on the patient within L&D Hospital, prior to arranging for the patient to be discharged.

Delivery and Implementation

Under CQC, Care Homes have to agree to have the patient back in their care, with regards to Care Home staffing levels and resources available for patient care following patient return**.**

- Starts at point when patient is confirmed as "Medically fit" and is able to transfer from an acute hospital setting.
- Care Home staff requirement to do a patient assessment in acute hospital following notification of medically fit patient.
- 1-3 day length of stay (LOS) delays can be caused.

Data Collection

- Data will become available shortly to support this project to show how many patients are affected by this process and any additional LOS caused. This will include all wards, all patient ages, elective and emergency admissions.

3. Section 2 Initial Assessment form for Local Authorities (Social Care Referrals)

Pathway affects all patient discharges requiring social care assessments.

Needs further scoping to establish the following points:-

- The Section 2 form is electronic and in the future will populate via Extramed (system used in hospitals for base ward patients). It is envisaged that this will then be sent by secure email to social care contact(s) but it is currently in early stages of development (Luton & Dunstable Hospital information).

  The form is only completed if the patient is currently having Social Care involvement prior to admission, or will be requiring Social Care input for the first time following discharge.

National Standard for Section 2 to be completed and Social Care Assessment within 48 hours.

- Any forms received by Social Care after 2pm are counted as being received the following day, 2pm cut off time, clock starts at 9am following day.
- This means that if the Social Care assessment is carried out within the 48 hour timeframe this will not show as a breach. Having the 2pm cut off time in effect may cause an additional 24 hour length of stay (LOS) in an acute hospital setting on top of the 48 hours, i.e. 72 hours. 48 hours is built into the discharge planning process.
- Can we aim below National standard for faster turnaround of patient/reduction in LOS? Additional staffing required or smarter way of working?

4. Section 5 Delayed Transfer of Care Form

A Section 5 form will be completed for all patient discharges experiencing a Delayed Transfer of Care (DTOC), for either health or social reasons.

Department of Health standard – Section 5 notice is issued at least 24 hours prior to discharge.

Any forms received by Social Care after 2pm are counted as being received the following day**.**

Needs further scoping to establish

- Electronic Section 5 form is now in use and emailed to Social Care where appropriate.
- After 2pm cut of time, clock starts from 9am following day, ie could stay within 24 hour timeframe (not in breach), but cause additional 24 hour LOS in acute. NOTE if changing cut off time, will also need to change Luton Social Care and Hertfordshire Social Care.
- Need to understand how 7 day week discharges would impact longer term re staffing levels of health and social care resource to support.

5. Locality Discharge Coordinator (informed by West Mid Beds pilot)

To engage a dedicated Locality Discharge Coordinator role specifically focused on providing co-ordinated discharges from acute providers for patients over the age of 18 years, for both elective and non-elective admissions.

Locality driven facilitated discharge “pull” from acute, enforcing strong communication links between primary and secondary care, and including social care where applicable.

The Co-ordinator role will include:-

- Prompt agreement of discharge plan following admission. Daily data feed of all admissions split by locality will be required.
- Provide assistance for discharges with Palliative and End of Life patients in liaison

with Bedfordshire Partnership for Excellence in Palliative Support (PEPS).

- Ensure patient's carers/family are aware of discharge date in advance.
- Review the patient's progress through discharge, liaising with GPs and relevant stakeholders at an early stage.
- Participate in MDT meetings at GP practice and acute hospitals, which include Local Authority and Community Health Service stakeholders to discuss specific cases and improvements required to continuously improve discharge.
- Engage in ward round at acute hospital providers as appropriate.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:-

- Bedfordshire Clinical Commissioning Group
- Central Bedfordshire Council (Social Care)

Providers:-

- Luton & Dunstable University Hospital NHS Foundation Trust
- Cambridge Community Services (L&D Hospital)
- GP's (Primary Care)
- South Essex Partnership Trust (SEPT) - Community Teams
- Permanent Residential (Nursing and Care Homes).
- Charity and voluntary sectors

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

NHS England - Best Practice Discharge Bed Based Systems

1. Communication links between Discharge Planning, GP's and Community Teams. To incorporate any Social Care element when known.

Initial scoping has highlighted the following areas for improvement and development:-

- Community Teams are advised of patient discharge by Discharge Officer on Ward, by contacting the patients GP either by phone or by email.
- This information is not consistently filtering down to the Community Nursing teams unless organized prior to discharge for complex patients, eg Continuing Healthcare/Fast Track. Social Care would be included here.
- As an example, a typical practice would average of 13 discharges per day (based on 5 day week). Information source: - Mede Analytics 2013/14.

- Discharge Planning are made aware of Community Team input to the patient by either:-
- The patient themselves, or
- "Transfer of Care" form - received from relevant service.

Further scoping is required with Discharge Planning to understand current process and thoughts to bridge the gaps. This needs to include the function of the secure GP Portal and clarification of what this communication channel is used for. GP Portal runs from Extramed. Need further scoping of ICE system capabilities for all discharges.

2. Restarts (Permanent Residential), Nursing or Care Home

Delays experienced within L&D Hospital awaiting Permanent Residential Restarts for patients ready for discharge.

- Review capacity available within Care Homes to do patient assessments prior to the patient being received back into residential care.
- Other factors to be aware of include:-
  - Any cut off points and times Mon-Fri to be adhered to.
  - Weekend visits by Care Home staff to the hospital.
  - Hospital @ Home service from Luton & Dunstable Hospital is accepted by Nursing Homes but not currently accepted in Residential Homes.
  - Inclusion of estimated discharge date notification to streamline flow.

This includes all Restarts for permanent residents, including hospital stays of less than 3 days LOS**.**

3. Section 2 Initial Assessment form for Local Authorities (Social Care Referrals)

Evidenced by Luton & Dunstable Hospital Discharge Planning meetings and conference calls. Analysis of process maps in areas identified.

- Data not readily available to support rejection/rework figures.
- It is currently unknown until data received how much of an issue this causes although 2pm cut off time is known to cause unnecessary delays.
- National Standard for Section 2's to be completed and Social Care Assessment within 48 hours.

Key Benefits (Section 2 and Section 5):-

- Reduction in any unnecessary length of stay by the patient awaiting assessments and Social Care involvement.
- Less rework would free up time both in Discharge Planning and Social Care allowing each to be more proactive with patient discharges and less reactive.
- More streamlined and mistake proofed process with expectation of being right first time (exception where patient needs change).
- Greater control and reliable expected discharge dates (EDD) which can then be fed through to all channels, i.e. GP's, Community Teams to pick up upon

following patient discharge if required in the future.

- Social Worker staffing levels available to meet demand for quicker turnaround, although by cutting down on any unnecessary rejects (unknown until data received), would free up available time.
- Department of Health Guidelines for Section 2's (48 hours to complete initial assessment) and Section 5's DTOC forms to be issued at least 24 hours prior to discharge. These are guidelines only and the hope is that we can better this in creating a better service more suited to our discharge planning and patient need.

5 Locality Discharge Coordinator (informed by West Mid Beds pilot)

Links to BCCG's strategic vision – Bedfordshire Plan for Patients 2013) "Care for when it is not that simple".

The West Mid Beds pilot is currently still running (start date February 2014), and is already achieving some good results shown in the reduction of excess bed days in WMB's locality by co-ordinating patient discharges in a different way ("pull" rather than "push" approach).

Excess bed days in West Mid Beds, although in line with the BCCG average, was higher than seen in the other localities.

Below is a comparison between the first 5 months of this year versus the previous year showing excess bed days both in number (weighted per 1000), and cost, to show whether or not this service has had an effect. Data *source: - Mede Analytics.*

Weighted Excess Bed Days per 1000 population for West Mid Beds

Data comparison versus same time period previous year.

	Jan	Feb	March	April	May	Total
2013/14	4.27	4.18	7.29	5.81	7.04	**29**
2014/15	6.29	3.11	2.83	3.26	9.5	**25**
variance	-2.02	1.07	4.47	2.55	-2.46	**4**
variance %	47.31%	-25.60%	-61.18%	-43.89%	34.94%	-13.79%

In the 5 month comparison, there has been a reduction of 14% on Excess Bed days achieved during 2014/15 versus 2013/14.

Excess Bed Days Costs

Data comparison versus same time period previous year.

	Jan	Feb	March	April	May	Total
2013/14	£55,788	£55,018	£77,973	£58,781	£67,095	**£314,655**
2014/15	£74,185	£36,079	£28,746	£40,118	£37,533	**£216,661**
variance	-£18,397	£18,939	£49,227	£18,663	£29,562	**£97,994**
% variance	32.98%	-34.42%	-63.13%	-31.75%	-44.06%	**-31.14%**

There has also been a reduction of £98k in costs (31.14%).

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

The investment in Supported Discharge is £1.957m in 2014/15 and £2.682m in 2015/16. This includes activity through providing care home placements together with discharge facilitation through hospital social work teams and discharge coordinators.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.
Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

The resulting anticipated benefits from this scheme are a reduction in the number of delayed transfers of care, calculated as the reduction in the number of bed days of 597, a financial saving of £0.065m in 2015/16.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Each work stream will have a specific set of measures against which it will be monitored. These will include activity, patient outcomes and patient experience. These will be monitored on a weekly basis initially if possible to create more learning opportunities. In addition some of the information (S2 and S5 process impact), will need to be gathered manually as this is not available on hospital systems. Measures will be developed to monitor the following impact.

Communication Links

- Integrated patient care at the right time by the appropriate service.
- Defined and streamlined communication links

Residential/Care Home Restarts

- Enhanced and streamlined way of working between provider services.
- Enabling patients to return back to their usual place of residence as soon as possible once confirmed Medically Fit.
- Decrease Length of stay (LOS) by 1 day for patients awaiting assessment for Restart by Care Homes.

Section 2 & Section 5

- Reduction in LOS / reduction in excess bed days for patients receiving Social Care input. Reduction in LOS for any Delayed Transfer of Care (DTOC).
- More timely streamlined process – as “live” as possible, no batching (reducing backlog of patients waiting for assessments).
- Enhanced more streamlined discharge process.
- Enhanced smoother way of working between providers.

Manual data collection will be needed to gauge the levels of re-work of the S2 and S5 forms initially in order to streamline and mistake proof the process. We will also need

to build in a method of continually monitoring progress to ensure robust data capture to feed into any financial cost savings that this may bring. The aim is to show a reduction in LOS / reduction in excess bed days for patients receiving Social Care input and reduction in Delayed Transfer of Care due to process changes.

Locality Discharge Co-ordinator

- Reduction in LOS / reduction in excess bed days.
- Primary and secondary input to patient discharge, including social care.
- Enhanced patient experience.

What are the key success factors for implementation of this scheme?

- Funding to ensure resources are available if required to meet the required process changes.
- Engagement with and buy in from identified providers

ANNEX 1 – Detailed Scheme Description

Scheme 5 – Implementing the Care Act

Scheme ref no.
5
Scheme name
Implementing the Care Act 2014
What is the strategic objective of this scheme?
The Care Act represents the most significant reform of care and support in more than 60 years, putting people and their carers in control of their care and support. Central to the Act is the concept of wellbeing. Councils will now have a duty to consider the physical, mental and emotional wellbeing of the individual needing care and a new duty to provide preventative services to maintain people's health.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A Programme Steering Board and supporting governance structure has been set up to ensure the successful delivery of the Care Bill. This incorporates 4 key workstreams: • Promoting Individual Wellbeing (Prevention, Housing & Public Health) and Information, Advice and Advocacy • Assessment & Eligibility and Care Planning & Personalisation • Paying and Charging for Care • Quality & Safety and Care Markets The additional duties set out in the Care Act reinforce the imperative to protect social care services in order to meet the increasing demand due to both demographic changes and wider responsibilities. The Care Act requires local authorities to provide comprehensive information and advice on all care and support services in their local area, how the services work, and how to access them. To meet the requirements of the Care Act and to advance its implementation the focus will be on the following key areas: widening provision of assessment and impact of the national minimum eligibility criteria; the requirement to provide timely and appropriate access to information, advice and advocacy' the duty to meet the needs of carers and the challenges of the information systems to enable this. The Act brings together legislation on all carers, apart from young carers (under 18) and adults caring for disabled children, who will continue to be supported through children's law and services. Carer's rights are brought more into line with those of the people who they care for, and they no longer need to be providing "a substantial amount of care on a regular basis" to qualify for an assessment. A joint assessment of the needs of a carer and the person that they care for can be undertaken if both agree. Carers should receive a personal budget from the local authority and have the right to request direct payment.

With the assumption that the Council currently supports around 40 -50% of social care customers in Central Bedfordshire, the duties of the Care Act will require a significant increase in number of people requesting an assessment of their care needs and financial reckoning. Key challenges will be the implementation of the new funding reforms which will bring in large numbers of 'new' people (self funders) to the social care system, and will have significant financial implications. Initial modelling around the likely increased demands on assessments for self funders and carers.

Social Care Assessments and Reviews - The Council currently undertakes approximately 4,800 assessments and 9,700 reviews per annum for people aged 18+. It is forecast that as a result of the Act, the number of assessments will increase to between 9,700 and 12,100 social care assessments and the number of reviews will increase to between 14,100 and 17,700, per annum.

To cope with this additional activity, an increase in the social care workforce (both qualified and unqualified) will be required to carry out these additional assessments/reviews. Using the current establishment as a baseline, an extra 134 – 201 social care staff will be required.

Occupational Therapy Assessment and Reviews - The Council currently undertakes approximately 800 assessments and 2,200 reviews per annum. The forecast increased in activity will be between 1,500 and 2,000 assessments and between 4,500 and 5,600 reviews, per annum. To cope with this additional activity, an increase in the occupational therapy workforce (both qualified and unqualified) will be required to carry out these additional assessments/reviews.

Using the current establishment as a baseline, an extra 16 - 24 occupational therapy staff will be required. The forecast increase in the number of Occupational Therapy assessments will also place a greater pressure on the expenditure of equipment to maintain independence, as this provision is not means tested.

Financial Assessments - The Council undertakes 1,500 financial assessments per annum. The impact of the Act is likely to increase this activity to between 3,000 and 3,800 financial assessments per annum.
To cope with this additional activity, an increase in the financial assessment workforce will be required to carry out these additional assessments/reviews. Using the current establishment as a baseline, an extra 17 - 26 financial assessment staff will be required.

Carers - The Act sets out a duty to support informal carers. Carers in Bedfordshire currently support over 3000 carers. Of these 1,500 are known to the Council through assessment and other support. However, the 2011 Census indicates that over 25,800 people classed themselves as carers. The resources required to support the assessment of this numbers of carers is not yet quantifiable**.**

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Care Act will have an impact across all health and social care providers. The reforms will introduce new demands on existing IT systems for managing case records. The existing IT system

(SWIFT) will need substantial consideration and investment to ensure it is fit for purpose post April 2015 and is able to support on-line options for self assessment; personal accounts as well as electronic methods of data transfer of care information between agencies and other authorities.

Currently the Council is the sole commissioner and main provider of assessments and reviews, however due to the increased requirements new models of providing these service will need to be considered, including different providers.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A clause by clause analysis of the Care Act was undertaken to fully understand the requirement and identify the strategic implications for services. This work identified a number of workstreams and these form the Programme Management structure for implementation.

In addition, implementing the information system changes/ upgrades required by the Care Act will be complex. Key priority areas for the Council include ensuring that current IT systems for client records are upgraded to meet requirements of the Care Act within the timescale for implementing the Act. Other wider changes include information systems that could support new duties, for example consideration of the case for online assessment for self-funders.

The impact on Carers and evidence on supporting the Health Economy is substantial. Effective Carers services can help to reduce avoidable and emergency admissions. It can help to facilitate reduced length of stay through effective Carer engagement and support.

The important variable is estimating the numbers of self funders and carers that will present for an assessment of their needs . Initial modelling work is ongoing to better understand the full impact of the Care Act and the cost of additional burdens. Consequently, it is not possible to quantify the level of resource that be underpinning the delivery of the Care

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

It is not possible at this stage to determine with certainty what the costs and funding implications are for the Care Act (2014). The Council is working with partners regionally and nationally to further refine these costs.

However, the Better Care Fund has allowed for an allocation of £0.100m in 2014/15 and £0.554m in 2015/16 to support the implementation of the Act.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reducing emergency admission
- Reducing delayed transfer of Care
- Support for Carers - to enable them continue their caring role, remaining healthy and promoting their independence. The relates to all carers across the social care client groups: Older people; with learning disability; mental health, parent carers and young carers.
- Person centred and flexible support based on assessment of carer needs
- Timely access to Information and advice
- Improved Health and well Being support for Carers
- Promoting independence and opportunities for Carers
- Support to stay in employment

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A Programme Management Approach is being which will monitor the progress of the workstreams and towards implementation of key requirements of the Care Bill. As a key scheme within the BCF this will report progress through the integrated governance and ultimately the Health and Wellbeing Board. This will ensure feedback about what is working and not working will be highlighted or escalated to the appropriate level.

What are the key success factors for implementation of this scheme?

Key success factors will be:

- A strong Programme Management approach
- Capacity and capability of staff to deliver requirements
- Well developed modelling of the impacts

ANNEX 1 – Detailed Scheme Description

Scheme 6 – Implementing the Better Care Plan and wider integration agenda in Central Bedfordshire

Scheme ref no.
6
Scheme name
Implementing the Better Care Plan and wider integration agenda in Central Bedfordshire
What is the strategic objective of this scheme?
This scheme will ensure that a robust framework for delivering the Better Care Plan is established. These aspects will provide the enablers to ensure that the others schemes can be successfully delivered.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The following workstreams will form part of this overarching scheme: **1. Governance (Programme, Organisational, Clinical and Social Care)** Responsible for managing the operational structure required to support the implementation of BCF. Senior executives from all participating organisations will be engaged at the appropriate level. **2. Communications & Engagement** This will co-ordinate activity across teams and participating organisations to ensure that public, patients, staff and providers understand the change, can input into the change, understand what this means for them personally. This will ensure that the Communication and engagement plan developed is delivered appropriately to all audiences. **3. Finance & Performance** This workstream will ensure the creation and monitoring of the pooled budget, explore and identify new funding solutions that facilitate integrated working. It will also ensure that performance against the requirements is monitored and interact with relevant projects to ensure action is taken to bring performance in line. **4. Information Governance (IG)/Sharing and IT Systems** This workstream will identify, evaluate and agree how patient information will be shared. It will ensure NHS Number is used as the primary identifier across all agencies and systems. It will ensure that an Information Governance model for the BCF is agreed and signed off. It will identify what IT solutions are required to facilitated health and social care teams working together and co-ordinate funding to enable this. Luton and Bedfordshire have been successful in

reaching the next round in a bid for funding to develop an integrated portal for sharing health and social care integration from the Integrated Digital Care Record Fund (IDCR).

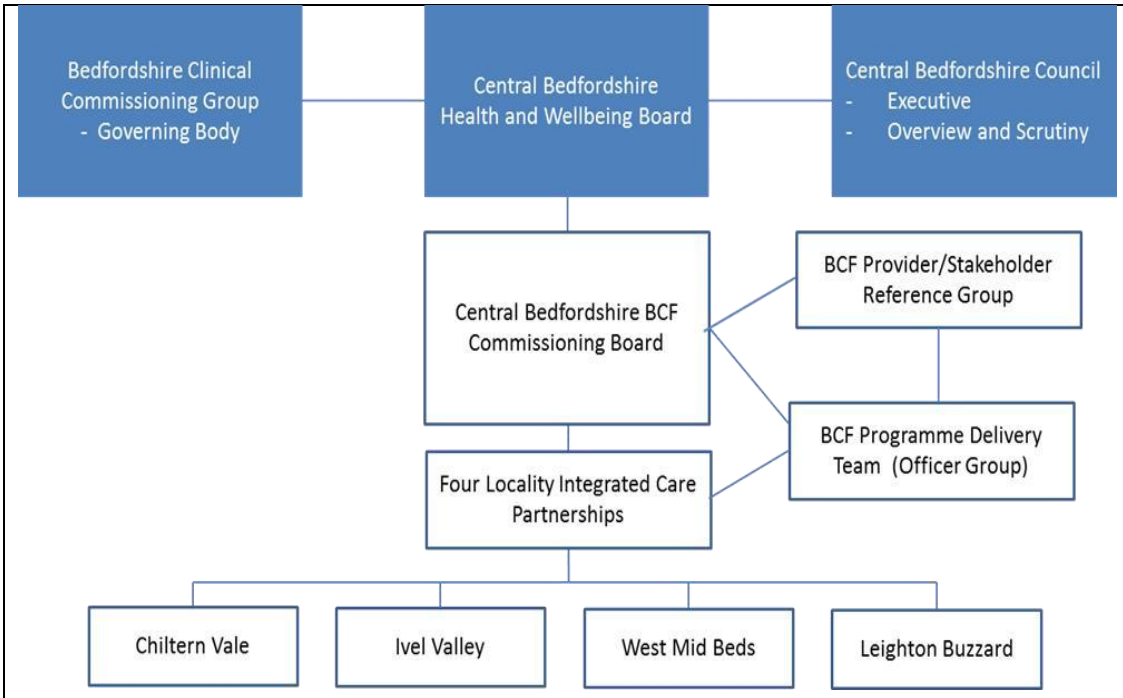
5. Workforce and Training (Including 24/7 working)
This workstream will review and develop an understanding of the workforce required to deliver the BCF. It will map current roles and tasks, explore new roles. It will ensure required support is gained from key learning organisations to develop the training requirements to support the new workforce structures

6. Design & Implementation
This workstream embraces thinking from patients, health and social care colleagues in order to design aspects of what the integrated care model should look like and how it should operate. This will develop creative and integrated solutions to deliver projects. This workstream will ensure there is efficient and considered implementation of projects and concept designs in a phased approach. This will ensure standardised approaches across the area and that key learnings are shared.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The BCF plan and overall integration programme for Central Bedfordshire will be overseen by the Health and Wellbeing Board. A Chief Officer Group has been established to commission for integrated care (the BCF Commissioning Board). A Delivery Programme Group comprising locality leads has been set up and is working closely with locality colleagues to set up the planned four locality Integrated Care Partnerships.

The HWB membership includes the executive member for Health, Social Care and Housing and the Chief Officers of the CCG and Council. The BCF Commissioning Board will have oversight of finance and performance and will report to the Health and Wellbeing Board. The performance framework will align equally to the Council and CCG performance monitoring processes. A programme management approach is being adopted. Local integrated partnerships will be established across Central Bedfordshire's four localities.



Our emphasis in devising these arrangements will be to mainstream BCF governance to the greatest extent possible in order to achieve the maximum alignment of the programmes involved into existing change programmes. The BCF governance arrangements will link into an Integrated Care Partnership.

Management responsibility for the delivery of integrated health and social care services lies with the Director of Social Care, Health and Housing and the Chief Operating Officer for Bedfordshire Clinical Commissioning Group.

The evidence base
Please reference the evidence base which you have drawn on

The Better Care Fund Plan is based on a substantial amount of previous partnership working in Central Bedfordshire to develop a shared approach to integration, including the Community Beds review, Joint Health and Well Being Strategy, the Joint Strategic Approach to Prevention and Early Intervention and the Integrated Pioneer Bid. Plans and governance are also aligned to be fit for the future of the current Review of Health Services in Bedfordshire and Milton Keynes, with matching priorities and schemes and evidence from the Case for change document being crucial to the development of this programme.

The development of the locality model of programme delivery and governance is based on evidence of a robust history of GP Consortium working across the 4 key localities in Central Bedfordshire. There is a strong framework in place and successful existing locality focus and alignment of health and social care services and team across Central Bedfordshire.

A shared vision for integration has been developed, based on good practice and evidence based in Torbay and the National Voices work.

The following key national evidence base have shaped the development of the framework for

the Better Care Fund Plan:

- National Voices- Evidence and experiences of users of health and care have been essential to guide and develop a joint definition.
- Kings Fund – Evidence and lessons learnt from 'Transforming Health and Social Care Services' and 'Making integrated care happen at scale and pace' have been key to developing the local model.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

It is not possible at this stage to determine with certainty the costs of implementing the Better Care Plan. Resources have been identified to support the implementation of the BCFP, as detailed below:-

Investment Name	FYE
Programme Manager	£ 150,000
Financial/Analytical support	£ 25,000
Project Managers	£ 200,000
Locality BCF project support	£ 50,000

In total an amount of £0.529m revenue funding has been set aside in 2014/15 and an amount of £0.482m of capital funding in 2015/16 to support ICT system and data sharing investment.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The impact of the scheme is difficult to quantify in terms of reduced activity or savings; this is due to this consisting of enabling aspects towards integrated working.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The BCF metrics, including the local metric, will be used to measure the outcomes of the schemes identified within the plan, together with any metrics identified within specific schemes.

Where possible, these metrics will be broken down to the four locality areas identified within Central Bedfordshire to understand the impact within each community.

Where possible, existing data sources will be used to populate the metrics. Where data is not available, consideration will be given to other proxy measures and new data collection process, if appropriate.

The resulting performance framework will be monitored at least monthly, where data releases

allow, and will be reported to Locality meetings, through to the Health and Wellbeing Board.

Clear terms of reference have been developed for all the groups within the governance structure outlining accountabilities and monitoring of the overall plan and schemes. This will ensure feedback about what is working and not working will be highlighted or escalated to the appropriate level.

What are the key success factors for implementation of this scheme?

The key success factors will be:

- A strong Programme Management approach
- Capacity and capability of staff to deliver requirements
- Strong partnership working across organisations
- Strong financial management and oversight of pooled budget
- Clear communication and engagement with all stakeholders
- Shared Patient Record with real-time information across multiple agencies to support integrated joined up care